

Psychological First Aid

Second Edition



Field Operations Guide for Nursing Homes



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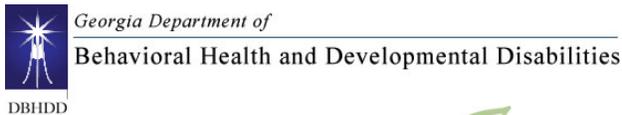
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If you use these guidelines to provide assistance to nursing home residents, please notify Lisa M. Brown at lbrown@fmhi.usf.edu. Any recommendations for improving the guide are appreciated.

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Introduction to the Psychological First Aid Field Operations Guide for Nursing Homes, 2nd Edition

Terrorist activities, natural disasters, and technological catastrophes seem to be occurring with increasing frequency. Data reported by the World Health Organization reveals that on average, a disaster occurs every day somewhere in the world. Fortunately, there is also a growing awareness by agencies and organizations involved with disaster preparedness and response of the importance of appropriate mental health intervention for disaster affected populations.

Because nursing home residents usually do not stay in public shelters and are evacuated to other facilities where they can receive needed skilled nursing care, residents typically do not interact with responders and relief workers who provide Psychological First Aid. To address this gap in care, the *Psychological First Aid Field Operations Guide for Nursing Homes* was developed for nursing home staff to use with residents. The 2nd edition of the guide, like the 1st edition, reflects a multidisciplinary approach to care. The changes made to the 2nd edition of the *Psychological First Aid Field Operations Guide for Nursing Homes* broaden the scope of how, when, and where the intervention should be applied.

Based on consultation with experts in disaster planning and response, nursing homes, mental health, and aging, three new sections have been added to the 2nd edition: palliative care and end-of-life issues; behavioral interventions for people with dementia; and use of Psychological First Aid to help older adults deal with significant life changes, events, or losses. Experiencing a disaster or traumatic event may be especially difficult for residents with compromised coping abilities due to cognitive impairment, end-of-life issues, and loss and change. Residents who are likely to have a more favorable outcome are those who receive timely support and appropriate resources.

The recent threat of an H1N1 pandemic highlighted the need for information on palliative care and end-of-life issues. Moreover, large numbers of people may require comfort care and help with end-of-life care if exposed to radiation poisoning, biological agents, weapons of mass destruction, or pandemic illness. In the years since the publication of the 1st edition, there have been numerous requests for an additional section that describes behavioral interventions to use with residents who are cognitively impaired. It is estimated that 50% to 70% of nursing home residents have some type of cognitive impairment, including dementia. To meet the needs of staff who provide care to people with dementia, content that highlights considerations and interventions for people with mild, moderate, or severe cognitive impairment have been added to the 2nd edition.

In addition to high profile disasters covered by the media, people of all ages experience a variety of personal traumas, losses, and changes that can result in significant emotional distress and sometimes escalate to a state of crisis. Death of a loved one or friend, accidents, suicide, violence, and illness are a few examples of the types of traumatic events that commonly occur over the lifespan. In recognition that personal emergencies happen with relative frequency, the core components presented in the 1st edition of the guide have been expanded and adapted to encompass these individual life events and to encourage staff to use Psychological First Aid to assist people who are in need of this support, regardless of the magnitude or nature of the cause.

Staff who believe that Psychological First Aid techniques are solely limited to times of disaster miss important opportunities to enhance resident resilience and to promote adaptive coping and behaviors in those who have experienced personal traumas.

Because nursing home residents typically receive care from a multidisciplinary team comprised of a variety of professions such as nurses, certified nursing assistants, social workers, psychologists, physicians, physical therapists, nutritionists, and pharmacists, Psychological First Aid is an ideal intervention for staff to learn and use with distressed residents and staff.

Psychological First Aid is similar to medical first aid in that anyone, not just licensed mental health clinicians, can be trained to successfully use the techniques. With appropriate training, Psychological First Aid can be used wherever residents and staff are located, by the staff who are on hand to assist with the events as they unfold. Having all nursing home staff trained to use psychological first aid increases the likelihood that appropriate mental health intervention will be provided to those in need.

Psychological First Aid

Field Operations Guide for Nursing Homes

Table of Contents

Acknowledgements.....	1
Introduction.....	3
Table of Contents.....	5
Icons Used in this Manual.....	9
Introduction and Overview	11
What is Psychological First Aid?.....	12
Who is Psychological First Aid for?.....	12
Who delivers Psychological First Aid?.....	13
When should Psychological First Aid be used?.....	13
Where should Psychological First Aid be used?.....	13
Strengths of Psychological First Aid	14
Basic Objectives of Psychological First Aid	14
Delivering Psychological First Aid.....	15
Preparing to Deliver Psychological First Aid	19
Entering the Setting.....	20
Providing Services	20
Group Settings	21
Maintain a Calm Presence	21
Be Sensitive to Culture and Diversity.....	21
Be Aware of At-Risk Populations.....	22
Core Actions	23
Contact and Engagement	24
Safety and Comfort.....	24
Stabilization (if needed).....	24
Information Gathering: Current Needs and Concerns	24
Practical Assistance	24
Connection with Social Supports.....	24
Information on Coping.....	24
Linkage with Collaborative Services	24
Contact and Engagement	26
Ask about Immediate Needs	28
Confidentiality	28
Safety and Comfort.....	29
Ensure Immediate Physical Safety.....	30
Provide Information about Disaster Response Activities and Services.....	31
Attend to Physical Comfort	32
Promote Social Engagement.....	33
Protect From Additional Traumatic Experiences and Trauma Reminders.....	33
Help Residents Who Have a Missing Family Member	34

Help Residents When a Family Member or Close Friend Has Died	35
Attend to Grief and Spiritual Issues.....	37
Attend to Issues Related to Traumatic Grief.....	38
Support Residents Who Receive Death Notification.....	38
Stabilization	41
Stabilize Emotionally Overwhelmed Residents.....	42
Orient Emotionally Overwhelmed Residents	43
The Role of Medications in Stabilization	44
Information Gathering: Needs and Current Concerns	45
Nature and Severity of Experiences during the Disaster	46
Concerns about Immediate Post-Disaster Circumstances and Ongoing Threat	47
Separation From or Concern about the Safety of Loved Ones	47
Physical Illness, Mental Health Conditions, and Need for Medication.....	47
Losses (Family Home, Neighborhood, and Personal Property)	48
Extreme Feelings of Guilt or Shame.....	48
Thoughts about Causing Harm to Self or Others.....	48
Availability of Social Support	49
Prior Alcohol or Drug Use.....	49
Prior Exposure to Trauma and Death of Loved Ones.....	50
Practical Assistance	51
Step 1: Identify the Most Immediate Needs	52
Step 2: Clarify the Need.....	52
Step 3: Discuss an Action Plan	53
Step 4: Act to Address the Need.....	53
Connection with Social Supports.....	54
Enhance Access to Primary Support Persons (Family and Significant Others)	56
Encourage Use of Immediately Available Support Persons	57
Discuss Support-Seeking and Giving	57
Modeling Support	58
Information on Coping.....	61
Provide Basic Information about Stress Reactions.....	62
Review Common Psychological Reactions to Traumatic Experiences and Losses	62
Provide Basic Information on Ways of Coping.....	65
Coping for the Nursing Home Resident.....	66
Teach Simple Relaxation Techniques.....	66
Assist with Anger Management.....	67
Address Highly Negative Emotions (Guilt and Shame).....	67
Help with Sleep Problems.....	68
Address Alcohol and Substance Use	68
Linkage with Collaborative Services.....	71
Provide Direct Link to Additional Needed Services.....	72
Referrals for Older Adults	72
Considerations for Residents with Special Needs	75
Older Adults with Dementia or Cognitive Impairment	77
Older Adults Near the End-Of-Life	79
Older Adults Dealing with Loss, Change, and Traumatic Events	81
Appendix A: Psychological First Aid Resources for Staff and Residents	83
Overview of Psychological First Aid.....	87

Psychological First Aid Provider Care	89
Tips for Nursing Home Staff Assisting Residents with Special Needs	95
Appendix B: Nursing Home Staff Worksheets.....	97
Resident Current Needs	99
Psychological First Aid Components Provided	103
Appendix C: Handouts for Residents	105
Connecting With Others	107
When Terrible Things Happen: What You May Experience.....	109
Tips for Nursing Home Staff and Residents after Disasters.....	111
Nursing Home Staff and Residents: Tips For Relaxation.....	113
Alcohol, Medication, and Drug Use After Disaster.....	115

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Psychological First Aid

Field Operations Guide for Nursing Homes

Icons Used in this Manual

Icons have been used throughout this manual to assist the reader in quickly finding particularly important pieces of information. The icons and their meaning are listed below:

	The Alert icon calls attention to information of particular concern or vital issues in providing Psychological First Aid.
	The Dialog icon gives specific examples of what a psychological first aid provider may choose to say to the recipient of the psychological first aid.
	The Additional Information icon gives reference to other resources that might provide further assistance to the psychological first aid provider.

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Psychological First Aid

Field Operations Guide for Nursing Homes

Introduction and Overview

- What is Psychological First Aid?
- Who is Psychological First Aid for?
- Who delivers Psychological First Aid?
- When should Psychological First Aid be used?
- Where should Psychological First Aid be used?
- Strengths of Psychological First Aid
- Basic objectives of Psychological First Aid
- Delivering Psychological First Aid



FEMA Photo/Leif Skoogfors

What is Psychological First Aid?

Psychological First Aid is an evidence-informed¹ modular approach to help elderly persons and persons with disabilities in nursing homes, other adults, families, adolescents, and children in the immediate aftermath of disasters and acts of terrorism.

Psychological First Aid is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping. Principles and techniques of Psychological First Aid meet four basic standards. They are:

- consistent with research on risk and resilience following trauma,
- applicable and practical in field settings,
- appropriate for developmental levels across the lifespan, and
- culturally informed and delivered in a flexible manner.

Psychological First Aid does not assume that all disaster survivors will develop severe mental health problems or long-term difficulties in recovery. Instead, it is based on an understanding that disaster survivors and others affected by such events will experience a broad range of early reactions (e.g., physical, psychological, behavioral, spiritual). Some of these reactions will cause enough distress to interfere with adaptive coping, and recovery may be helped by support from compassionate and caring nursing home staff who are responsible for resident care during a disaster.

Who is Psychological First Aid for?

Although Psychological First Aid intervention strategies may be used with people of any age who have been exposed to disaster or terrorism, this field operations guide has been tailored to address the specific emotional needs and concerns of older individuals who reside in nursing homes. Nursing homes are unique environments in that they are self-contained communal living facilities that provide health and social services to residents who require this assistance. Nursing home residents, especially the frailest among them, should be considered an at-risk population for developing emotional distress after a disaster. They are at-risk because disasters can compound difficulties associated with the aging process, such as changes that may occur in physical, social, and cognitive functioning. In addition to frail elders, nursing home populations also include residents with serious physical and/or mental illness. These residents may be younger than traditional nursing home residents, but will experience high levels of distress, confusion, and may potentially engage in dangerous or

¹ Psychological First Aid is supported by disaster mental health experts as the "acute intervention of choice" when responding to the psychosocial needs of children, adults, and families affected by disaster and terrorism. At the time of this writing, this model requires systematic empirical support; however, because many of the components have been guided by research, there is consensus among experts that these components provide effective ways to help survivors manage post-disaster distress and adversities, and to identify those who may require additional services.

disruptive behaviors as a result. Although this manual does not directly address the specific needs of residents with severe and persistent mental illness, it is important for nursing home staff to be responsive to this segment of the general nursing home population and to provide them with the same levels of adequate support and Psychological First Aid intervention as their fellow residents.

Who delivers Psychological First Aid?

Psychological First Aid was originally intended for delivery by mental health and other disaster response workers as part of organized disaster response efforts for affected communities. These providers may be imbedded in a variety of response units, including first responder teams, Incident Command Systems (ICS), primary and emergency health care, faith-based organizations, Community Emergency Response Teams (CERT), Medical Reserve Corps, the Citizens Corps, and other disaster relief organizations. Psychological First Aid was always intended for delivery in diverse settings, including general population shelters, special needs shelters, field hospitals and medical triage areas, acute care facilities (e.g., emergency departments), feeding locations, disaster assistance service centers, and other community settings.

So that the *Psychological First Aid Field Operation Guide* would be suitable for nurses, certified nurse aides, social workers, and other direct care staff to use with nursing home residents, the content of the original guide has been adapted. This adapted version assumes that nursing home staff:

- have had prior contact or possess knowledge of the disaster-affected residents,
- have existing formal or informal work relationships with other members of the disaster response team, and
- have regulations that the nursing home must recognize and adhere to during the disaster response and recovery process.

When should Psychological First Aid be used?

Psychological First Aid is a supportive intervention that was originally developed for use in the immediate aftermath of disasters and acts of terrorism. Because nursing home staff have an ongoing relationship with residents and are responsible for providing care at all phases of a disaster, the *Psychological First Aid for Nursing Homes Field Operations Guide* has been modified so that it is possible to use appropriate core components before (i.e., evacuation), during (i.e., sheltering in place), and after (i.e., during the recovery phase) a disaster. For example, if evacuation takes place prior to a hurricane, it might be desirable to use techniques developed to stabilize and orient overwhelmed residents during this early phase of the disaster.

Where should Psychological First Aid be used?

The *Psychological First Aid Field Operation Guide for Nursing Homes* is designed for nursing home staff who will be providing Psychological First Aid to older adult nursing

home residents. It has been developed so that it is appropriate for use with residents who have:

- sheltered in place during a disaster (i.e., hurricane),
- evacuated to a host facility or community shelter prior to an impending event (i.e., a forecasted hurricane or threatening wild fire),
- evacuated after a disaster because of damage to their home facility (i.e., tornado, hurricane, flood), or
- evacuated during or after an unpredicted disaster or act of terrorism where no advance warning was given (i.e., local human caused or natural disaster) to a host facility or community shelter.

Psychological First Aid can be used with residents in any physical setting. Although residents evacuated prior to an event are not directly exposed to the disaster, they may still experience significant trauma from relocation activities. Transfer trauma or relocation stress is common when people are moved from one facility to another during non-disaster conditions (i.e., home to nursing home, hospital to nursing home, etc.).

Because it is unknown how evacuation may be similar to or different from transfer from a facility, we recommend that residents who are distressed during an evacuation be treated with the appropriate core components of Psychological First Aid.



It may be desirable and beneficial to use relevant techniques while residents are being transported to reduce their distress and enhance coping. Thus, it is not necessary to wait and use Psychological First Aid upon arrival at the host facility.

Strengths of Psychological First Aid

- Psychological First Aid includes basic information-gathering techniques to help nursing home staff make a rapid assessment of residents' immediate concerns and needs, and to implement supportive activities in a flexible manner.
- Psychological First Aid relies on field-tested, evidence-informed strategies that can be provided in a variety of disaster settings.
- Psychological First Aid emphasizes developmentally and culturally appropriate interventions for survivors of various ages and backgrounds.
- Psychological First Aid includes handouts that provide important information for survivors for their use over the course of recovery.

Basic Objectives of Psychological First Aid

- Establish a human connection in a non-intrusive, compassionate manner.
- Calm and orient emotionally overwhelmed or distraught residents.
- Provide physical and emotional comfort.
- Enhance immediate and ongoing safety.

- Help residents tell you specifically what their immediate needs and concerns are, and gather additional information as appropriate.
- Offer practical assistance and information to help residents address their immediate needs and concerns.
- Connect residents as soon as possible to social support networks that could include other residents, family members, friends, volunteers and community organizations (such as Rotary, Kiwanis, etc.), and spiritual support.
- Support adaptive coping, acknowledge coping efforts and strengths, and empower residents; encourage residents to take an active role in their recovery.
- Provide information that may help residents cope effectively with the psychological impact of disasters.

Delivering Psychological First Aid

Professional Behavior

- Operate only within the framework of your facility and the authorized disaster response system.
- Model healthy responses; be calm, courteous, organized, and helpful.
- Be visible and available.
- Maintain confidentiality as appropriate.
- Remain within the scope of your expertise and your designated role.
- Make appropriate referrals when additional expertise is needed or requested by the resident.
- Be knowledgeable and sensitive to issues of culture and diversity.
- Pay attention to your own emotional and physical reactions, and practice self-care.
- Be knowledgeable regarding residents' present cognitive status and do not overwhelm them with information.

Guidelines for Delivering Psychological First Aid

- Older adults/frail elders have strengths, as well as vulnerabilities. Many older adults/frail elders have acquired effective coping skills over a lifetime of dealing with adversities. These coping skills should be identified and reinforced.
- Politely observe first; don't intrude. Then ask simple respectful questions to determine how you may help.
- Often, the best way to make contact is to provide practical assistance (food, water, blankets).
- Initiate contact only after you have observed the situation and the resident and have determined that contact is not likely to be intrusive or disruptive.
- Be prepared for residents who may either avoid you or demand excessive attention.
- Interact face-to-face with the resident and do not have gum or other food in your mouth.
- Speak calmly. Be patient, responsive, and sensitive.
- Speak slowly, in simple concrete terms; don't use acronyms or jargon.
- Speak clearly and in a low pitched voice to those who may have a hearing difficulty.

- Have a communication plan in place for residents who are not fluent in English. Consider using written materials available in their preferred language, or coordinate the use of an interpreter. Determine in advance what the resources will be for these residents.
- When communicating through a translator or interpreter, look at and talk directly with the person you are addressing, not at the translator or interpreter.
- Check to see if the resident uses any communication devices such as hearing aids, eyeglasses, or communication boards.
- If residents want to talk, be prepared to listen. When you listen, focus on hearing what they want to tell you and how you can be of help.
- Acknowledge the positive features of what the resident has done to cope or keep safe.
- Give information that directly addresses the resident’s immediate goals and clarify answers repeatedly as needed.
- Give information that is age-appropriate, accurate, and targeted to the cognitive level of the recipient.
- Many older adults/frail elders have significant experience helping others and some may be enlisted to assist others who are experiencing emotional distress.
- Be clear about your availability and (when appropriate) link the resident to other nursing home staff, the disaster response team or to local recovery systems, mental health services, public-sector services, and relief organizations.
- Remember that the goal of Psychological First Aid is to reduce distress, assist with current needs, and promote adaptive functioning, not to elicit details of traumatic experiences and losses.

