

Psychological First Aid

*Overall Effects of Disaster on Humans:
Civilians & Responders*



Sam D. Bernard, Ph.D.

Bernard & Associates PC

Chattanooga, TN

Thank You

- Anna Allen, DVM
- Connie McElroy-Bacon
- Laina Stensvold
- Planning Committee
- YOU!
- ...and those covering for you!

Welcome also to:

- National Animal Rescue and Sheltering Coalition (NARSC)
- National Alliance of State Animal and Agriculture Emergency Programs (NASAAEP)

Goals

- Have a better overall understanding of psychological impact of crisis:
 - Principles
 - Effects
 - Interventions
- Know when to call for assistance,
- Know how to self-care,
- Access further training and education.

Agenda

- Disaster Mental Health Core Concepts
- Psychological First Aid
- Caring for the Caregiver
- Resources

Impact Statement

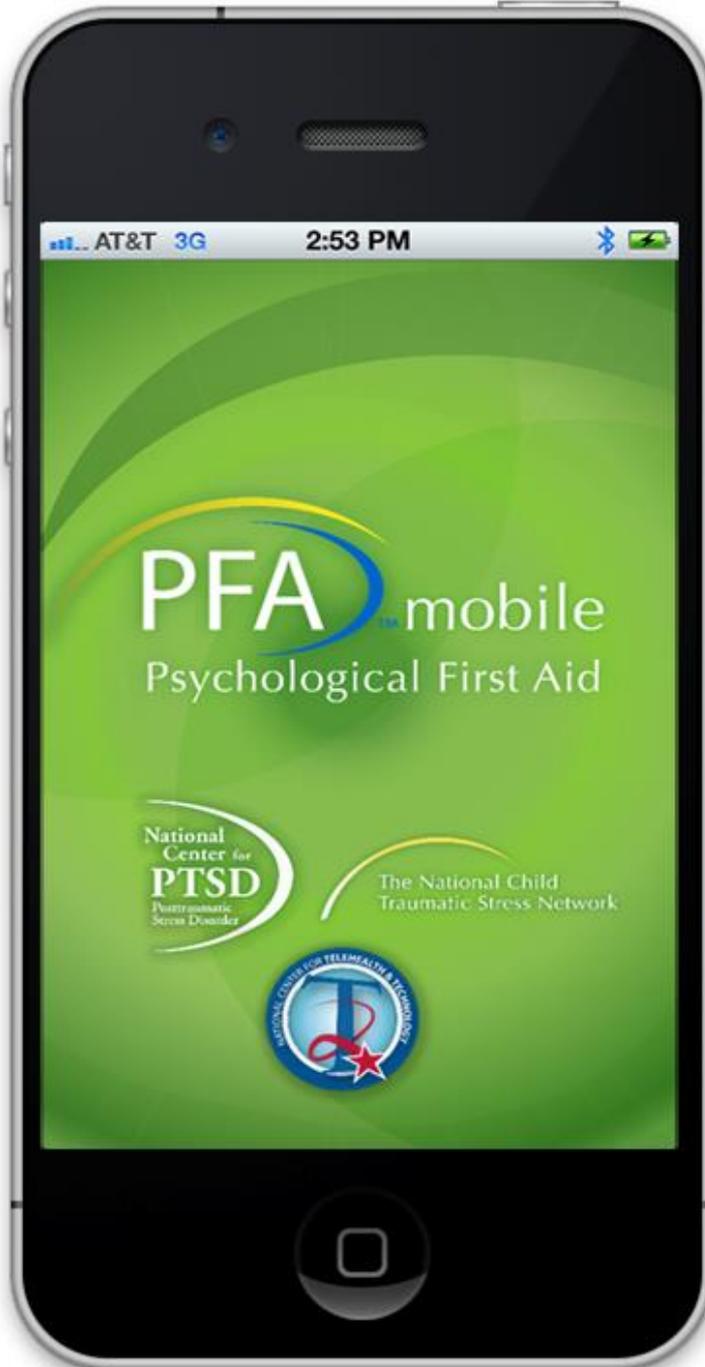
- Topic: School Crisis
- Scenarios: Real Life & Customized for you
- Psychological Activation:
 - If you become activated, take care of yourself,
 - Take a break,
 - Come back and re-join us, we need you,
- Memories: “Where You have Been, Not Where You Are”
- I’ll Help:
 - I’ll stay after presentation
 - (423) 322-3297

Facing Your Worst Fears . . .

Psychological First Aid

- Preparing to deliver PFA
- Contact & Engagement
- Safety & Comfort
- Stabilization
- Information Gathering:
 - Current Needs
 - Concerns
- Practical Assistance
- Connection with Social Supports
- Information on Coping
- Linkage with Collaborative Services





Psychological First Aid Tutorial

PFA Key Actions:

- Promote Safety
- Calm and Comfort
- Connectedness
- Self Empowerment

Choose from the options below:



PFA Basics



Traumatic Stress Reactions



How to Provide PFA



Interacting with the Survivor