Some Behaviors to Avoid

- Do not make assumptions about what residents are experiencing or what they have been through.
- Do not assume that everyone exposed to a disaster will be traumatized.
- Do not pathologize. Most acute reactions are understandable and can be expected given what people exposed to the disaster have experienced. Do not label reactions as “symptoms” or speak in terms of “diagnoses,” “conditions,” “pathologies,” or “disorders.”
- Do not talk down to or patronize the resident, or focus on his/her helplessness, weaknesses, mistakes, or disability. Focus instead on what the person has done that is effective or may have contributed to helping others in need, both during the disaster and in the present setting. Refer to the individualized care plan to frame your interaction with the resident.
- Do not assume that all residents want to talk or need to talk to you. Often, being physically present in a supportive and calm way helps affected people feel safer and more able to cope.
- Do not “debrief” by asking for details of what happened.
- Do not speculate or offer possibly inaccurate information. If you cannot answer a resident’s question, acknowledge this and do your best to learn the facts.
- Do not make assumptions based only on physical appearance or age, for example, that a confused older adult/frail elder has irreversible problems with memory, reasoning, or judgment. Reasons for apparent confusion may include disaster-related disorientation due to change in surroundings and disruption of normal routines, poor vision or hearing, poor nutrition or dehydration, sleep deprivation, a medical condition or problems with medications, a sense of isolation, and feeling helpless or vulnerable. It is important to

report new or emerging symptoms of increased confusion to your supervisor. If the residents' behavior is markedly different from what is typically normal for them, an urgent evaluation may be needed to rule out an acute medical condition.

- An older adult/frail elder with a mental health disorder may be more upset or confused in unfamiliar surroundings. If you identify such an individual, help to make arrangements for a mental health consultation or referral.
- If you detect a change in cognitive status during the disaster or in the present setting, have the resident evaluated for delirium or other possible conditions that affect mental status.

Working with Older Adults with Disabilities

- When needed, try to provide assistance in an area with little noise or other stimulation, maintaining confidentiality to the extent possible.
- Address the person directly, rather than the caretaker, unless direct communication is not possible.
- If communication (hearing, memory, speech) seems impaired, speak simply, clearly and slowly. Make sure hearing aids and devices are used if needed and available.
- Take the word of a person who claims to have a disability even if the disability is not obvious or familiar to you.
- Ask, "What can I do to help?" when you are unsure of how to help.
- When possible, encourage the person to be self-sufficient.
- Offer a blind or visually impaired person your arm to help him/her move about in unfamiliar surroundings.
- Determine the person's assistance needs relative to their current functional ability.
- If needed, offer to write down information and make arrangements for the person to receive written announcements.
- Keep essential aids (such as medications, oxygen tank, respiratory equipment, hearing aids, eyeglasses, mobility aids, or wheelchair) with the person.

Working with Older Adults with Dementia or Cognitive Impairment

- Communicate reassurance using a calm, clear voice. Address the person by name.
- Limit distractions as much as possible when providing assistance.
- Provide reality orientation or validation as needed.
- Attend to the environment; if it appears environmental factors are contributing to agitations or problem behaviors, move the person to a quieter, less stimulating location if possible.
- Use familiar items such as family photo albums or other keepsakes to help distract, orient, and comfort the person; try to ensure these items remain available to the person and are not lost.
- Try using familiar music and activities to calm and distract the person; avoid overstimulation.
- Maintain the person's daily routine (sleep/wake cycle, mealtimes, activity/rest periods) as much as possible.
- Avoid television or radio reports that continually replay the event or are anxiety producing.

Working with Older Adults Near the End-of-Life

- Try to ensure someone is with the person if they prefer not to be left alone; assure them someone will be there to ease worry and distress.
- Provide physical contact, such as holding their hand.
- Allow them to express their feelings regarding terminal illness and through life review.
- Assure person advance directives will be honored.
- Offer emotional and spiritual support as desired by the person; be responsive to changing needs and adjust provision of support accordingly. Facilitate rituals and/or meaningful interventions according to the person's wishes.
- Attend to the environment; if environmental factors are contributing to distress, try to modify so that the person feels a greater sense of calmness and security.
- Offer to move the person to a private, quiet location where their status can be monitored; recognize some people will not prefer this as it may increase their sense of isolation.
- Continue to treat the person with dignity and ensure they do not feel their value is diminished by their proximity to death.
- Ensure continuity in symptom management, including medications for pain and other symptoms.
- Facilitate connections with family and friends as desired, both in person and at a distance, to reduce worry and strengthen support; alternatives may be needed to maintain communication when usual interaction patterns are disrupted.
- Have a viable plan for coordination with outside palliative and hospice care providers as needed under both usual and extra-ordinary circumstances.

Working with Older Adults Dealing with Loss, Change, and Traumatic Events

- Empathize; people need to know their reactions are normal and understandable.
- Offer comfort that meets the person's needs; ask what would help and provide support accordingly to the extent possible.
- Validate the person's emotional response even if there is a need to subsequently follow-up on a reaction that was not appropriate (e.g. aggression towards others).
- Be present for the person; ensure they have your undivided attention and let them know you are there to provide support.
- Avoid minimizing the person's feelings about the experience or offering suggestions or examples as to how it could be worse.
- Recognize that the person may be overwhelmed by an experience if they are already dealing with other changes or losses; be alert to such possibilities and augment support accordingly.

Psychological First Aid

Field Operations Guide for Nursing Homes

Preparing to Deliver Psychological First Aid

- Entering the setting
- Providing services
- Group settings
- Maintain a calm presence
- Be sensitive to culture and diversity
- Be aware of at-risk populations



FEMA Photo/Leif Skoogfors

Preparing to Deliver Psychological First Aid

In order to be of assistance to disaster-affected residents, you must be knowledgeable about the nature of the event, current circumstances, and the type and availability of relief and support services.

Planning and preparation are important when working as part of a disaster response team. Up-to-date training in Psychological First Aid and knowledge of your facility's Incident Command Structure (ICS) are critical components in undertaking disaster response work. Before a disaster occurs, you should consider your current health needs, your family circumstances, and be prepared to engage in appropriate self-care.



See Appendix A for more guidance in regard to these topics.

Entering the Setting

Historically, disaster responders and relief workers have been trained to deliver Psychological First Aid to affected populations after a disaster. However, given the potential benefits of Psychological First Aid, staff should be encouraged to use appropriate techniques to assist people who are in need of this support, regardless of the magnitude, stage, or nature of the event. For example, for facilities who evacuate it may be appropriate to use Psychological First Aid to help residents manage stress and to enhance coping while in transit.

Successful disaster response involves working within the framework of the setting's ICS and leadership and decision-making roles that have been defined to operate during disasters. It is essential to establish communication and coordinate all activities with authorized personnel or organizations that are managing the setting. For evacuating facilities, effective response also includes learning as much as you can about the host facility or temporary shelter (e.g., leadership, organization, policies and procedures, security, available support services). You need to have accurate information about what is going to happen, what services are available, and where they can be found. This information should be provided by your facility administrator and management as it becomes known. Providing timely, accurate information is often critical to reducing resident distress and promoting adapting coping.

Providing Services

In some settings, Psychological First Aid may be provided in designated areas. In other settings, nursing home staff may circulate around the facility to identify those who might need assistance. Focus your attention on how people are reacting and interacting in the setting. Residents who may need assistance include those showing signs of acute distress. Watch for residents who are:

- disoriented;
- confused;
- suspicious;
- frantic or agitated;
- panicky;
- extremely withdrawn, apathetic, or “shut down”;
- extremely irritable;
- exceedingly worried;
- focused on somatic concerns; or
- screaming, yelling, or pacing.

Group Settings

Many components of Psychological First Aid can be used in group settings, such as when residents gather together for information about the recovery process and for security briefings. The components of providing information, support, comfort, and safety can be applied to planned group situations as well as spontaneous gatherings.

When meeting with groups, keep the following in mind:

- Tailor the discussion to the groups’ shared needs and concerns.
- Focus the discussion on problem-solving and applying coping strategies to immediate issues.
- Do not let discussion about concerns lapse into complaints.
- If a resident needs further support, offer to meet with him/her after the group discussion.

Maintain a Calm Presence

People take their cue from how others are reacting. By demonstrating calmness and clear thinking, you can help residents feel they can rely on you. Others may follow your lead in remaining focused, even if they do not feel calm, safe, effective, or hopeful. Model the sense of hope that residents cannot always feel while they are still attempting to deal with what has happened and their current pressing concerns.

Be Sensitive to Culture and Diversity

Nursing home staff should show the same consideration and respect to residents in their care regarding culture and diversity as in non-disaster periods. Therefore, staff who provide Psychological First Aid must be sensitive to cultural, ethnic, religious, racial, and language diversity. You should be aware of your own values and prejudices, and how these may agree with or differ from those of the residents being served. Training in cultural competence can facilitate this awareness. Maintaining or reestablishing customs, traditions, rituals, religious beliefs, gender roles, and social bonds is important in helping residents cope with the impact of a disaster. Information about the residents, including how they typically express emotions and other psychological reactions and their receptivity to counseling, should be understood

by facility staff. When appropriate, community-based cultural or religious leaders may be able to contribute to this understanding.

Be Aware of At-Risk Populations

When providing Psychological First Aid, nursing home staff need to be aware of special circumstances that make residents more susceptible to developing emotional distress after a disaster, including:

- impaired functional capacity in the normal activities of daily living (i.e., bathing and grooming) or in the instrumental activities of daily living (i.e., using the telephone);
- physical disability, illness, or sensory deficit (i.e., residents may require assistance with hearing aids, dentures, eyeglasses);
- memory and cognitive loss or various forms of dementia, including Alzheimer’s disease;
- serious mental illness (i.e., schizophrenia, bipolar disorder);
- near the end-of-life or in circumstances where death is imminent;
- multiple evacuations and displacements, sometimes resulting in “transfer trauma”;
- injuries or worsening of medical conditions due to the disaster;
- low literacy level or non-English speaking;
- significant loss of possessions (e.g., memorabilia and photos) due to the disaster;
- disruptions in staffing due to the disaster;
- previous exposure to grotesque scenes or extreme life threat;
- type of residents (i.e., pediatric residents) and units (i.e., specialized units for the mentally ill); and
- specialized needs (i.e., ventilator or dialysis care) that may enhance fears associated with the threat of interrupted services as a result of the disaster.

Nursing home staff should be sensitive to the fact that residents may have potentially experienced a number of distressing situations both before and after entering the nursing home, such as the loss of a spouse, isolation, feelings of abandonment by family and friends, a significant medical event, loss of home and sense of independence, and the loss of meaningful roles in society. As a consequence, nursing home residents may be at greater risk for developing problems following a disaster. Mistrust, stigma associated with mental health, personal pride, a sense of independence, and lack of knowledge about disaster mental health services are important barriers to consider when offering or providing services to residents. Those living in disaster-prone regions are more likely to have had prior disaster experiences.

In many instances, nursing home staff involved in response activities are also disaster survivors. They may be very distressed from the disaster due to concerns for their own homes and families while they continue to work and care for residents. They, too, may have felt their lives were in danger or witnessed horrific scenes. Their workloads and hours of work may increase dramatically because other employees are unable to work due to the disaster. Some workers may have lost their homes to the disaster and are now living in temporary quarters. As a result, they may be eating poorly or not sleeping well. These circumstances can quickly lead to what is commonly referred to as compassion fatigue. Compassion fatigue results when people become emotionally overcome from providing care to others and experience a gradual loss of sympathy for the suffering of others. Therefore, nursing home staff should be attuned to signs of distress in other staff members while they are trying to assist the residents.

Psychological First Aid

Field Operations Guide for Nursing Homes

Core Actions

- Contact and engagement
- Safety and comfort
- Stabilization
- Information gathering: Current needs and concerns
- Practical assistance
- Connection with social supports
- Information on coping
- Linkage with collaborative services



FEMA Photo/Michael Raphael

Contact and Engagement

Goal: To respond to contacts initiated by residents, or to initiate contacts in a non-intrusive, compassionate, and helpful manner.

Safety and Comfort

Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfort.

Stabilization (if needed)

Goal: To calm and orient emotionally overwhelmed or disoriented residents.

Information Gathering: Current Needs and Concerns

Goal: To identify immediate needs and concerns, gather additional information, and tailor Psychological First Aid interventions for use with residents.

Practical Assistance

Goal: To offer practical help to residents in addressing immediate needs and concerns.

Connection with Social Supports

Goal: To help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, spiritual supports, and community helping resources.

Information on Coping

Goal: To provide information about stress reactions and coping skills to reduce distress and promote adaptive functioning.

Linkage with Collaborative Services

Goal: To link residents with available, needed services.



These core actions of Psychological First Aid constitute the basic objectives of providing early assistance during or within hours, days or weeks following an event. Nursing home staff should be flexible and base the amount of time they spend on each core action on the residents' specific needs and concerns while also taking into account the collective needs of all facility residents.

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Psychological First Aid

Field Operations Guide for Nursing Homes

Contact and Engagement

- Ask about immediate needs
- Confidentiality



FEMA Photo/Patsy Lynch

Contact and Engagement

Goal: To respond to contacts initiated by residents, or to initiate contacts in a non-intrusive, compassionate, culturally appropriate, and helpful manner.

Your interaction with residents is important. If managed in a respectful and compassionate way, you can establish an effective helping relationship and increase the person's receptiveness to further help. If you are already familiar with the resident, build on your existing relationship and tie your previous knowledge of the person into your interaction. Your first priority should be to respond to residents who seek you out. If a number of residents approach you simultaneously, make contact with as many of them as you can. Even a brief look of interest and calm concern can be grounding and helpful to people who are feeling overwhelmed or confused.



The type of physical or personal contact considered appropriate may vary from person to person and across cultures and social groups (e.g., how close to stand to someone, how much eye contact to make or whether or not to touch someone, especially someone of the opposite sex). Unless you are familiar with the resident, you should seek guidance about cultural norms from your colleagues who know the resident.

Some residents may not seek your help, but may benefit from assistance. When you identify such persons, timing is important. Do not interrupt conversations. Do not assume that people will respond to your outreach with immediate positive reactions. It may take time for some residents or bereaved persons to feel some degree of safety, confidence, and trust.

Ask about Immediate Needs

Ask the resident if they would like to share their feelings and concerns with you, and explain that you would like to help. Invite the resident to sit, try to ensure some level of privacy for the conversation, and give the person your full attention. Speak softly and calmly. Refrain from looking around or being distracted. Find out whether there is any pressing problem that needs immediate attention. Immediate medical concerns have the utmost priority.

Confidentiality

Protecting the confidentiality of your interactions with residents after a disaster can be challenging, especially given the lack of privacy in some post-disaster settings. However, maintaining the highest level of confidentiality possible in any conversation you have with residents and other disaster responders is extremely important. If you are a professional who has mandatory reporting requirements, you must abide by state abuse and neglect reporting laws. You should also be aware of the Health Insurance Portability and Accountability Act (HIPAA) and the provisions related to disaster and terrorism. If you have questions about releasing information, discuss this with a supervisor or an official in charge. Talking to coworkers about the challenges of working in the post-disaster environment can be helpful, but any discussions organized for this purpose also need to preserve strict confidentiality.

Psychological First Aid

Field Operations Guide for Nursing Homes

Safety and Comfort

- Ensure immediate physical safety
- Provide information about response activities and services
- Attend to physical comfort
- Promote social engagement
- Protect from additional traumatic experiences and trauma reminders
- Help residents who have a missing family member
- Help residents when a family member or close friend has died
- Attend to grief and spiritual issues
- Attend to issues related to traumatic grief
- Support residents who receive death notification



FEMA Photo/Jocelyn Augustino

Safety and Comfort

Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfort.

Restoration of a sense of safety is an important goal in the immediate aftermath of disaster and terrorism. Promoting safety and comfort can reduce distress and worry. Assisting residents in circumstances of missing loved ones, death of loved ones, and death notification is a critical component of providing emotional comfort and support.

Comfort and safety can be supported in a number of ways, including helping residents:

- do things that are active (rather than passive waiting), practical (using available resources), and familiar (drawing on past experience);
- stay calm;
- get current, accurate and up-to-date information, while avoiding exposure to information that is inaccurate or excessively upsetting;
- get connected with available practical resources;
- get information about how public officials and disaster responders are making the situation safer for the residents under your care;
- get connected with others who have shared similar experiences; and
- become familiar with the facility's disaster plan.

Ensure Immediate Physical Safety

Make sure that nursing home residents are physically safe to the extent possible. If necessary, reorganize the immediate environment to increase physical and emotional safety. For example:

- Find appropriate officials who can resolve safety concerns that are beyond your control, such as interruptions or changes in services, medications or staffing.
- Determine if evacuating to another facility is being considered due to damage to the nursing home.
- Remove broken glass, sharp objects, furniture, spilled liquids, and other objects that could cause people to trip and fall.

Promote safety and comfort for nursing home residents. For example:

- Help make the physical environment safer (e.g., try to ensure adequate lighting, protect against slipping and falling).
- Ask specifically about the need for eyeglasses, hearing aids, wheelchairs, dentures, walkers, canes, or other devices. Try to ensure that all essential aids are kept with the person. If necessary, speak to other direct care staff to secure any aids the resident has identified as missing or needed.
- Ask whether the resident has experienced difficulty with health-related issues or in performing daily life activities (e.g., assistance with dressing, use of bathroom, daily

grooming, feeding) that they were able to perform prior to the disaster. Ask if they need additional help from nursing home staff.

- Monitor residents whose needs may require frequent checks.
- Setup a regular schedule for mealtimes, activities, and sleep.

Consult with other nursing home staff to further ensure safety, nutrition, medication, and rest. Make sure that the authorities and other organizations involved in the relief effort are aware of any daily needs such as water and food that are not being met.

Contact appropriate facility personnel or other medical professionals immediately if there are medical concerns requiring urgent attention or immediate need for medication. Remain with residents who are in acute crises or find someone to stay with them until you obtain help.

Other safety concerns involve:

- Threat of harm to self or others: Look for signs that residents may hurt themselves or others (e.g., the person expresses intense anger towards self or others, exhibits extreme agitation). If so, seek immediate support for containment and management by medical and nursing staff.
- Shock: If a resident is showing signs of shock (pale, clammy skin; weak or rapid pulse; dizziness; irregular breathing; dull or glassy eyes; unresponsive to communication; lack of bladder or bowel control; restless, agitated, or confused), seek immediate medical support.

Provide Information about Disaster Response Activities and Services

To help reorient and comfort residents, provide information about:

- what to do next;
- what is being done to assist them;
- what is currently known about the unfolding event;
- available services;
- common stress reactions; and
- self-care, family care, spiritual care, and coping.

When providing information:

- Use your judgment as to whether and when to present information. Does the resident appear to be able to comprehend what is being said, and is he/she ready to hear the content of the messages?
- Address immediate needs and concerns, answer pressing questions, and support adaptive coping.
- Use clear and concise language, and speak in a low pitched voice while avoiding technical jargon.

Ask residents if they have any questions about what is going to happen, and give simple accurate information about what they can expect. Be sure to ask about concerns regarding current danger and safety in their new situation. Try to provide residents with information

that address these concerns. If you do not have specific information, do not guess or invent information to provide reassurance. Examples of what you might say include:



“From what I understand, we will start transporting people to Sunny Shores Nursing Home in about an hour. Your comfort, medical, and nutritional needs will be looked after there. You will remain at Sunny Shores until power has been restored and your own nursing home meets safety standards.”

Do not reassure people they are safe unless you have definite factual information that this is the case. Also, do not reassure people of the availability of goods or services (e.g., food and medicines) unless you have definite information that such goods and services will be available. However, do address safety concerns based on your understanding of the current situation. For example, you might say:



“Mrs. Williams, I want to assure you that the authorities are responding as well as they can right now. I am not sure if the fire has been completely contained, but you and the other residents are not in danger here. Do you have any concerns about your safety or the safety of others right now?”

Attend to Physical Comfort

Look for simple ways to make the physical environment more comfortable. If possible, consider things like temperature, lighting, air quality, access to furniture, and how the furniture is arranged. Whenever possible, encourage residents to participate in getting things needed for their personal comfort (e.g., offer to walk over to the supply area with the person rather than retrieving supplies yourself) to reduce feelings of helplessness or dependency. Help residents to soothe and comfort themselves and others around them.

When working with older adults, especially frail elders, pay attention to factors that may increase their vulnerability to stress or worsen medical conditions. When attending to the physical needs of these residents, be mindful of:

- health problems, such as acute or chronic pain and respiratory issues (supplemental oxygen dependency);
- medication or multiple medications, each with its own side effects and risks;
- frailty, which increases susceptibility to falls, minor injuries, bruising, and temperature extremes;
- other chronic diseases, or the existence of multiple chronic diseases;
- behaviors that might suggest pain and require a clinical intervention (if observed report to appropriate staff and medical personnel);
- visual impairment, which may limit awareness of surroundings and create or increase confusion;
- hearing loss, which can result in difficulty comprehending conversations or not hearing important information;
- dentures, potentially resulting in difficulty conversing and being understood;
- cognitive impairments, such as difficulty with attention, concentration, and memory;

- mobility issues,—such as a person who has not needed a wheelchair before the disaster may temporarily need one now;
- unfamiliar or over-stimulating surroundings;
- noise that can limit hearing and interfere with hearing devices; and
- limited access to bathroom facilities or group eating areas, or having to wait in long lines.

Promote Social Engagement

Facilitate group and social interactions as appropriate. Draw on your pre-existing knowledge of the resident’s social and recreational patterns of activity to guide this facilitation. It is generally soothing and reassuring to be near people who are coping adequately with the situation. On the other hand, it is upsetting to be near others who appear very agitated and emotionally overwhelmed. If residents have heard upsetting information or been exposed to rumors, help to clarify and correct misinformation.

As appropriate, encourage nursing home residents who are coping adequately to talk with others who are distressed or not coping as well. Reassure them that talking to other residents, especially about things they have in common (e.g., coming from nearby communities or having grandchildren about the same age), can help them support one another. This often reduces a sense of isolation and helplessness in both parties. Encourage social activities like playing cards, and board and group games.

Protect from Additional Traumatic Experiences and Trauma Reminders

In addition to securing physical safety, it is also important to protect residents from unnecessary exposure to additional traumatic events and trauma reminders, including sights, sounds, or smells that may be frightening. To help protect their privacy, shield residents from unwelcome or unsolicited contact with reporters, other media personnel, onlookers, or attorneys.

If nursing home residents have access to media coverage (e.g., television or radio broadcasts), point out that excessive viewing of such coverage can be highly upsetting. Encourage your colleagues and residents to monitor and limit their exposure to the media, and to discuss any concerns after such viewing. Nursing home staff can let residents know they are keeping track of information, and to come to them for updates instead of watching television. Remind your colleagues to be careful about what they say in front of residents and to clarify things that might be upsetting to them. For example, you might say:



“You’ve been through a lot, and it’s a good idea to shield yourself from further frightening or disturbing sights and sounds as much as possible. Even televised scenes of the disaster can be very disturbing to you, other residents, and staff.” You may find that the residents feel better if you limit their television viewing of the disaster. It doesn’t hurt for staff to take a break from all the media coverage, too.

Help Residents Who Have a Missing Family Member

Coping while believing that a loved one is missing is extremely difficult. Residents may experience a number of different feelings: denial, worry, hope, anger, shock, or guilt. They may alternate between certainty that the person is alive - even in the face of contradictory evidence - and hopelessness and despair. They may blame authorities, even staff members, for not having answers, for not trying hard enough, or for delays. They may also blame those they consider responsible for locating their missing relative or friend. It is extremely important to reassure residents that other family members and the police are doing everything possible to find the missing loved one. Likewise, it is imperative to keep family members informed about where residents have been moved to for their safety and to reconnect them as quickly as possible.

When a nursing home becomes severely damaged or destroyed, it may become necessary to evacuate the residents to various facilities. This situation can be distressing for the residents who are being evacuated because they may be separated from fellow residents to whom they have formed emotional attachments. It is important, therefore, to help these residents understand why they had to be split up and to assure them of their friends' safety.

Additionally, it is important to identify and recognize residents with cognitive impairment who are not connected to current reality. Their responses and fears may be focused on a previously experienced disaster or trauma, and they may be unable to process what is occurring in the present. Nursing home staff and those working with the resident need to be cognizant of the challenges associated with orienting these residents to the current situation and not force the issue.

For those aware of what is occurring, you should work with the facility social service director to assist residents who believe they have a missing loved one by helping them obtain updated information about missing persons. Work with facility staff to direct them to designated locations for updated briefings, and keep them updated on the plan in place for reuniting them. The American Red Cross has established a "Disaster Welfare Information System" to support family communication and reunification, and a "Safe and Well" website located at www.redcross.org. It provides a variety of tools and services needed to communicate with loved ones during times of emergency. Since many older adults do not use the internet, it is important to make this site known to staff members so they can assist the residents with locating loved ones. Try to identify other official sources of updated information (police, official radio and television channels, etc.) and share these with residents.

You may want to take extra time with residents who are worried about a missing family member. Just being there to listen to their hopes and fears, and being honest in giving information and answering questions is often deeply appreciated. Keep a log or note residents' concerns in their chart so that follow-up occurs in a timely fashion. Some residents may want to leave a safe area to attempt to find or rescue a missing loved one. In this case, inform the resident about the current circumstances in the search area, specific dangers, needed precautions, the efforts of first responders, and when updated information may be available. In some cases, authorities may ask residents to give information or other evidence to help the search. Authorities may have nursing home residents or family members file a missing

persons report or provide information about when and where the missing person was last seen, who else was there, and what he/she was wearing.

Sometimes in the case of missing persons, the evidence will strongly suggest that the person is dead. There may be disagreement among residents about the status of a loved one. You should let residents know that these differences (some giving up hope and some remaining hopeful) are common when a loved one is missing, and not a measure of how much they love the person or each other. You can encourage the residents to be patient, understanding, and respectful of each other's feelings until there is more definite news. Ensure that your colleagues do not assume that it is better for a resident to keep hoping that the person is alive, but instead honestly share the concern that the loved one may be dead. In these instances, advise your colleagues to check with the resident to make sure that the information has been understood, and answer any questions that are asked. Note, however, that with residents with significant cognitive impairments who repetitively ask the same questions and are not able to process complex information, it is better to provide emotional support and distraction rather than to try to help them understand and retain specific information.

Help Residents When a Family Member or Close Friend Has Died

The death of loved ones under traumatic circumstances is devastating and over time can greatly complicate the grieving process. For those who experienced the death of a loved one, provide emotional comfort, information about coping, social support and acute grief, and offer a follow-up meeting.

Acute grief reactions are likely to be intense and prevalent among those who have suffered the death of a loved one or close friend. They may feel sadness and anger over the death, feel guilt over not having been able to prevent the death, have regrets about not providing comfort or saying good-bye, miss the deceased, and wish for reunion (including dreams of seeing the person again). Although painful to experience at first, grief reactions are healthy responses that reflect the significance of the death. Over time, grief reactions tend to include more pleasant thoughts and activities, such as telling positive stories about a loved one and comforting ways of remembering him/her. However, some residents, particularly those with cognitive impairment, may not display the expected reaction. You should remember:

- Treat acutely bereaved residents with dignity, respect, and compassion.
- Grief reactions vary from person to person.
- There is no single “correct” course of grieving.
- Be aware of the potential implications of grief. Grief puts people at risk for abuse of over-the-counter medications, increased smoking, and consumption of alcohol. Make staff and family members who have lost a loved one in a nursing home or in the community aware of these risks, the importance of self-care, and the availability of professional help.
- Be mindful residents may try to leave the facility and are at risk for elopement as well as other reactive behaviors.

In working with residents who have experienced the death of a family member or close friend, you can:

- Discuss how people each have their own special set of reactions, no particular way of grieving is right or wrong, and there is not a “normal” period of time for grieving. What is most important is to respect and understand how each may be experiencing their own course of grief.
- Discuss with residents how culture or religious beliefs influence how people grieve and especially how rituals may or may not satisfy current feelings.
- Provide information about the funeral arrangements, if requested by the resident.

Do:

- Reassure grieving residents that what they are experiencing is understandable and expected.
- Use the deceased person’s name rather than referring to him/her as “the deceased.”
- Let them know they will most likely continue to experience periods of sadness, loneliness, or anger.
- Tell them if they continue to experience grief or depression that affects daily functioning, talking to a member of the clergy or a counselor who specializes in grief is advisable and that people often find counseling very helpful.
- Tell them their doctor, social worker, and community liaisons can help refer them for appropriate internal or external mental health services if they are available.

Don’t say:

- I know how you feel.
- It was probably for the best.
- He is better off now.
- It was her time to go.
- At least he went quickly.
- Let’s talk about something else.
- You should work towards getting over this.
- You are strong enough to deal with this.
- You should be glad he passed quickly.
- That which doesn’t kill us makes us stronger.
- You’ll feel better soon.
- You did everything you could.
- You need to grieve.
- You need to relax.
- It’s good that you are alive.
- It’s good that no one else died.
- It could be worse; you still have a brother/sister/mother/father.
- Everything happens for the best according to a higher plan.
- We are not given more than we can bear.
- Someday you will have an answer.

If the grieving resident says any of the above things, you can respectfully acknowledge the feeling or thought, but don’t initiate a statement like these yourself.

Attend to Grief and Spiritual Issues

In order to assist residents with spiritual needs after a death, you should become familiar with clergy who may be part of the disaster response team on-site, and with ways to obtain contact information for clergy of local religious groups to whom you can refer residents. It is common for people to rely on religious and spiritual beliefs/practices as a way to cope with the death of a loved one. Residents may use religious language to talk about what is happening or want to engage in prayer or other religious practices. It is not necessary for you to share these beliefs to be supportive. You are not required to do or say anything that violates your own beliefs. Often, simply listening and attending is all that is required.



A good way to introduce this topic is to ask, “Do you have any religious or spiritual needs at this time?” This question is not meant to lead to a theological discussion or to your engaging in spiritual counseling. If requested, you can refer them to a clergy member of their choice. Do not contradict or try to “correct” what a person says about his/her religious beliefs, even if you disagree and think that it may be causing them distress.

Things to keep in mind include:

- Do not try to answer religious questions like, “Why was this allowed to happen?” These questions generally represent expressions of emotion rather than real requests for an answer.
- Ask people who have a clear religious affiliation if they want to see a clergy member of their faith. Many people rely on religious objects, such as prayer beads, statues, or sacred texts that they may have lost or left behind. Locating an object like this can help to increase their level of security and sense of control. A local clergy member can often be of help in providing these items.
- Residents may want to pray alone or in a group. You may help by finding a suitable place for them to do so. For some people, facing in the proper direction while praying is important. You can help to orient them.
- You may also provide information to officials in charge of shelters and other gathering points about space and religious items needed for religious observances.
- If you are asked to join in prayer, you may decline if you feel uncomfortable. Keep in mind that joining may only involve standing in silence while someone prays. If you are comfortable joining in at the end with an “Amen,” this can help your relationship with the person and the family.
- Many people routinely light candles or incense when they pray. If it is not allowed in the setting, explain this to residents and assist them in finding a nearby place where an open flame is allowed or see if there is an acceptable substitute (e.g., a battery-operated flameless candle).
- A resident may voice hope for a miracle, even in the face of virtual certainty that their loved one has died. Do not take this as evidence that he/she has lost touch with reality or has not heard what has been said, but as the resident’s way of continuing to function in devastating circumstances. It is important to neither encourage nor discourage such hope.
- Every religion has specific practices around death, particularly in regard to the care of dead bodies. These issues may be especially complicated when the body is not recovered.

Ask residents about their religious needs in this area. They may want a clergy member to advise them.

- In some cultures, expressions of grief can be very loud and may seem out of control. It may be helpful to move families to a more private space to prevent them from upsetting others. If the behavior is upsetting to you, you should find someone else to assist the family.
- If a resident expresses anger associated with his/her religious beliefs (a sign of spiritual distress), do not judge or argue with him/her. Most people are not looking for an “answer,” but for a willing, nonjudgmental listener. If spiritual concerns are contributing to significant distress, guilt, or functional impairment, you can ask if he/she would like a referral to a clergy member or counselor.



Many times during disaster situations, well-meaning religious people seek out residents to proclaim their religious beliefs. If you become aware of activities like this, do not try to intervene; instead, notify security personnel or others in charge.

Attend to Issues Related to Traumatic Grief

After traumatic death, some residents may stay focused on the circumstances of the death, including being preoccupied with how the death could have been prevented, what the last moments were like, and who was at fault. These reactions may interfere with grieving, making it more difficult for residents to adjust to the death. These reactions include:

- intrusive, disturbing images of the death that interfere with positive remembering and reminiscing;
- retreat from close relationships with family and friends; and
- avoidance of usual activities because they are reminders of the traumatic death.

These reactions can change mourning. Let the person know that talking to a resident, friend, mental health professional, or clergy member may be very helpful.

Support Residents Who Receive Death Notification

Although it is unlikely that you will be asked to notify a family member of a death, you may assist family members who have been informed of a death. You may be asked by police, FBI, your nursing home or hospital personnel, or Disaster Mortuary Operational Response Team (DMORT) members to be present at the time of death notification. In some catastrophic situations, such as airline crashes, the news media may report that there were no survivors of the accident before family members have been officially notified. As incorrect information is sometimes circulated by the media or other residents, caution family members to wait for official confirmation from the authorities.

After learning of the death of a family member or close friend, people may have psychological and physiological reactions that vary from agitation to numbness. At the same

time, they must cope with the continuing stress of still being in the disaster environment. In providing support, keep the following in mind:

- Don't rush. Family members need time to process the news and ask questions.
- Allow for initial strong reactions; these will likely improve over time.
- When talking about a person who is a confirmed fatality, use the word "died," not "lost" or "passed away."
- Remember that family members do not want to know how YOU feel (sympathy); they want to know you are trying to understand how THEY feel (empathy).

Active steps to help support residents in dealing with death notification include:

- Take the lead from the resident, accept a limited reaction or non-reaction to the notification if that is the expressed response.
- Seek assistance from medical support personnel if a medical need arises.
- Get help from other nursing home personnel if the resident is at risk for hurting themselves or others.
- Make sure that social supports are available, such as family, friends, fellow residents, or clergy.
- Provide information about practical issues, such as next steps authorities are taking to allow the resident to become involved in funeral arrangements, if desired.

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Psychological First Aid

Field Operations Guide for Nursing Homes

Stabilization

- Stabilize emotionally overwhelmed residents
- Orient emotionally overwhelmed residents
- The role of medications in stabilization



FEMA Photo/Liz Roll

Stabilization (*if needed*)

Goal: To calm and orient emotionally overwhelmed or disoriented residents.

Some residents affected by the disaster will not require stabilization. Expressions of strong emotions, even muted emotions (e.g., numb, indifferent, spaced-out, or confused) are expected reactions and do not necessarily signal the need for additional intervention beyond ordinary supportive contact. While expression of strong emotions, numbing, and anxiety are normal and healthy responses to traumatic stress, extremely high arousal, numbing, or extreme anxiety can interfere with sleep, eating, decision-making, and other life tasks. You should be concerned about those residents whose reactions are so intense and persistent that they significantly interfere with their ability to function or result in severe confusion or delirium.

Stabilize Emotionally Overwhelmed Residents

Observe residents for these signs of being disoriented or overwhelmed:

- looking glassy-eyed and vacant - unable to find direction;
- unresponsiveness to verbal questions or commands;
- disorientation (e.g., engaging in aimless disorganized behavior);
- exhibiting strong emotional responses, uncontrollable crying, hyperventilating, rocking or regressive behavior;
- experiencing uncontrollable physical reactions (shaking, trembling);
- exhibiting frantic searching behavior;
- feeling incapacitated by worry; or
- engaging in risky activities.

Note that some of these signs are associated with medical conditions, and are not necessarily sole indicators of being emotionally overwhelmed. Residents with acute changes in personality or mental status should be evaluated by medical personnel.

If the person is too upset, agitated, withdrawn, disoriented to talk, or shows extreme anxiety, fear, or panic, consider:

- Does this person have a medical or psychological issue that maybe causing or contributing to the behavior? Often, some of these feelings and behaviors may be manifested as symptoms of illnesses more common among the nursing home resident population, such as anxiety disorders, serious mental illness, or dementia. It is important to either rule these issues out or to seek the appropriate intervention.
- Does the person have family and friends? If so, enlist them in comforting the distressed person. You may want to take a distressed resident to a quiet place or speak quietly with that person while family/friends are nearby.
- Attempt to identify what coping strategies have been used in the past. Offer interventions of preference to the resident such as a warm blanket, music, prayer, etc.
- What is the person experiencing? Is he/she crying, panicking, experiencing a “flashback” or imagining that the event is taking place again? When intervening, address the person’s

primary immediate concern or difficulty rather than simply trying to convince the person to “calm down” or to “feel safe” (neither of which tends to be effective).

In general, the following steps will help stabilize the majority of distressed residents:

- If possible, find a more private space or quiet area.
- Respect the person’s privacy and give him/her a few minutes before you intervene. Say you will be available if they need you or that you will check back with them in a few minutes to see how they are doing and if there is anything you can do to help at that time.
- Remain calm, quiet, and present rather than trying to talk directly to the person, as this may contribute to cognitive/emotional overload. Just remain available, while giving him/her a few minutes to calm down.
- Stand close by as you talk to other residents, do some paperwork, or other tasks while being available should the person need or wish to receive further help.
- Offer support and help him/her focus on specific manageable feelings, thoughts, and goals.
- Give information that orients him/her to the surroundings, such as how the setting is organized, what will be happening, and what steps he/she may consider.

Orient Emotionally Overwhelmed Residents

Use these points to help residents understand their reactions:

- Intense emotions may come and go in waves.
- Shocking experiences may trigger strong, often upsetting, “alarm” reactions in the body, such as startle reactions.
- Sometimes the best way to recover is to take a few moments for calming routines (e.g., go for a walk, breathe deeply, practice muscle relaxation techniques).
- Friends and family are very important sources of support to help calm down.

If the resident appears extremely agitated, shows a rush of speech, seems to be losing touch with the surroundings, or is experiencing ongoing intense crying, it may be helpful to:

- ask the resident to listen to you and look at you;
- find out whether the resident is oriented to date/time, person (resident knows who he/she is), place (where resident is), and event (what is happening) and determine if this is in consistent with their usual level of orientation and functioning; and
- ask the resident to describe the surroundings if they know where he/she is.

If none of these actions help stabilize an agitated resident, a technique called “grounding” may be helpful. You can introduce grounding by saying:



“After a frightening experience, you can sometimes find yourself overwhelmed with emotions or unable to stop thinking about or imagining what happened. You can use a method called ‘grounding’ to feel less overwhelmed. Grounding works by turning your attention from your thoughts back to the outside world. Here’s what you do...”

- Sit in a comfortable position with your legs and arms uncrossed.
- Breathe in and out slowly and deeply.
- Look around you and name five non-distressing objects that you can see. For example you could say, “I see the floor, I see a shoe, I see a table, I see a chair, I see a person.”
- Breathe in and out slowly and deeply.
- Next, name five non-distressing sounds you can hear. For example: “I hear a woman talking, I hear myself breathing, I hear a door close, I hear someone typing, I hear a cell phone ringing.”
- Breathe in and out slowly and deeply.
- Next, name five non-distressing things you can feel. For example: “I can feel this wooden armrest with my hands, I can feel my toes inside my shoes, I can feel my back pressing against my chair, I can feel the blanket in my hands, I can feel my lips pressed together.”
- Breathe in and out slowly and deeply.

If none of these interventions aid in emotional stabilization, consult with medical or mental health professionals, as medication may be needed. Modify these interventions for a person who has difficulty with vision, hearing, or expressive language.

The Role of Medications in Stabilization

In most cases, the above-described ways of stabilizing nursing home residents will be adequate. Medication for acute traumatic stress reactions is not recommended as a routine way of meeting the goals of Psychological First Aid, and medication should be considered only if a resident has not responded to other ways of helping. Any use of medication in residents should have a specific target (e.g., sleep, control of panic attacks) and be time-limited. Medications may be necessary when the resident is experiencing extreme agitation, extreme anxiety and panic, psychosis, or is dangerous to self or others.

You should be mindful of the following:

- Exposure to disaster may worsen pre-existing conditions (e.g., schizophrenia, depression, anxiety, pre-existing post-traumatic stress disorder).
- Some residents may be off their schedule for taking medications, or face uncertainty about continued access to medications.
- Communication with psychiatrists, physicians, or pharmacies may be disrupted.
- Monitoring of medication blood levels may be interrupted.

Gather information that will be helpful when referring to a physician, including:

- list of current medications;
- current medications that require ongoing monitoring by a physician;
- access to currently prescribed medications, doctors, and dispensing pharmacy;
- the resident’s compliance with taking prescribed medication; and
- ongoing medical and mental health conditions.

If you are unfamiliar with a resident, it is important to obtain information about current medications from other nursing home staff members to ensure the information is as accurate as possible.

Psychological First Aid

Field Operations Guide for Nursing Homes

Information Gathering: Needs and Current Concerns

- Nature and severity of experiences during the disaster
- Concerns about immediate post-disaster circumstances and ongoing threat
- Separation from or concern about the safety of loved ones
- Physical illness, mental health conditions, and need for medication
- Losses (family home, neighborhood, and personal property)
- Extreme feelings of guilt or shame
- Thoughts about causing harm to self or others
- Availability of social support
- Prior alcohol or drug use
- Prior exposure to trauma and death of loved ones



FEMA Photo/Andrea Booher

Information Gathering: Needs and Current Concerns

Goal: To identify immediate needs and concerns, gather additional information, and tailor Psychological First Aid interventions.

You should be flexible in providing Psychological First Aid and adapt interventions for specific residents, and their identified needs and concerns. Gather enough information so you can tailor and prioritize your interventions to meet these needs. Your ability to gather information will be limited by time, resident's needs and priorities, and competing demands. Competing resident demands are typical in nursing homes and may be multiplied during a traumatic event. Although a formal assessment is not appropriate, you may need to determine:

- need for immediate referral,
- need for additional services,
- need a follow up meeting, and
- which components of Psychological First Aid may be helpful.



The form Resident Current Needs (Appendix B) may be helpful in documenting the basic information gathered from residents. Likewise, the Psychological First Aid Provider Worksheet (Appendix B) may be useful in documenting services provided. These forms were designed for use within an ICS for evaluation purposes, and where there are proper safeguards for confidentiality.

Nature and Severity of Experiences during the Disaster

Residents who experienced direct life-threat to self, injury to self, or witnessed injury or death of others are at increased risk for more severe and prolonged distress. Those who felt extremely terrified and helpless may have more difficulty in recovering.



In clarifying disaster-related traumatic experiences, avoid asking for in-depth descriptions that may provoke additional distress. Follow the resident's lead in discussing what happened. Don't press residents to disclose details of any trauma or loss. On the other hand, if they are anxious to talk about their experiences, politely and respectfully tell them that what would be most helpful now is to get some basic information so you can help with their current needs and plan for future care. Let them know the opportunity to discuss their experiences can be arranged for the future.

For residents with these kinds of experiences, provide information about post-disaster reactions and coping (see Information on Coping), and offer a follow-up meeting. For those who were injured, arrange medical consultation as appropriate. Ask questions like:



“You’ve been through a lot of difficult things. May I ask you some questions so that I can assist you? Did you get hurt? Did you see anyone get hurt?”

Concerns about Immediate Post-Disaster Circumstances and Ongoing Threat

Residents may be highly concerned about immediate and ongoing danger. You may ask questions like:



“Do you need any information to help you better understand what has happened? Do you need information about how to keep yourself safe? Do you need information about what is being done to protect the public?”

For those with these concerns, help them obtain information about safety and protection.

Separation from or Concern about the Safety of Loved Ones

Separation from loved ones and concern about their safety is an additional source of distress. If not addressed earlier, get information with questions like these:



“Are you worried about anyone close to you right now? Do you know where they are? Is there anyone especially important like a family member or friend who is missing?” If family members or friends have been contacted, provide reassurance that they have been notified regarding the resident’s location and status.

For residents with these concerns, provide practical assistance in connecting them with available information sources and registries that can help locate and reunite family members. See Safety and Comfort and Connection with Social Supports.

Physical Illness, Mental Health Conditions, and Need for Medication

Pre-existing medical or mental health conditions and need for medications are additional sources of post-disaster distress. Those with a history of psychological problems may experience a worsening of these problems, as well as more severe and prolonged post-disaster reactions. Give a high priority to immediate medical and mental health concerns. Ask questions like:



“Do you have any medical or mental health condition that needs attention? Do you need any medications that you don’t have?”

For those with medical or mental health conditions, provide practical assistance in obtaining medical or psychological care and medication.

Losses (Family Home, Neighborhood, and Personal Property)

If residents have families who have extensive material losses and post-disaster adversities, their recovery may be complicated with feelings of depression, demoralization, and hopelessness. For information about such loss, ask questions like:



“Was your daughter’s home badly damaged or destroyed? Did you lose any important personal property? Was your old neighborhood badly damaged, and were your family/friends who were still living there affected?”

For those with losses, provide emotional comfort, practical assistance to help link them with available resources, and information about coping and social support.

Extreme Feelings of Guilt or Shame

Extreme negative emotions can be very painful, difficult, and challenging. Residents may be ashamed to discuss these feelings. Listen carefully for signs of guilt or shame in their comments. There may be occasions when a nursing home resident feels guilty or ashamed because he/she has been well cared for and kept safe by staff while a family member living locally has had to deal with the disaster and its aftermath. You may clarify the resident’s feelings by saying:



“It sounds like you are being really hard on yourself about what happened. Do you feel that you could have done more?”

For those experiencing guilt or shame, provide emotional comfort and information about coping with these emotions. This can be found in the section Information on Coping.

Thoughts about Causing Harm to Self or Others

It is a priority to get a sense of whether a resident is having thoughts about causing harm to self or others. To explore these thoughts and feelings, ask questions like:



“Sometimes situations like these can be very overwhelming. Have you had any thoughts about harming yourself? Have you had any thoughts about harming someone else?”

For those with these thoughts, get medical or mental health assistance immediately. If the resident is at immediate risk of hurting self or others, stay with him/her until appropriate personnel arrive on the scene and assume care of the resident.

Availability of Social Support

Family, friends, and community support can greatly enhance the ability to cope with distress and post-disaster adversity. Ask about social support as follows:



“Are there family members, friends, or clergy that you can rely on for help with problems that you are facing as a result of the disaster?”

Help those lacking adequate social support to connect with available resources and services, provide information about coping and social support, and offer a follow-up meeting. Remember that nursing home residents who have lived in the facility for a long period of time may have a social support network limited to facility staff, with few outside contacts available.



There may be occasions when you will have to provide Psychological First Aid to residents who you have not dealt with before. In clarifying prior history of trauma and loss, and prior mental-health problems, you should be sensitive to the immediate needs of the resident, avoid asking for a history if not appropriate, and avoid asking for in-depth description. Give clear reasons for asking, for example, “Sometimes events like this can remind people of previous bad times.”

Prior Alcohol or Drug Use

While the residents in your care may have no or limited access to alcohol or drugs, exposure to trauma and post-disaster adversities can increase the desire to use substances or cause them to re-live emotional and physiological urges associated with past substance abuse. You may also have to contend with colleagues who are dealing with their own post-disaster distress through the use of drugs or alcohol. Depending on your knowledge of the situation, obtain needed information by asking:



“Has your use of alcohol, prescription medications, or drugs increased since the disaster? Have you had any problems in the past with alcohol or drug use? Are you currently experiencing withdrawal symptoms from drug use?”

For those with potential substance use problems, provide information about coping and social support, link to appropriate services, and offer a follow-up meeting. For those with withdrawal symptoms, seek medical referral. You should emphasize to family members and friends the importance of not bringing the residents any alcoholic beverages or products containing alcohol without first consulting with you or other staff members who are familiar with the residents' past substance use habits and current issues. You may also be faced with

having to go to the nursing home’s administrators to seek advice and support for the temporary removal of a colleague if they pose any danger to the residents due to alcohol or drug abuse.

Prior Exposure to Trauma and Death of Loved Ones

Those with a history of exposure to trauma or death of loved ones may experience more severe and prolonged post-disaster reactions and a renewal of prior trauma and grief reactions. For information about prior trauma, ask:



“Sometimes events like this can remind people of previous bad times. Have you ever been in a disaster? Have other bad things happened to you in the past?”

Veterans may be particularly impacted by a disaster due to re-traumatization and a history of post-traumatic stress disorder. Thus, it is essential to give residents who have had prior exposure and/or loss information about post-disaster and grief reactions, information about coping and social support, and offer a follow-up meeting.

Psychological First Aid

Field Operations Guide for Nursing Homes

Practical Assistance

- Step 1: Identify the most immediate needs
- Step 2: Clarify the need
- Step 3: Discuss an action plan
- Step 4: Act to address the need



FEMA Photo/Jocelyn Augustino

Practical Assistance

Goal: To offer practical help to residents in addressing immediate needs and concerns.

Exposure to disaster, terrorism, and post-event adversities is often accompanied by a loss of hope. Those who are likely to have more favorable outcomes are those who maintain one or more of the following characteristics:

- Optimism (because they can have hope for their future)
- Confidence that life is predictable
- Belief that things will work out as well as can reasonably be expected
- Belief that outside sources act benevolently on one's behalf (responsive government)
- Strong faith-based beliefs
- Positive belief (e.g., "I'm lucky, things usually work out for me.")
- Resources, including housing and financial

Providing residents with needed resources can increase a sense of empowerment, hope, and restored dignity. Therefore, assisting the resident with current or anticipated problems is a central component of Psychological First Aid. Residents may welcome a pragmatic focus and assistance with problem-solving.

As much as possible, help residents address their own identified needs. Problem-solving may be more difficult under conditions of stress and adversity. Teaching residents to set achievable goals may reverse feelings of failure and inability to cope, help residents to have repeated success experiences, and help to reestablish a sense of environmental control necessary for successful disaster recovery.

Step 1: Identify the Most Immediate Needs

If the resident has identified several needs or current concerns, it will be necessary to focus on them one at a time. For some needs, there will be immediate solutions (e.g., getting something to eat, phoning a family member to reassure them that the resident is okay). Other problems (e.g., locating a lost loved one, returning to previous routines, etc.) may not be solved quickly, but the resident may be able to take concrete steps to address the problem (e.g., completing a missing persons report).



"I understand from what you're telling me, that your main goal right now is to find your son and make sure he's okay. We need to focus on helping you get in contact with him. Let's make a plan on how to go about getting this information."

Step 2: Clarify the Need

Talk with the resident to specify the problem. If the problem is understood and clarified, it will be easier to identify practical steps that can be taken to address it.

Step 3: Discuss an Action Plan

Discuss what can be done to address the resident's need or concern. The residents may say what they would like to have done, or you can offer suggestions. If you know what services are available ahead of time, you can help obtain food, clothing, shelter, medical care, mental health or spiritual care services, or financial assistance; assist in locating missing family members or friends; and find opportunities to help other residents. For example, encourage nursing home residents to help each other by providing emotional support.

Step 4: Act to Address the Need

Help the resident to take action. For example, help him/her set an appointment with a needed service or assist him/her in completing paperwork. Help residents to pair/buddy up with another more able resident to accomplish needed tasks. At the same time, be aware residents may be limited in their capacity to take individual initiative due to functional limitations and may need staff assistance to obtain needed services.

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Psychological First Aid

Field Operations Guide for Nursing Homes

Connection with Social Supports

- Enhance access to primary support persons (family and significant others)
- Encourage use of immediately available support persons
- Discuss support-seeking and giving
- Modeling support



FEMA NewsPhoto

Connection with Social Supports

Goal: To help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, and community resources.

Social support is related to emotional well-being and recovery following disasters and acts of terrorism. People who are well connected to others are more likely to engage in supportive activities (both receiving and giving support) that assist with disaster recovery. Social support can come in many forms. These include:

- Emotional Support: hugs, a listening ear, understanding, love, acceptance
- Social Connection: feeling like you fit in and have things in common with other people, having people to share activities
- Feeling Needed: feeling that you are important to others; that you are valued, useful, and productive; that people appreciate you
- Reassurance of Self-Worth: having people help you have confidence in yourself and your abilities, feeling that you can handle the challenges you face
- Reliable Support: having people reassure you they will be there for you in case you need them, believing that you have people you can rely on to help you
- Advice and Information: having people show you how to do something or give you information or good advice, having people help you understand that your way of reacting to what has happened is common, having good examples to learn from about how to cope in positive ways with what is happening
- Physical Assistance: having people help you perform tasks, like carrying things, organizing your belongings, and helping you do paperwork
- Material Assistance: having people give you things, like food, clothing, shelter, medicine, building materials, or money

Fostering connections as soon as possible and assisting residents in developing and maintaining social connections is critical to recovery. Benefits of social connectedness include:

- Increased opportunities for knowledge essential to disaster recovery
- Opportunities for a range of social support activities, including:
 - Practical problem-solving
 - Emotional understanding and acceptance
 - Sharing of experiences and concerns
 - Clarifying reactions
 - Sharing information about coping

Enhance Access to Primary Support Persons (Family and Significant Others)

An immediate concern for most residents is to contact those with whom they have a primary relationship (e.g., spouse/partner, children, other family members, close friends, fellow residents, staff members, clergy). Take practical steps to assist residents to reach these

individuals in person, by phone or e-mail, or through web-based resources. Other sources of social support may include other nursing home residents who the resident engages in activities with, such as art and crafts and playing cards. Residents who belong to religious organizations may have access to a valuable supportive network that can help facilitate recovery. Keep in mind residents may rely on staff for their support and may be socially isolated from others outside of the facility.

Encourage Use of Immediately Available Support Persons

If residents are disconnected from their social support network, encourage them to make use of immediately available sources of social support (e.g., the facility social worker(s), yourself, other relief workers, other residents), while being respectful of resident preferences. Residents may be primarily reliant on staff and other facility members. It can help to offer reading materials (e.g., magazines, newspapers, fact sheets) and discuss the material with them. Nursing home staff (as available) can read to residents if they are visually impaired or have a low level of literacy.

It is important to connect with the activities staff in the nursing home. They may have planned activities such as “Current Events” that a resident can participate in. When people are in a group, ask if they have questions. When members of the group are from different neighborhoods or communities, facilitate introductions among members. This is especially helpful for residents who have been evacuated from their own nursing home and transferred to different nursing homes. Small group discussions can provide a starting point for further conversations and social connectedness. When working with frail elders, you may try to connect them with a younger adult, less frail resident or a volunteer, if available, who can provide social contact and assistance with daily activities.

Discuss Support-Seeking and Giving

If residents are reluctant to seek support, there may be many reasons, including:

- not knowing what they need (and perhaps feeling that they should know);
- feeling embarrassed or weak because of needing help;
- feeling guilty about receiving help when others are in greater need;
- not knowing where to turn for help;
- worrying that they will be a burden or depress others;
- fearing that they will get so upset that they will lose control;
- doubting that support will be available or helpful;
- thinking, “No one can understand what I’m going through”;
- having tried to get help and finding it wasn’t there (feeling let down or betrayed); or
- fearing people they ask will be angry or make them feel guilty for needing help.

In helping residents to appreciate the value of social support and to engage with others, you may need to address some of the above concerns.

For those who have become withdrawn or socially isolated, you can be of assistance by helping them to:

- think about the type of support that would be most helpful,
- think about whom they can approach for that type of support,
- choose the right time and place to approach the person,
- talk to the person and explain how he/she can be of help, and
- afterwards, thank the person for his/her time and help.

Let residents know that, following a disaster, some people choose not to talk about their experiences, and that spending time with people one feels close to without talking can feel good. For example, your message might be:



“When you’re able to return to Sunny Shores Nursing Home, you may want to be with the people there that you feel close to. You may find it helpful to talk about what each of you has been through. You can decide when and what to talk about. You don’t have to talk about everything that occurred, only what you choose to share with each person.”

For nursing home residents who would like to provide support to others, you can help them to:

- identify ways that they can be helpful to others (provide emotional support for other residents, acknowledge the distress of their caregivers by asking how they are dealing with the stress of the disaster, etc.);
- identify a person or persons they can help;
- find an uninterrupted time and place to talk or to help them;
- show interest, attention, and care; and
- offer to talk or spend time together as many times as needed.

The focus should not be on discussing disaster-related experiences or losses, but rather on providing practical assistance and problem-solving current needs and concerns.

Modeling Support

As a nursing home staff member who is providing Psychological First Aid, you can model positive supportive responses, such as:

- Reflective comments



“From what you are saying, I can see how you would be...”
 “It sounds like you are saying...”
 “It seems that you are...”

- Clarifying comments



“Tell me if I’m wrong...it sounds like you...”
“Am I right when I say that you...”

- Supportive comments



“I understand that you feel...”
“It sounds really hard...”
“It sounds like you’re being hard on yourself.”
“It is such a tough thing to go through something like this.”
“I am really sorry this is such a tough time for you.”
“We can talk more tomorrow if you’d like.”

- Empowering comments and questions



“What have you done in the past to make yourself better when things got difficult?”
“Are there any things that you think would help you feel better?”
“I have an information sheet with some ideas about how to deal with difficult situations. Maybe there is an idea or two here that might be helpful for you.”
“People can be very different in what helps them to feel better. When things get difficult for me, it has helped me to...Do you think something like that would work for you?”



If appropriate, distribute handouts *Connecting with Others: Seeking Social Support* and *Giving Social Support* provided in Appendix C. These handouts are intended for older adults and frail elders.

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Psychological First Aid

Field Operations Guide for Nursing Homes

Information on Coping

- Provide basic information about stress reactions
- Review common psychological reactions to traumatic experiences and losses
- Provide basic information on ways of coping
- Coping for the nursing home resident
- Teach simple relaxation techniques
- Assist with anger management
- Address highly negative emotions (guilt and shame)
- Help with sleep problems
- Address alcohol and substance use



FEMA Photo/Andrea Booher

Information on Coping

Goal: To provide information about stress reactions and coping to reduce distress and promote adaptive functioning.

Disasters can be disorienting, confusing, and overwhelming, putting residents at risk for losing their sense of competence to handle problems. Significant worry about individual safety and support may also be issues of concern for resident coping. Feeling one can cope with disaster-related stress and adversity is beneficial to recovery.

Various types of information can help residents manage their stress reactions and deal more effectively with problems. Such information includes:

- what is currently known about the unfolding event;
- what is being done to assist them;
- what, where, and when services are available;
- post-disaster reactions and how to manage them; and
- self-care, family care, and coping.

Provide Basic Information about Stress Reactions

If appropriate, briefly discuss common stress reactions experienced by the resident. Stress reactions may be alarming. Some will be frightened or alarmed by their own responses; some may view their reactions in negative ways (e.g., “There’s something wrong with me” or “I’m weak”). You should take care to avoid pathologizing residents’ responses; do not use terms like “symptoms” or “disorder.” You may also see positive reactions, including appreciating life, family, and friends, or strengthening of spiritual beliefs and social connections.



While it may be helpful to describe common stress reactions and to note that intense reactions are common but often diminish over time, it is also important to avoid providing “blanket” reassurance that stress reactions will disappear. Such reassurance may set up unrealistic expectations about the time it takes to recover.

Review Common Psychological Reactions to Traumatic Experiences and Losses

For residents who have had significant exposure to trauma and have sustained significant losses, provide basic education about common distress reactions. You can review these common reactions, emphasizing that such reactions are understandable and expected. Inform residents that if these reactions continue to interfere with their ability to function adequately for over a month, psychological services should be considered. The following basic information is presented as an overview so that you can discuss issues arising from residents’ post-disaster reactions.

There are three types of post-traumatic stress reactions:

- 1. Intrusive reactions** are ways in which the traumatic experience comes back to mind. These reactions include distressing thoughts or mental images of the event (e.g., picturing what one saw), or dreams about what happened. Intrusive reactions also include upsetting emotional or physical reactions to reminders of the experiences. Some people may feel and act like one of their worst experiences is happening all over again. This is called a “flashback.”
- 2. Avoidance and withdrawal reactions** are ways people use to keep away from, or protect against, distress. These reactions include trying to avoid talking, thinking, and having feelings about the traumatic event, and avoiding any reminders of the event, including places and people connected to what happened. Emotions can become restricted, even numb, to protect against distress. Feelings of detachment and estrangement from others may lead to social withdrawal. There may be a loss of interest in usually pleasurable activities.
- 3. Physical arousal reactions** are physical changes that make the body react as if danger is still present. These reactions include constantly being “on the lookout” for danger, startling easily or being jumpy, irritable or having outbursts of anger, difficulty falling or staying asleep, and difficulty concentrating or paying attention.

It is also helpful to discuss the role of trauma reminders, loss reminders, change reminders, and hardships in contributing to distress.

Trauma reminders can be sights, sounds, places, smells, specific people, the time of day, situations, or even feelings, like being afraid or anxious. Trauma reminders can evoke upsetting thoughts and feelings about what happened. Examples include the sound of wind, rain, helicopters, screaming or shouting, and specific people who were present at the time. Reminders are related to the specific type of event, such as hurricane, earthquake, flood, tornado, or fire. Over time, avoidance of reminders can make it hard for people to do what they normally do or need to do.

Loss reminders can also be sights, sounds, places, smells, specific people, the time of day, situations, or feelings. Examples include seeing a picture of a lost loved one or their belongings, like their clothes. Loss reminders bring to mind the absence of a loved one. Missing the deceased can bring up strong feelings, like sadness, nervousness, uncertainty about what life will be without them, anger, feeling alone or abandoned, or hopelessness. Loss reminders can also lead to avoiding things that people want to do or need to do.

Change reminders can be people, places, things, activities, or hardships that remind someone of how life has changed as a result of the disaster. This can be something like waking up in a different bed in the morning or being in a different place. Even nice things can remind a resident of how life has changed and make the person miss what has been lost.

Hardships often follow in the wake of disasters and can make it more difficult to recover. Hardships place additional strains on residents and can contribute to feelings of anxiety, depression, irritability, uncertainty, and mental and physical exhaustion. Examples of hardships include: loss of home or possessions, lack of money, shortages of food or water, separations from friends and family, health problems, the process of obtaining compensation for losses, being moved to a new area or residence, and lack of enjoyable activities.

Other kinds of reactions include grief reactions, traumatic grief, depression, and physical reactions.

Grief reactions will be prevalent among those who survived the disaster but have suffered many types of losses, including the death of loved ones and loss of home, possessions, pets, and community. Loss may lead to feelings of sadness and anger, guilt or regret over the death, missing or longing for the deceased, and dreams of seeing the person again. More information on grief reactions and how to respond to residents experiencing acute grief reactions can be found in the section on Safety and Comfort.

Traumatic grief reactions occur when people have suffered the traumatic death of a loved one. Some residents may stay focused on the circumstances of the death, including being preoccupied with how the death could have been prevented, what the last moments were like, and who was at fault. These reactions may interfere with grieving, making it more difficult for residents to adjust to the death over time. More information on traumatic grief reactions and how to respond can be found in the section on Safety and Comfort.

Depression is associated with prolonged grief reactions and strongly related to the accumulation of post-disaster adversities. Reactions include persistent depressed or irritable mood, loss of appetite, sleep disturbance, greatly diminished interest or pleasure in life activities, fatigue or loss of energy, feelings of worthlessness or guilt, feelings of hopelessness, and sometimes thoughts about suicide. Older adults are more likely to exhibit symptoms of depression through somatic complaints, such as unexplained aches and pains rather than some of the more traditional indicators mentioned above. Demoralization is a common response to unfulfilled expectations about improvement in post-disaster adversities and resignation to adverse changes in life circumstances.

Physical reactions may be commonly experienced, even in the absence of any underlying physical injury or illness. These reactions include headaches, dizziness, stomach aches, muscle aches, rapid heartbeat, tightness in the chest, hyperventilation, loss of appetite, and bowel problems.



Several handouts found in Appendix C may be useful. When Terrible Things Happen describes common reactions and positive/negative coping.

Provide Basic Information on Ways of Coping

You can discuss a variety of ways to effectively cope with post-disaster reactions and adversity.

Adaptive coping actions are those that help to reduce anxiety, lessen other distressing reactions, improve the situation, or help people get through bad times. In general, coping methods that are likely to be helpful include:

- talking to another person for support;
- getting needed information;
- getting adequate rest, nutrition, and exercise;
- engaging in positive distracting activities, such as hobbies and reading;
- engaging in meditation and/or prayer;
- trying to maintain a normal schedule to the extent possible;
- telling yourself that it is natural to be upset for some period of time ;
- scheduling pleasant activities;
- eating healthy meals;
- taking breaks;
- spending time with others;
- participating in a support group;
- using relaxation methods;
- using calming self-talk;
- exercising in moderation;
- seeking counseling;
- keeping a journal;
- using coping methods that have been successful for you in the past, and
- focusing on something practical that you can do right now to manage the situation better

Maladaptive coping actions tend to be ineffective in addressing problems. Such actions include:

- using alcohol or drugs to cope,
- withdrawing from activities,
- withdrawing from family or friends,
- excessive blaming of self or others,
- overeating or undereating,
- watching too much TV,
- doing risky or dangerous things, and
- not taking care of yourself (sleep, diet, exercise, etc.).

The aim of discussing positive and negative forms of coping is to:

- help residents consider different coping options,
- identify and acknowledge their personal coping strengths,
- think through the negative consequences of maladaptive coping actions,
- encourage residents to make conscious goal-oriented choices about how to cope, and
- enhance a sense of personal control over coping and adjustment.

Coping for the Nursing Home Resident

- Reestablishing familiar routines to the extent possible after a disaster is important for the recovery of the residents and staff. Encourage staff and family caregivers to try to maintain facility routines such as meal times, bedtime, wake time, reading time, and spiritual activities, and to set aside time for the residents to enjoy social activities together.
- If a resident has a pre-existing emotional or behavioral problem that has been worsened by the current events, discuss with the family or staff members strategies they may have learned from a therapist to manage these problems. Discuss ways that these strategies may be adapted for the current setting. If the resident continues to have difficulties, consider a mental health consultation.
- It is especially important to assist residents and staff members in developing a mutual understanding of their different experiences, reactions, and course of recovery, and to help develop a facility-wide plan for communicating about these differences. For example, you might say:



“Often, due to differences in what each of you experienced during and after the disaster, each person will have different reactions and courses of recovery. These differences can be difficult to deal with and can lead to people not feeling understood, getting into arguments, or not supporting each other. For example, one of your fellow residents may be more troubled by a trauma or loss reminder than others.”

You should encourage residents to be understanding, patient, and tolerant of differences in their reactions, and to talk about things that are bothering them so the others will know when and how to support them. You can help each other in a number of ways, like listening and trying to understand, comforting with a hug, doing something thoughtful like writing a note, or getting his/her mind off things by playing a game.

Teach Simple Relaxation Techniques

Breathing exercises help reduce feelings of over-arousal and physical tension which, if practiced regularly, can improve sleep, eating, and functioning. Simple breathing exercises can be taught quickly. It is best to teach these techniques when the resident is calm and can pay attention. It may also be helpful for family members, friends, or staff members to prompt each other to use and practice these techniques regularly.



The handout *Tips for Relaxation* (Appendix C) can be provided to reinforce the use and practice of relaxation techniques.

Assist with Anger Management

Stressful post-disaster situations can make residents feel irritable and increase their difficulty in managing their anger. Addressing resident anger problems is important as they may put other residents or facility staff at risk. In addressing anger, you can:

- explain that feelings of anger and frustration are common to residents after a disaster;
- discuss how the anger is affecting their life (e.g., relationship with family members, friends, and fellow residents);
- normalize the experience of anger while discussing how anger can increase interpersonal conflict, push others away, or potentially lead to violent emotions and behaviors;
- ask residents to identify changes they would like to make to address their anger;
- compare how holding on to the anger can hurt them, versus how coping with, letting go of anger or directing it toward positive activities can help; and
- emphasize that some anger is normal and even helpful, while too much anger can undermine what they want to do.

Some anger management skills that you can suggest include:

- Take a “time out” or “cool down” (walk away and calm down, do something else for a while). (Note: not necessarily applicable to skilled nursing facility residents.)
- Talk to a friend about what is angering you.
- Blow off steam through light physical exercise (go for a walk).
- Keep a journal in which you describe how you feel and what you can do to change the situation.
- Remind yourself that being angry will not help you achieve what you want and may harm important relationships.
- Distract yourself with positive activities like reading a book, praying or meditating, listening to upbeat music, going to religious services or other uplifting group activities, helping a friend or someone in need, etc.
- Look at your situation in a different way, see it from another’s viewpoint, or find reasons your anger may be over the top.
- Help the resident think through what options, both in terms of what is feasible (i.e., given physical capacity and local resources) and acceptable, may help manage feelings of anger.
- For staff members/caregivers, have another employee or family member temporarily supervise the residents’ activities while you are feeling particularly angry or irritable.

If the angry person appears uncontrollable or becomes violent, seek immediate psychiatric care and contact security.

Address Highly Negative Emotions (Guilt and Shame)

In the aftermath of disasters, residents may think about what caused the event, how they reacted, and what the future holds. Attributing excessive blame to themselves or others may add to their distress. You should listen for such negative beliefs and help residents to look at the situation in ways that are less upsetting. You might ask:



“How could you look at the situation that would be less upsetting and more helpful? What is another way of thinking about this? How might you respond if a good friend was talking to himself/herself like this? What would you say to him/her? Can you say the same things to yourself?”

Tell the resident that even if he/she thinks he/she is at fault, that does not make it true. If the resident is receptive, offer some alternative ways of looking at the situation. Help to clarify misunderstandings, rumors, and distortions that exacerbate distress, unwarranted guilt, or shame. For residents who may have difficulty labeling thoughts due to cognitive impairments, you can write the negative thoughts on a piece of paper (e.g., “I did something wrong,” “I caused it to happen,” or “I was misbehaving”) and have the resident add to them. You can then discuss each one, clarify any misunderstandings, discuss more helpful thoughts, and write them down. Remind the resident that he/she is not at fault, even if he/she has not expressed these concerns.

Help with Sleep Problems

Sleep difficulties are common among older adults and may be further exacerbated following a disaster. People tend to stay on alert at night, making it hard to fall asleep and causing frequent awakenings. Worries about adversities and life changes can also make it hard to fall asleep. Disturbance in sleep can have a major effect on mood, concentration, decision-making, and risk for injury. Facility lighting and periodic disruptions may also make it difficult for residents to fall asleep or remain asleep. Changes in the environmental lighting may assist with sleep issues. Ask whether the resident is having any trouble sleeping and about sleep routines and sleep-related habits. Problem-solve ways to improve sleep. For example the resident might try to:

- go to sleep at the same time and get up at the same time each day;
- eliminate or reduce consumption of caffeinated beverages in the afternoon or evening;
- increase regular light exercise, such as a walk, though not too close to bedtime;
- relax before bedtime by doing something calming, like listening to soothing music, meditating, or praying;
- limit daytime naps to 15 minutes and limit napping later than 4:00 PM; and
- avoid drinks (coffee, tea, soda) and food (chocolate) for four to six hours before bedtime.

Discuss that worry over immediate concerns and exposure to daily reminders can make it more difficult to sleep, and that being able to discuss these and get support from others can improve sleep over time.

Address Alcohol and Substance Use

When residents desire to use alcohol and other substances as a means of dealing with their distress:

- explain to the resident that many people who experience reactions to trauma crave alcohol or drugs/medications to reduce their bad feelings;
- clarify it is against facility policy to use alcohol or other substances;

- ask the individual to identify what he/she sees as the positives and negatives of using alcohol or drugs to cope;
- discuss and try to mutually agree on abstinence;
- discuss anticipated difficulties in changing behavior;
- if appropriate and acceptable to the person, make a referral for abuse counseling or detoxification; and
- if the individual has previously received treatment for substance abuse, encourage him/her to once again seek treatment to get through the next few weeks and months.



The handout *Alcohol, Medication, and Drug Use after Disasters* (Appendix C) gives an overview of this information and is intended for residents with concerns in this area.

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Psychological First Aid

Field Operations Guide for Nursing Homes

Linkage with Collaborative Services

- Provide direct link to additional needed services
- Referrals for older adults



FEMA Photo/Marvin Nauman

Linkage with Collaborative Services

Goal: To link residents with available services needed at the time or in the future.

Provide Direct Link to Additional Needed Services

As you provide information, also discuss which of the resident's needs and current concerns require additional information or services. Do what is necessary to ensure effective linkage with those services (e.g., set up a meeting with a nursing home administrator who may authorize appropriate referrals). When possible, promote continuity in helping relationships. Examples of situations requiring a referral include:

- an acute medical problem that needs immediate attention;
- an acute mental health problem that needs immediate attention;
- worsening of a preexisting medical, emotional, or behavioral problem;
- threat of harm to self or others;
- cases involving elder abuse (remember reporting laws);
- medication needed for stabilization;
- pastoral counseling, if desired;
- ongoing difficulties with coping (four weeks or more after the disaster); and
- when requested by the resident.

When making a referral:

- summarize your discussion with the person about his/her needs and concerns;
- check for the accuracy of your summary;
- describe the option of referral, including how this may help and what will take place if the resident seeks further help;
- ask about the resident's reaction to the suggested referral;
- give written referral information, or if possible, make an appointment then and there; and
- describe the resident's behaviors and quote what the resident said, but do not make a diagnosis.

Referrals for Older Adults

Most often, nursing home residents will be returning to their nursing facility, but it is possible that a resident may be moved to a different facility or moving in with a family member due to damage to their home facility. The facility social worker(s) will be a key contact person for coordination of services regarding transfer or discharge. Additional community resources might include:

- a primary care physician or other medical services,
- local Area Agency on Aging,
- social support services,
- mental health services,
- drug and alcohol support groups,

- a local senior center,
- Council on Aging programs,
- Meals on Wheels,
- assisted living,
- nursing home/skilled nursing care,
- home- and community-based services,
- transportation services, and
- spiritual support.



Sometimes residents feel as if they are meeting a never-ending succession of helpers, and that they have to go on explaining their situation and telling their story to each one in turn. To the extent possible, minimize this. If you go off duty, let the resident know; and if possible, ensure a direct “hand-off” to another staff member, one who will be in a position to maintain an ongoing helping relationship with the person. Orient the new provider to what he/she needs to know about the person, and if possible, provide an introduction. If moved to a different nursing home, make sure the resident is provided with orientation to the new facility.

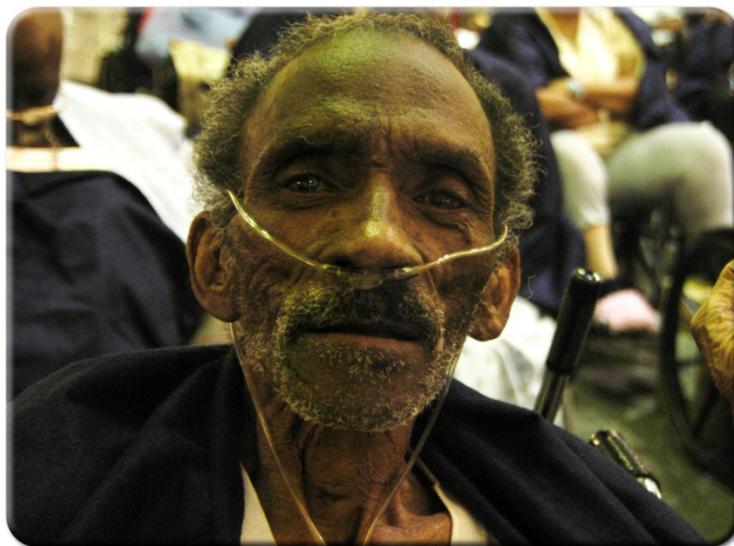
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Psychological First Aid

Field Operations Guide for Nursing Homes

Considerations for Residents with Special Needs

- Older adults with dementia or cognitive impairment
- Older adults near the end-of-life
- Older adults dealing with loss, change, and traumatic events



FEMA Photo/Liz Roll

Considerations for Residents with Special Needs

Goal: To address the needs residents who may require additional assistance or special attention due to their health status.

Experiencing a disaster or traumatic event may be especially difficult for populations with compromised personal coping abilities, including people with cognitive impairment, those near the end-of-life, and nursing home residents dealing with loss and change. Those who are likely to have more favorable outcomes are those who receive the support and resources needed to help them cope, such as:

- Moving them to another location if necessary to better meet their needs.
- Reassure them that someone is there to support and comfort them.
- Considering behavioral as well as cognitive interventions that may ease anxiety and reduce distress.
- Continuing to provide necessary treatments to ensure needs are met.
- Avoiding disruptions in their daily routine and activities to the extent possible.
- Empathizing with them and providing assurance while recognizing their feelings and reactions to the experience.
- Maintaining continuity of care.

Providing residents with timely and appropriate support can ease anxiety, distress, disorientation, and agitation as well as increase levels of calmness, relief, and comfort. Residents with dementia may require more directive support and assistance to cope with environmental and personal changes. Those near the end-of-life may require more attention to ensuring physical symptoms continue to be managed, as well as attending to their emotional and spiritual needs. Residents already dealing with loss and change may find themselves overwhelmed by an additional stressor and at risk for having their need for support misjudged if only the new event and not their life circumstances are considered. Supportive interventions and assistance should be tailored to the unique behavioral and emotional reactions, in the context of their personal history and present situation.

To the extent possible, residents should be asked what they need to help them cope with a crisis or traumatic situation. At the same time, it is important to use clinical knowledge to identify issues that the resident may be unable or unwilling to raise. Residents with various medical conditions and reduced coping abilities may require more active intervention to determine what assistance they require. Assisting a resident to cope with the experience of a disaster or traumatic event requires skillful communication and empathy in general, and will be more difficult under conditions of stress and adversity. Specific communication and intervention techniques may be more effective with different residents in crises than in routine care. Strategies should be matched to different levels of functioning. At the same time, individualization is important; people who have special needs such as residents with cognitive impairment and dementia, those near the end-of-life, and those who are emotionally vulnerable because of life changes or loss all have unique personalities and histories.

Older Adults with Dementia or Cognitive Impairment

Goal: To minimize anxiety and disruption in functioning and routine for residents with dementia or cognitive impairment.

Exposure to disaster, terrorism, and post-event misfortunes may be accompanied by disorientation and agitation, reflecting limited ability to understand the experience or to undertake coping efforts independently.

Things to Consider: Residents with dementia vary widely in their level of functioning and understanding of their surroundings. This variability will influence their reactions to a traumatic event. Some residents may seem unaware, while others may become agitated and distressed. Interventions need to be tailored to the individual's level of cognition and the behaviors that are shown.

Appropriate assistance will depend on the severity of the older adult's cognitive impairment. Mild cognitive impairment includes some memory loss, particularly for recent events, and people with mild impairment may frequently misplace objects or forget common words. While full functioning may be somewhat reduced, residents with mild dementia may understand the severity of a disaster experience or traumatic event and respond to usual forms of assistance and reassurance.

Residents with moderate cognitive impairment often fail to remember recent events, lose the ability to start activities or organize tasks, and may become confused or disoriented easily. However, while they may require assistance with independent daily activities, people with moderate impairment are able to perform most activities of daily living, such as eating and toileting independently. The consequences of a traumatic occurrence may be less easily understood by residents with moderate impairment levels.

Finally, residents with severe cognitive impairment or advanced dementia may no longer remember familiar people, lose track of their surroundings, and require increased assistance with everyday activities. People with severe impairment may be totally dependent on others for their basic care, including feeding and toileting, and may wander and become lost. Residents with very severe decline may no longer be able to communicate, have difficulty swallowing, and lose the ability to sit or hold their head up. Those with severe impairment may not detect changes in their usual care, or in contrast, may become unusually anxious because they sense a negative event has occurred but they are not able to express their feelings.

In addition to providing verbal support and intervention for residents with cognitive impairment, behavioral interventions also may be necessary or more appropriate to reduce levels of resident anxiety and agitation. Such activities may include providing them with familiar objects, music, or surroundings, or simply moving them to a familiar or more calming location.



Depending on the level of severity, people with dementia and cognitive impairment who appear to be aware of the event may be significantly distressed by the changes in surroundings and circumstances. Based on the resident's level of dementia, interventions may need to be tailored to be appropriate and applicable to people with mild, moderate, or severe dementia.

For residents with mild forms of dementia or cognitive impairment, it may be more appropriate to use verbal reassurance. People experiencing more moderate impairment may be more likely to benefit from both verbal and behavioral intervention. Residents with severe dementia may not be aware of what is occurring in the environment, and just meeting their physical needs in the least disruptive environment possible may be the best response.

Actions:

- Limit distractions and stimulation as much as possible when providing assistance.
- Attend to the environment; if necessary, move resident to a different location to reduce agitation or problem behaviors.
- Offer assurance to resident in a calm, clear voice.
- Use familiar items such as family photos and keepsakes to help orient and comfort the resident.
- Try using techniques such as familiar music and activities to calm the resident while avoiding overstimulation.
- Orient the resident using concrete items easily recognizable to them.
- Maintain the resident's daily routine (sleep/wake cycle, mealtimes, activity/rest periods) as much as possible.
- Avoid media reports that continually replay the event or are anxiety producing.
- Monitor for new behaviors and respond with appropriate action (e.g. redirection, validation).

For a resident with mild cognitive impairment:



“You look upset. Are you? I would like to help. I understand you may be distressed by this experience. Can you tell me what would be helpful for you?”

For a resident with moderate cognitive impairment:



“You look upset. It is noisy and busy here. Would you like to move? I am here to help you.”

For a resident with severe cognitive impairment:

Behavioral interventions rather than verbal communication may be more effective for residents with severe cognitive impairment. Simply moving them to an alternative location where they can be monitored may be appropriate.



A handout for use with nursing home residents with special needs including those with dementia and cognitive impairment, is provided on page 95 and can be used as a quick reference guide when providing PFA.

Older Adults Near the End-of-Life

Goal: To offer supportive assistance to residents near the end-of-life to address immediate needs and provide comfort and reassurance. To assure residents that their wishes will continue to be honored and they will not be left alone.

Exposure to disaster, terrorism, and post-event adversities may involve residents who are near the end-of-life or become so as a result of the traumatic event. For these individuals, the opportunity to die peacefully is at risk. Some residents who are near the end-of-life will be in the process of coming to terms with this, while others may not have accepted their fate. In both instances, a traumatic event changes the emotional, social, and possibly even the physical environment in which their death will occur. People who face death as a result of injury or illness secondary to the traumatic event are suddenly faced with dying, having little time to comprehend or prepare for this final life event.

Things to Consider: Due to the overall condition and status of the nursing home population, it is inevitable that at least some residents will be near the end-of-life in the event of a disaster. Following a disaster, two distinct groups of nursing home residents can be identified as nearing the end-of-life. First are the residents already at the end-of-life who are receiving on-going comfort care services. As a consequence of the disaster, a second group of residents may be needing end-of-life care as a result of injuries received during the disaster. Both groups will be in need of critical physical and mental health care services to ensure their needs are adequately met at the end-of-life and they are allowed to die with dignity.

For nursing home residents already receiving end-of-life services, coordinating with an outside contracted hospice organization may be necessary to adequately manage the residents' care and the provision of prescribed services, including pain medication, food and hydration, and spiritual services. If possible, updating family members on the status of the resident will reduce some concern as well as provide residents with the assurance their family has been informed. Perhaps most importantly, providing on-going services with as little disruption to the usual plan of care as possible, in addition to addressing any issues arising from the disaster, will allow residents at the end-of-life to receive appropriate and necessary services in a dignified manner.

As noted above, nursing home residents previously not considered to be near death may now require end-of-life care due to a disaster. Services to alleviate pain and suffering as well as providing comfort care and support are critical. While residents who were already near the end-of-life before the disaster have previously had time to understand and cope with their condition, those who face death as a result of a disaster may have varying reactions and require different mental health and psychological support. Again, informing family when possible may ease some of their distress as well as promote contact with family members prior to death.



Adapt PFA techniques accordingly to meet the individual mental health and spiritual needs of residents who are at the end stage of life.

Actions:

- Avoid media reports that replay the event or constantly show the approaching disaster.
- Try to ensure someone is with the resident if they prefer not to be alone; assure them someone will be there to ease anxiety and distress.
- Assure resident that you will continue to honor advance directives.
- Offer emotional and spiritual support as desired by the resident; be responsive to changing resident needs and adjust support provided as needed.
- Attend to environmental factors; establish a supportive environment of calmness and security to provide for resident needs.
- Offer to move resident to a private, quiet location where current status and functioning can be monitored, recognizing this may not be preferred by as all it may increase their sense of isolation.
- Continue to treat the resident with respect and autonomy and ensure they do not feel their value is diminished because they are near the end-of-life.
- Ensure continuity in symptom management, including medications for pain and other symptoms.
- Facilitate communication with resident's family and friends as desired, both in person and at a distance, to reduce worry and to strengthen support; alternatives may be needed to maintain communication if there is a disruption in usual interaction patterns.
- Have a viable plan for coordination with outside palliative and hospice care providers as needed to provide care for residents at end-of-life under both usual and extra-ordinary circumstances.



Be aware that needs may differ among residents who were already receiving end-of-life care prior to the traumatic event and for those who may require end-of-life services because of the event. Ensure the needs of the former group are not lost in the attention that is understandably directed to the needs of those whose deaths are precipitated by the event.

- Supportive comments



“There is a lot happening right now, but I want you to know you will not be forgotten in the excitement. I understand this may be distressing. We will continue to do all we can to keep you comfortable and safe.”
“I am here for you and will provide you with support and comfort in any way I can. Please let me know if there is anything you would like me to do for you.”
“Someone can sit with you until your daughter arrives. Would you like me to arrange that?”



A handout for use with nursing home residents with special needs, including those with dementia and cognitive impairment is provided on page....and can be used as a quick reference guide when providing PFA.

Older Adults Dealing with Loss, Change, and Traumatic Events

Goal: To minimize the negative effects a traumatic event has on functioning ability and enhance resident ability to successfully cope when a disaster occurs on top of other challenging life changes or losses.

Life events, such as the death of family member or friend, the sale of one's home or vehicle, or the loss of function are common events for nursing home residents. Nursing home residents are also regularly exposed to death as their co-residents pass away. The accumulation of stressors, losses, and grief may result in feeling emotionally overwhelmed or unable to cope. While some people may handle change and loss fairly well, others may be devastated by the event. The experience of a disaster or traumatic event may result in the decompensation of residents who previously had been coping successfully.

Things to Consider: Older adults who are already dealing with significant life changes or loss may be especially vulnerable to experiencing negative mental health outcomes because of a disaster. In particular, nursing home residents may be dealing with multiple changes or loss at the same time, increasing the risk for a disaster or trauma experience to overwhelm their coping abilities. For example, residents may experience a loss of independence, change in environment, AND the loss of physical functioning. Dealing with each these challenges alone is a significant task, let alone coping with multiple events together or adding a disaster to the mix.

Reactions to loss and change may include confusion or withdrawal as residents feel emotionally overwhelmed. Responses also may vary greatly for residents, with some appearing clearly emotionally distressed and others showing little or no emotion in response to the traumatic event. Exhibiting no emotion does not mean that the resident is not stressed. People often need time to understand the extent of their loss, with successful coping dependent upon the ability to accept the changes that have occurred.

Actions:

- Empathize with the resident; people need to know their reactions are understandable and normal.
- Offer comfort to the resident to meet their needs; ask what would help and provide support to them to the extent possible.
- Validate the resident's emotional reaction even if their response to the situation was not appropriate (e.g. acting aggressively towards others).
- Be present for the person; assure them you are there to provide support and that they have your undivided attention.
- Genuinely listen to what they need to say; avoid minimizing the resident's feelings about the experience.
- Recognize residents may be overwhelmed by the experience if they are already dealing with other life changes or losses and be alert to such possibilities.

These skills should be applied in any situation, including any time when an older adult experiences a loss or change in their daily life. Using these intervention techniques may also be effective at any point when residents find themselves in circumstances where they must face either a sudden or expected change in their life or a loss of some type.



Watch for residents who seem particularly distressed by the traumatic event or others who display a change in their behaviors or actions, especially those who you are aware are already coping with other changes or loss in their lives.

- Clarifying comments and questions



“How are you doing? I know this is a lot to deal with on top of the other things that have happened to you. Is there anything I can do to help you?”
“How is this experience affecting you? If you would like to tell me about it, I am here to listen.”

- Empowering comments and questions



“When you have had troubles or changes in your life in the past, what have you done to make yourself feel better?”

“Is there anything you can think of right now that would help you to feel better?”



A handout for use with nursing home residents with special needs, including those with dementia and cognitive impairment is provided on page....and can be used as a quick reference guide when providing PFA.

Psychological First Aid

Field Operations Guide for Nursing Homes

List of Appendices

- Appendix A: Psychological First Aid Resources for Staff and Residents
- Appendix B: Nursing Home Staff Worksheets
- Appendix C: Handouts for Residents



FEMA Photo/Andrea Booher

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Appendix A: Psychological First Aid Resources for Staff & Residents

- Overview of Psychological First Aid
- Psychological First Aid Provider Care
- Tips for Nursing Home Staff Assisting Residents with Special Needs

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Overview of Psychological First Aid

Section Headers	
Preparing to Deliver Psychological First Aid	<ul style="list-style-type: none"> Entering the setting Providing services Group settings Maintain a calm presence Be sensitive to culture and diversity Be aware of at-risk populations
Core Actions	<ul style="list-style-type: none"> Contact and engagement Safety and comfort Stabilization (if needed) Information gathering: current needs and concerns Practical assistance Connection with social supports Information on coping Linkage with collaborative services
Contact and Engagement	<ul style="list-style-type: none"> Ask about immediate needs Confidentiality
Safety and Comfort	<ul style="list-style-type: none"> Ensure immediate physical safety Provide information about disaster response activities and services Attend to physical comfort Promote social engagement Protect from additional traumatic experiences and trauma reminders Help residents who have a missing family member, fellow resident, or staff member Help residents when a family member or close friend has died Attend to grief and spiritual issues Attend to issues related to traumatic grief Support residents who receive death notifications
Stabilization	<ul style="list-style-type: none"> Stabilize emotionally overwhelmed residents Orient emotionally overwhelmed residents The role of medications in stabilization
Information Gathering: Needs and Current Concerns	<ul style="list-style-type: none"> Nature and severity of experiences during the disaster Concerns about immediate post-disaster circumstances and ongoing threat Separation from or concern about the safety of loved ones Physical illness, mental health conditions, and need for medications losses (family home, neighborhood, and personal property) Extreme feelings of guilt or shame Thoughts about causing harm to self or others Availability of social support Prior alcohol or drug use Prior exposure to trauma and death of loved ones

Overview of Psychological First Aid - *Continued*

	Section Headers
Practical Assistance	Step 1: Identify the most immediate needs Step 2: Clarify the need Step 3: Discuss an action plan Step 4: Act to address the need
Connection with Social Supports	Enhance access to primary support persons (family and significant others) Encourage use of immediately available support persons Discuss support-seeking and giving Modeling support
Information on Coping	Provide basic information about stress reactions Review common psychological reactions to traumatic experiences and losses <ul style="list-style-type: none"> • Intrusive reactions • Avoidance and withdrawal reactions • Physical arousal reactions • Trauma reminders • Loss reminders • Change reminders • Hardships • Grief reactions • Traumatic grief reactions • Depression • Physical reactions Provide basic information on ways of coping Coping for the nursing home resident Teach simple relaxation techniques Assist with anger management Address highly negative emotions (guilt and shame) Help with sleep problems Address alcohol and substance use
Link with Collaborative Services	Provide direct link to additional needed services Refer to agencies that provide services to older adults
Considerations for Residents with Special Needs	Older adults with dementia or cognitive impairment Older adults near the end-of-life Older adults dealing with loss, change, and traumatic events

Psychological First Aid Provider Care

Providing care and support in the immediate aftermath of disaster can be an enriching professional and personal experience that enhances satisfaction through helping others. It can also be physically and emotionally exhausting. The following sections provide information to consider before, during, and after engaging in disaster relief work.

Before Relief Work

Before participating in the disaster response, you should consider your current health, family, and work circumstances. The requirements of your position may include disaster preparedness, response and recovery responsibilities. You should share any potential problems that would prevent you from participating fully in the disaster response efforts with your supervisor so that adequate planning can take place prior to an event. These considerations should include the following:

Personal Considerations

You should be aware of the various situations you may experience while providing care to residents during a disaster:

- Working with residents who are experiencing intense distress and extreme reactions, including screaming, hysterical crying, anger, or withdrawal
- Working with residents in non-traditional settings
- Working in a chaotic, unpredictable environment
- Accepting tasks that may not initially be viewed as mental health activities (e.g., distributing water, helping serve meals, sweeping the floor)
- Working in an environment with minimal or no supervision or conversely, micro-managed
- Working with and providing support to residents from diverse cultures, ethnic groups, developmental levels, and faith backgrounds
- Working in environments where the risk of harm or exposure is not fully known
- Working with residents who are not receptive to mental health support
- Working with a diverse group of professionals, often with different interaction styles

Health Considerations

Assess your current physical and emotional health status, and any conditions that may influence your ability to work long shifts in disaster settings that you may need to discuss with your supervisor, including:

- Recent surgeries or medical treatments
- Recent emotional or psychological challenges or problems
- Any significant life changes or losses within the past 6-12 months
- Earlier losses or other negative life events
- Dietary restrictions that would impede your work

- Ability to remain active for long periods of time and endure physically exhausting conditions
- Medication availability for the total length of your assignment, plus some extra days

Family Considerations

Assess your family's ability to cope with your providing care to residents during a disaster:

- Is your family prepared for your absence, which may span days or weeks?
- Is your family prepared for you to work in environments where there is a risk of harm or exposure to harm is not really known?
- Will your support system (family/friends) assume some of your family responsibilities and duties while you are away or working long hours?
- Do you have any unresolved family/relationship issues that will make it challenging for you to focus on disaster-related responsibilities?
- Do you have a strong, supportive environment to return to after your disaster assignment?

Before participating in disaster response, be sure to clarify your concerns to family members and clarify roles and responsibilities to avoid unnecessary distress.

Personal, Family, Work Life Plan

Before engaging in disaster response, take time to make preparations for the following:

- Family and other household responsibilities
- Pet care responsibilities
- Work responsibilities
- Community activities/responsibilities
- Other responsibilities and concerns

During Relief Work

In providing Psychological First Aid, it is important to recognize common and extreme stress reactions, how organizations can reduce the risk of extreme stress to nursing home staff, and how best to take care of yourself during your work.

Common Stress Reactions

Nursing home staff may experience a number of stress responses, which are considered common when working with residents:

- Increase or decrease in activity level
- Difficulty in sleeping
- Substance use
- Numbing
- Irritability, anger, and frustration
- Vicarious traumatization in the form of shock, tearfulness, horror, and helplessness

- Confusion, lack of attention, and difficulty making decisions
- Physical reactions (headaches, stomach aches, being easily startled)
- Depressive or anxiety symptoms
- Decreased social activities

Extreme Stress Reactions

Nursing home staff may experience more serious stress responses that warrant seeking support from a professional or monitoring by a supervisor. These include:

- Compassion stress: helplessness, confusion, isolation
- Compassion fatigue: demoralization, alienation, resignation
- Preoccupation or compulsive re-experiencing of trauma experienced either directly or indirectly
- Attempts to over-control in professional or personal situations
- Withdrawal and isolation
- Preventing feelings by relying on substances, becoming overly preoccupied by work, or drastic changes in sleep (avoidance of sleep or not wanting to get out of bed)
- Serious difficulties in interpersonal relationships, including domestic violence
- Depression accompanied by hopelessness (which has the potential to place residents at a higher risk for suicide)
- Unnecessary risk-taking

Organizational Care of Nursing Home Staff

Organizations that recruit nursing home staff can reduce the risk of extreme stress by putting supports and policies in place. These include:

- Limiting work shifts to no more than 12 hours and encouraging work breaks
- Rotation of nursing home staff from the most demanding assignments to lesser levels of responsibility.
- Mandating time off
- Identifying enough nursing home staff at all levels, including administration, supervision, and support
- Encouraging peer partners and peer consultation
- Monitoring nursing home staff who meet certain high risk criteria, such as:
 - Survivors of a disaster
 - Those having regular exposure to severely affected residents or communities
 - Those with pre-existing conditions such as psychiatric and medical conditions
 - Those with multiple stresses, including those who have responded to multiple disasters in a short period of time
- Establishing supervision, case conferencing, and staff events
- Conducting trainings on stress management practices

Nursing Home Staff Self-Care

Activities that promote self-care include:

- Managing personal resources

- Planning for family/home safety, including making child care and pet care plans
- Getting adequate exercise, nutrition, and relaxation
- Using stress management tools regularly, such as:
 - Accessing supervision routinely to share concerns, identifying difficult experiences, and strategizing to solve problems
 - Practicing brief relaxation techniques during the workday
 - Using the buddy system to share upsetting emotional responses
 - Staying aware of limitations and needs
 - Recognizing when one is Hungry, Angry, Lonely or Tired (HALT), and taking the appropriate self-care measures
 - Increasing activities that are positive
 - Practicing religious faith, philosophy, and spirituality
 - Spending time with family and friends
 - Learning how to “put stress away”
 - Writing, drawing, and painting
 - Limiting caffeine, tobacco, and substance use

As much as possible, you should make every effort to:

- Self-monitor and pace your efforts
- Maintain boundaries: delegate, say no, and when possible, avoid working with too many residents in a given shift
- Perform regular check-ins with colleagues, family, and friends
- Work with partners or in teams
- Take relaxation/stress management/bodily care/refreshment breaks
- Utilize regular peer consultation and supervision
- Try to be flexible, patient, and tolerant
- Accept that you cannot change everything

You should avoid engaging in:

- Extended periods of solo work without colleagues
- Working “round the clock” with few breaks
- Negative self-talk that reinforces feelings of inadequacy or incompetency
- Excessive use of food/substances as a support
- Common attitudinal obstacles to self-care:
 - “It would be selfish to take time to rest.”
 - “Others are working around the clock, so should I.”
 - “The needs of residents are more important than the needs of helpers.”
 - “I can contribute the most by working all the time.”
 - “Only I can do x, y, and z.”

After Relief Work

Expect a readjustment period after your temporary disaster duties have been completed. You may need to make reintegration with your pre-disaster social network a priority for a while. When possible spend time reuniting with family, friends, and colleagues.

Organizational Care of Nursing Home Staff

Organizations should:

- Encourage time off for nursing home staff who have experienced personal trauma or loss.
- Praise staff for disaster work.
- Institute exit interviews to help nursing home staff with their experience—this should include information about how to communicate with their families about their work.
- Encourage nursing home staff to seek counseling when needed, and provide referral information.
- Provide education on stress management.
- Facilitate ways nursing home staff can communicate with each other by establishing regular meetings.
- Provide information regarding positive aspects of the work.
- Seek suggestions on ways to improve future response to disasters.

Nursing Home Staff Self-Care

Make every effort to:

- Seek out and give social support.
- Check in with other relief colleagues to discuss relief work.
- Increase collegial support.
- Schedule time for a vacation or gradual reintegration into normal life.
- Prepare for worldview changes that may not be mirrored by others in your life.
- Participate in formal help to address your response to relief work if extreme stress persists for greater than two to three weeks.
- Increase leisure activities, stress management, and exercise.
- Pay extra attention to health and nutrition.
- Pay extra attention to rekindling close interpersonal relationships.
- Practice good sleep routines.
- Make time for self-reflection.
- Practice receiving from others.
- Find activities that you enjoy or that make you laugh.
- Try at times not to be in charge or the “expert.”
- Increase experiences that have spiritual or philosophical meaning to you.
- Anticipate that you will experience recurring thoughts or dreams, and that they will decrease over time.
- Keep a journal to get worries off your mind.
- Ask for help in parenting if you feel irritable or are having difficulties adjusting to being back at home.

Make every effort to avoid:

- Excessive use of alcohol, illicit drugs or excessive amounts of prescription drugs.
- Making any big life changes for at least a month.
- Negatively assessing your contribution to relief work.
- Worrying about readjusting.

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Tips for Nursing Home Staff Assisting Residents with Special Needs

Reactions/Behavior	Responses	Examples of things to do and say
<p>High anxiety/arousal: Residents with dementia may be particularly sensitive to becoming aroused in situations which differ from their regular routine.</p>	<ul style="list-style-type: none"> ● Provide familiar items to normalize the situation. ● Attempt to maintain resident’s routine or develop a routine in the new environment. ● Provide reassurance as needed. 	<ul style="list-style-type: none"> ● Look at photo albums (if available). ● Move to a different environment. ● Engage in alternative activities.
<p>Agitation: A resident may become restless or feel the need to move or pace repetitively in response to environmental stimuli. They may also become distraught or emotional if aware of changes in their environment.</p>	<ul style="list-style-type: none"> ● Try to identify the cause or specific trigger of the behavior. ● Provide resident with an appropriate place to move as needed. ● Respond in a calm, composed manner. ● Listen to the person and do not minimize their expressions or feelings. ● Stay with the person to assure safety and security. ● Provide reassurance as needed. 	<ul style="list-style-type: none"> ● “How can I help you?” ● “Would you like something to (add a distracter, such as eat or drink)?” ● Attempt to redirect by giving them a simple task (e.g. folding towels/paper).
<p>Behavioral Reactions: Residents may display aggressive behaviors when they experience a disruption in their daily routine or surroundings. They may also withdraw or become more physically compromised by the disaster or trauma.</p>	<ul style="list-style-type: none"> ● Try to identify the cause or specific trigger of the behavior. ● Address physical needs. ● Allow opportunity for companionship and physical comfort as needed. ● Respond in a calm, composed manner. ● Reduce over-stimulation. ● Focus on other actions. ● Provide a safe environment for resident. 	<ul style="list-style-type: none"> ● If possible, withdraw and re-approach later. ● “Is something bothering you?”
<p>Disorientation: Especially in the event of disaster evacuation or relocation, a resident may be unfamiliar and disoriented to their setting and surroundings.</p>	<ul style="list-style-type: none"> ● Provide consistent re-orientation and re-assurance. ● Address resident by name. ● Provide responses in a simple, concrete fashion. 	<ul style="list-style-type: none"> ● “We will all return home as soon as possible.” ● “Because of a storm, we are in this building and we are safe.”
<p>Loss of Hope: In the face of disaster or trauma, residents may feel they should give up as they have nothing left to live for.</p>	<ul style="list-style-type: none"> ● If applicable, discuss resident’s spiritual beliefs or strengths. ● Avoid minimizing feelings or thoughts. ● Listen without making judgments. 	<ul style="list-style-type: none"> ● “Are there any religious beliefs or rituals that may comfort you?” ● “I know this situation is difficult for you.” ● “I am here for you.”

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Appendix B: Nursing Home Staff Worksheets

- Resident current needs
- Psychological First Aid components provided

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Resident Current Needs

Date: _____ **Provider:** _____

Resident Name: _____

Location: _____

This session was conducted with (check all that apply):

Adult

Family

Group

Provider: Use this form to document what the resident needs the most at this time. This information can be used to communicate with referral agencies to help promote continuity of care.

1. Check the boxes corresponding to difficulties the resident does not normally exhibit, or if an increase is noted in behavior.

Behavioral	Emotional	Physical	Cognitive
<input type="checkbox"/> Extreme disorientation <input type="checkbox"/> Excessive drug, alcohol, or prescription drug use <input type="checkbox"/> Isolation/withdrawal <input type="checkbox"/> High risk behavior <input type="checkbox"/> Regressive behavior <input type="checkbox"/> Separation anxiety <input type="checkbox"/> Violent behavior <input type="checkbox"/> Restlessness, fidgeting, or hand wringing <input type="checkbox"/> Physically or verbally abusive behavior <input type="checkbox"/> Negative statements: e.g., “What is the use”; “I am no use to anyone”; “Why don’t I die.” <input type="checkbox"/> Repetitive verbalizations: e.g., “Don’t leave me”; “God help me.” <input type="checkbox"/> Recurrent statements that something terrible is about to happen: e.g., believes he/she is about to die, have a heart attack, etc. <input type="checkbox"/> Wandering behavior <input type="checkbox"/> Refusing care, medications, etc. <input type="checkbox"/> Maladaptive coping <input type="checkbox"/> Other _____	<input type="checkbox"/> Acute stress reactions <input type="checkbox"/> Acute grief reactions <input type="checkbox"/> Sadness, tearfulness <input type="checkbox"/> Irritability, anger <input type="checkbox"/> Feeling anxious, fearful <input type="checkbox"/> Despair, hopelessness <input type="checkbox"/> Feeling guilt or shame <input type="checkbox"/> Feeling emotionally numb, disconnected <input type="checkbox"/> Other _____	<input type="checkbox"/> Headaches <input type="checkbox"/> Stomach aches <input type="checkbox"/> Sleep difficulties <input type="checkbox"/> Difficulty eating <input type="checkbox"/> Worsening of health conditions <input type="checkbox"/> Fatigue/exhaustion <input type="checkbox"/> Chronic agitation <input type="checkbox"/> Decreased motivation <input type="checkbox"/> Other _____	<input type="checkbox"/> Inability to accept/cope with death of loved one(s) <input type="checkbox"/> Distressing dreams or nightmares <input type="checkbox"/> Intrusive thoughts or images <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Difficulty remembering <input type="checkbox"/> Difficulty making decisions <input type="checkbox"/> Preoccupation with death/destruction <input type="checkbox"/> Other _____

2. Check the boxes corresponding to difficulties the resident is experiencing.

- Past or preexisting trauma/psychological problems/substance abuse problems
- Injured as a result of a disaster
- Mobility issues
- Medical and medication issues
- Disorientation or confusion
- Difficulties with activities of daily living (toileting, dressing, feeding, bathing, etc.)
- Loved one(s), fellow residents, or staff members missing or dead
- Financial concerns
- Displaced from nursing home
- Living arrangements
- Assisted with rescue/emotional disability
- Medication stabilization
- Spiritual concerns
- Other: _____

3. Please make note of any other information that might be helpful in making a referral.

4. Referral

- | | |
|--|---|
| <input type="checkbox"/> Within the facility (specify) _____ | <input type="checkbox"/> Social work |
| <input type="checkbox"/> Other disaster agencies | <input type="checkbox"/> Other community services |
| <input type="checkbox"/> Professional mental health services | <input type="checkbox"/> Clergy |
| <input type="checkbox"/> Medical treatment | <input type="checkbox"/> Financial counselor |
| <input type="checkbox"/> Substance abuse treatment | <input type="checkbox"/> Other: _____ |

5. Was the referral accepted by the resident?

- Yes
- No

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Psychological First Aid Components Provided

Date: _____ **Provider:** _____

Resident Name: _____

Location: _____

This session was conducted with (check all that apply):

- Adult Family Group

Place a check mark in the box next to each component of Psychological First Aid that you provided in this session.

Contact and Engagement

- Initiated contact in an appropriate manner Asked about immediate need

Safety and Comfort

- Took steps to ensure immediate physical safety Helped residents regarding death notification
 Attended to physical comfort Gave information about the disaster/risks
 Assisted with concerns over missing loved one Encouraged social engagement
 Assisted with acute grief reactions (Note: involves physician. Most skilled nursing facility residents have health concerns which may be impacted by acute grief reactions.) Protect from additional trauma
 Attended to spiritual issues regarding death Assisted after death of loved one
 Provided information about funeral arrangements Attended to traumatic grief
 Other _____

Stabilization

- Helped with stabilization Used grounding technique
 Gathered information for medication if referral for stabilization

Information Gathering

- | | |
|---|--|
| <input type="checkbox"/> Nature and severity of disaster experiences | <input type="checkbox"/> Death of a family member or friend |
| <input type="checkbox"/> Concerns about ongoing threat | <input type="checkbox"/> Concerns about safety of a loved one(s) |
| <input type="checkbox"/> Physical/mental illness and medication(s) | <input type="checkbox"/> Disaster-related losses |
| <input type="checkbox"/> Separations from or concern about the safety of loved ones | <input type="checkbox"/> Thoughts about harming self or others |
| <input type="checkbox"/> Extreme guilt or shame | <input type="checkbox"/> Prior alcohol or drug abuse |
| <input type="checkbox"/> Availability of social support | <input type="checkbox"/> Concerns over developmental impact |
| <input type="checkbox"/> History of prior trauma and loss | <input type="checkbox"/> Other _____ |

Practical Assistance

- | | |
|--|--|
| <input type="checkbox"/> Helped to identify most immediate need(s) | <input type="checkbox"/> Helped to clarify need(s) |
| <input type="checkbox"/> Helped to develop an action plan | <input type="checkbox"/> Helped with action to address need(s) |

Connection with Social Supports

- | | |
|--|---|
| <input type="checkbox"/> Facilitated access to primary support persons | <input type="checkbox"/> Helped problem-solve obtaining/giving social support |
| <input type="checkbox"/> Modeled supportive behaviors | <input type="checkbox"/> Discussed support seeking and giving |

Information on Coping

- | | |
|--|---|
| <input type="checkbox"/> Gave basic information about stress reactions | <input type="checkbox"/> Assisted with anger management |
| <input type="checkbox"/> Taught simple relaxation technique (s) | <input type="checkbox"/> Helped with sleep problems |
| <input type="checkbox"/> Assisted with developmental concerns | <input type="checkbox"/> Addressed substance abuse problems |
| <input type="checkbox"/> Addressed negative emotions (shame/guilt) | <input type="checkbox"/> Gave basic information on coping |
| | <input type="checkbox"/> Helped with coping issues |

Linkage with Collaborative Services

- | | |
|---|---|
| <input type="checkbox"/> Provided a link to additional service(s) | <input type="checkbox"/> Provided handout |
| <input type="checkbox"/> Promoted for continuity of care | |

Appendix C: Handouts for Residents

- Connecting with others
- When terrible things happen: What you may experience
- Tips for nursing home staff and residents after disasters
- Nursing home staff and residents: tips for relaxation
- Alcohol, medication, and drug use after disaster

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Connecting With Others

Seeking Social Support

- Making contact with others can help reduce feelings of distress.
- Residents and staff can benefit from spending some time with other similar-age peers.
- Connections can be with family, friends, or others who are coping with the same traumatic event.

Social Support Options

- Spouse or partner
- Minister, Priest, Rabbi, or other clergy
- Support group
- Trusted family member
- Doctor or nurse
- Co-worker
- Close friend
- Crisis counselor or other counselor
- Pet

Do...

- Decide carefully whom to talk to
- Start by talking about practical things
- Ask others if it's a good time to talk
- Decide ahead of time what you want to discuss
- Let others know you need to talk or just to be with them
- Tell others you appreciate them listening
- Choose the right time and place
- Talk about painful thoughts and feelings when you're ready
- Tell others what you need or how they could help – one main thing that would help you right now

Don't...

- Keep quiet because you don't want to upset others
- Assume that others don't want to listen
- Keep quiet because you're worried about being a burden
- Wait until you're so stressed or exhausted that you can't fully benefit from help

Ways to Get Connected

- Calling friends or family on the phone
- Getting involved with a support group
- Increasing contact with acquaintances and friends
- Getting involved in community recovery activities
- Renewing or beginning involvement in church, synagogue, or other religious group activities

Connecting With Others

Giving Social Support

You can help family members and friends cope with the disaster by spending time with them and listening carefully. Most people recover better when they feel connected to others who care about them. Some people choose not to talk about their experiences very much, and others may need to. For some, talking about things that happened because of the disaster can help these things seem less overwhelming. For others, just spending time with people one feels close to and accepted by, without having to talk, can feel best. Here is some information about giving social support to other people.

Reasons Why People May Avoid Social Support

- Not knowing what they need
- Not wanting to burden others
- Wanting to avoid thinking or feeling about the event
- Feeling embarrassed or “weak”
- Doubting it will be helpful, or that others won’t understand
- Feeling that others will be disappointed or judgmental
- Feeling they will lose control
- Having tried to get help and felt that it wasn’t there before
- Not knowing where to get help

Good Things to Do When Giving Support

- Show interest, attention, and care
- Show respect for individuals’ reactions and ways of coping
- Talk about expected reactions to disasters and healthy coping
- Find an uninterrupted time and place to talk
- Acknowledge that this type of stress can take time to resolve
- Believe that the person is capable of recovery
- Be free of expectations or judgments
- Help brainstorm positive ways to deal with their reactions
- Offer to talk or spend time together as many times as is needed

Things that Interfere with Giving Support

- Rushing to tell someone that he/she will be okay or that they should just “get over it”
- Acting like someone is weak or exaggerating because he or she isn’t coping as well as you are
- Discussing your own personal experiences without listening to the other person’s story
- Giving advice without listening to the person’s concerns or asking the person what works for him or her
- Stopping the person from talking about what is bothering them
- Telling them they were lucky it wasn’t worse

When Your Support is Not Enough

- Let the person know that experts think that avoidance and withdrawal are likely to increase distress, and social support helps recovery
- Encourage the person to talk with a counselor, clergy, or medical professional, and offer to accompany them
- Encourage the person to get involved in a support group with others who have similar experiences
- Enlist help from others in your social circle so that you all take part in supporting the person

When Terrible Things Happen: What You May Experience

Immediate Reactions

There are a wide variety of positive and negative reactions that survivors can experience during and immediately after a disaster. These include:

Domain	Negative Responses	Positive Responses
Cognitive	Confusion, disorientation, worry, intrusive thoughts and images, self-blame	Determination and resolve, sharper perception, courage, optimism, faith
Emotional	Shock, sorrow, grief, sadness, fear, anger, numbness, irritability, guilt and shame	Feeling involved, challenged, mobilized
Social	Extreme withdrawal, interpersonal conflict	Social connectedness, altruistic helping behaviors
Physiological	Fatigue, headache, muscle tension, stomach ache, increased heart rate, exaggerated startle response, difficulties in sleeping	Alertness, readiness to respond, increased energy

Common negative reactions that may continue include:

Intrusive reactions

- Distressing thoughts or images of the event while awake or dreaming
- Upsetting emotional or physical reactions to reminders of the experience
- Feeling like the experience is happening all over again (“flashback”)

Avoidance and withdrawal reactions

- Avoid talking, thinking, and having feelings about the traumatic event
- Avoid reminders of the event (places and people connected to what happened)
- Restricted emotions; feeling numb
- Feelings of detachment and estrangement from others; social withdrawal
- Loss of interest in usually pleasurable activities

Physical arousal reactions

- Constantly being “on the lookout” for danger, startling easily, or being jumpy
- Irritability or outbursts of anger, feeling “on edge”
- Difficulty falling or staying asleep, problems concentrating or paying attention

Reactions to trauma and loss reminders

- Reactions to places, people, sights, sounds, smells, and feelings that are reminders of the disaster
- Reminders can bring on distressing mental images, thoughts, and emotional/physical reactions
- Common examples include: sudden loud noises, sirens, locations where the disaster occurred, seeing people with disabilities, funerals, anniversaries of the disaster, and television/radio news about the disaster

When Terrible Things Happen: What You May Experience

Positive changes in priorities, worldview, and expectations

- Enhanced appreciation that family and friends are precious and important
- Meeting the challenge of addressing difficulties (by taking positive action steps, changing the focus of thoughts, using humor, acceptance)
- Shifting expectations about what to expect from day-to-day and about what is considered a “good day”
- Shifting priorities to focus more on quality time with family or friends
- Increased commitment to self, family, friends, and spiritual/religious faith

Common reactions when a loved one dies

- Feeling confused, numb, disbelief, bewildered, or lost
- Feeling angry at the person who died or at people considered responsible for the death
- Strong physical reactions such as nausea, fatigue, shakiness, and muscle weakness
- Feeling guilty for still being alive
- Intense emotions such as extreme sadness, anger, or fear
- Increased risk for physical illness and injury
- Decreased productivity or difficulties making decisions
- Having thoughts about the person who died, even when you don’t want to
- Longing, missing, and wanting to search for the person who died
- Becoming anxious when separated from caregivers or other companions

What Helps

- Talking to another person for support or spending time with others
- Engaging in positive distracting activities (hobbies, reading, etc.)
- Getting adequate rest and eating healthy meals
- Trying to maintain a normal schedule
- Scheduling pleasant activities
- Taking breaks
- Reminiscing about a loved one who has died
- Focusing on something practical that you can do right now to manage the situation better
- Using relaxation methods (breathing exercises, meditation, calming self-talk, soothing music)
- Participating in a support group
- Exercising in moderation
- Keeping a journal
- Seeking counseling

What Does Not Help

- Using alcohol or drugs to cope
- Extreme withdrawal from family or friends
- Overeating or failing to eat
- Withdrawing from pleasant activities
- Working too much
- Violence or conflict
- Doing risky things (driving recklessly, substance abuse, not taking adequate precautions)
- Blaming others
- Extreme avoidance of thinking or talking about the event or a death of a loved one
- Not taking care of yourself
- Excessive TV or computer games

Tips for Nursing Home Staff and Residents after Disasters

Reactions/Behavior	Responses	Examples of things to do and say
<p><u>High anxiety/arousal:</u> Tension and anxiety are common after disasters. Adults may be excessively worried about the future, have difficulties sleeping, problems concentrating, and feel jumpy and nervous. These reactions can include rapid heartbeat and sweating.</p>	<ul style="list-style-type: none"> ● Use breathing and/or other relaxations skills. ● Take time during the day to calm yourself through relaxation exercises. These can make it easier to sleep, concentrate, and will give you energy. ● 	<ul style="list-style-type: none"> ● Breathing exercise: Inhale through your nose and comfortably fill your lungs all the way down to your stomach, while saying to yourself, “My body is filled with calm.” Exhale slowly through your mouth and empty your lungs, while silently saying to yourself, “My body is letting go.” Do this five times slowly, and as many times a day as needed.
<p><u>Concern or shame</u> over your own reactions. Many people have strong reactions after a disaster, including fear and anxiety, difficulty concentrating, shame about how they reacted, and feeling guilty about something. It is expected and understandable to feel many emotions in the aftermath of an extremely difficult event.</p>	<ul style="list-style-type: none"> ● Find a good time to discuss your reactions with a family member or trusted friend. ● Remember that these reactions are common and it takes time for them to subside. ● Correct excessive self-blame with realistic assessment of what actually could have been done. 	<ul style="list-style-type: none"> ● When talking with someone, find the right time and place, and ask if it is okay to talk about your feelings. ● Remind yourself that your feelings are expected and you are not “going crazy,” and that you are not at fault for the disaster. ● If these feelings persist for a month or more, you may wish to seek professional help.
<p><u>Feeling overwhelmed</u> by tasks that need to be accomplished (housing, food, paperwork for insurance, child care, parenting).</p>	<ul style="list-style-type: none"> ● Identify what your top priorities are. ● Find out what services are available to help get your needs met. ● Make a plan that breaks down the tasks into manageable steps. 	<ul style="list-style-type: none"> ● Make a list of your concerns and decide what to tackle first. Take one step at a time. ● Find out which agencies can help with your needs and how to access them. ● Where appropriate, rely on your family, friends, and community for practical assistance.
<p><u>Fear of recurrence and reactions to reminders:</u> It is common for survivors to fear that another disaster will occur, and to react to things that are reminders of what happened.</p>	<ul style="list-style-type: none"> ● Be aware that reminders can include people, places, sounds, smells, feelings, and time of day. ● Remember that media coverage of the disaster can be a reminder and trigger fears of it happening again. 	<ul style="list-style-type: none"> ● When you are reminded, try saying to yourself, “I am upset because I am being reminded of the disaster, but it is different now because the disaster is not happening and I am safe.” ● Limit your viewing of news reports so you can just get the information you need.
<p><u>Changes in attitude, view of the world and of oneself:</u> Strong changes in people’s attitudes after a disaster are common, including questioning one’s spiritual beliefs, trust in others and social agencies, and concerns about one’s own effectiveness, and dedication to helping others.</p>	<ul style="list-style-type: none"> ● Postpone any major unnecessary life changes in the immediate future. ● Remember that dealing with post-disaster difficulties increases your sense of courage and effectiveness. ● Get involved with community recovery efforts. 	<ul style="list-style-type: none"> ● Getting back to a more structured routine can help improve decision-making. ● Remind yourself that going through a disaster can have positive effects on what you value and how you spend your time.
<p><u>Using alcohol and drugs, or engaging in gambling or high-risk sexual behaviors:</u> Many</p>	<ul style="list-style-type: none"> ● Understand that using substances and engaging in addictive behaviors can be a dangerous 	<ul style="list-style-type: none"> ● Remember that substance use and other addictive behaviors can lead to problems with sleep,

Reactions/Behavior	Responses	Examples of things to do and say
<p>people feel out of control, scared, hopeless, or angry after a disaster and engage in these behaviors to feel better. This can especially be a problem if there was pre-existing substance abuse or addiction.</p>	<p>way to cope with what happened.</p> <ul style="list-style-type: none"> ● Get information about local support agencies. 	<p>relationships, jobs, and physical health.</p>
<p>Shifts in interpersonal relationships: People may feel differently towards family and friends; for example, they may feel overprotective and very concerned for each other’s safety, frustrated by the reactions of a family member or friend, or may feel like pulling away from family and friends.</p>	<ul style="list-style-type: none"> ● Understand that family and friends are a major form of support during the recovery period. ● It is important to understand and tolerate different courses of recovery among family members. ● Rely on other family members for help with parenting or other daily activities when you are upset or under stress. 	<ul style="list-style-type: none"> ● Don’t withdraw from others because you feel you might burden them. Most people do better turning to others after disasters. ● Ask your friends and family how they are doing rather than just giving advice or telling them to “get over it.” Offer a supportive ear or lend a helping hand. ● Say, “We’re crabby with each other and that is completely normal given what we’ve been through. I think we’re handling things amazingly. It’s a good thing we have each other.”
<p>Excessive anger: Some degree of anger is understandable and expected after a disaster, especially when something feels unfair. However, when it leads to violent behavior, extreme anger is a serious problem.</p>	<ul style="list-style-type: none"> ● Find ways to manage your anger that help you rather than hurt you. 	<ul style="list-style-type: none"> ● Take time to cool down, walk away from stressful situations, talk to a friend about what is making you angry, get physical exercise, distract yourself with positive activities, or problem-solve the situation that is making you angry. ● Remind yourself that being angry may harm important relationships. ● If you become violent, get immediate help.
<p>Sleep difficulties: Trouble falling asleep and frequent awakening is common after a disaster, as people are on edge and worried about adversities and life changes.</p>	<ul style="list-style-type: none"> ● Make sure you have good sleep routines. 	<ul style="list-style-type: none"> ● Go to sleep at the same time every day. ● Don’t have caffeinated drinks in the evening. ● Reduce alcohol consumption. ● Increase daytime exercise. ● Relax before bedtime. ● Limit daytime naps to 15 minutes and do not nap later than 4 pm.

Nursing Home Staff and Residents: Tips For Relaxation

Tension and anxiety are common after disasters. Unfortunately, they can make it more difficult to cope with the many things that must be done to recover. There is no easy solution to coping with post-disaster problems, but taking time during the day to calm yourself through relaxation exercises may make it easier to sleep, concentrate, and have energy for coping with life. These can include muscular relaxation exercises, breathing exercises, meditation, stretching, yoga, prayer, exercise, listening to quiet music, spending time in nature, and so on. Here are some basic breathing exercises that may help:

For Staff:

1. Inhale slowly (one-thousand one; one-thousand two; one-thousand three) through your nose and comfortably fill your lungs all the way down to your belly.
2. Silently and gently say to yourself, “My body is filled with calmness.” Exhale slowly (one-thousand one, one-thousand two, one-thousand three) through your mouth and comfortably empty your lungs all the way down to your abdomen.
3. Silently and gently say to yourself, “My body is releasing the tension.”
4. Repeat five times slowly and comfortably.
5. Do this as many times a day as needed.

For Residents:

Lead a resident through a breathing exercise:

1. “Let’s practice a different way of breathing that can help calm our bodies down.
2. Put one hand on your stomach, like this [demonstrate].
3. Okay, we are going to breathe in through our noses. When we breathe in, we are going to fill up with a lot of air and our stomachs are going to stick out like this [demonstrate].
4. Then, we will breathe out through our mouths. When we breathe out, our stomachs are going to suck in and up like this [demonstrate].
5. We are going to breathe in really slowly while I count to three. I’m also going to count to three while we breathe out really slowly.
6. Let’s try it together. Great job!”

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Alcohol, Medication, and Drug Use After Disaster

Some people increase their use of alcohol, prescription medications, or other drugs after a disaster. You may feel that using drugs and alcohol seem to help you escape bad feelings or physical symptoms related to stress responses (e.g., headaches, muscle tension). However, they can actually make these things worse in the long-term because they interrupt natural sleep cycles, create health problems, interfere with relationships, and create potential dependence on the substance. If your use of alcohol or drugs has increased since the disaster or is causing problems for you, it is important for you to reduce your level of use or seek help in gaining control over your use.

Managing Alcohol, Medication, and Drug Use

- Pay attention to any change in your use of alcohol and/or drugs.
- Correctly use prescription and over-the-counter medications as indicated.
- Eat well, exercise, get enough sleep, and use your family and others for support.
- If you feel like using larger amounts of either prescribed or over-the-counter medications, consult a healthcare professional.
- Consult with a healthcare professional about safe ways to reduce anxiety, depression, muscle tension, and sleep difficulties.
- If you find that you have greater difficulty controlling alcohol/substance use since the disaster, seek support in doing so.
- If you believe you have a problem with substance abuse, talk to your doctor or a counselor about it.

If You Have Had an Alcohol, Medication, or Drug Problem in the Past

For people who have successfully stopped drinking or using drugs, experiencing a disaster can sometimes result in strong urges to drink or use again. Sometimes it can lead them to strengthen their commitment to recovery. Whatever your experience, it is important to consciously choose to stay in recovery.

- Increase your attendance at substance abuse support groups.
- If you are receiving disaster crisis counseling, talk to your counselor about your past alcohol or drug use.
- If you have been forced to move out of your local community, talk to disaster workers about helping to locate nearby alcohol or drug recovery groups, or ask them to help organize a new support group.
- Talk with family and friends about supporting you to avoid use of alcohol or substances.
- If you have a 12-step sponsor or substance abuse counselor, talk to him or her about your situation.
- Increase your use of other supports that have helped you avoid relapse in the past.

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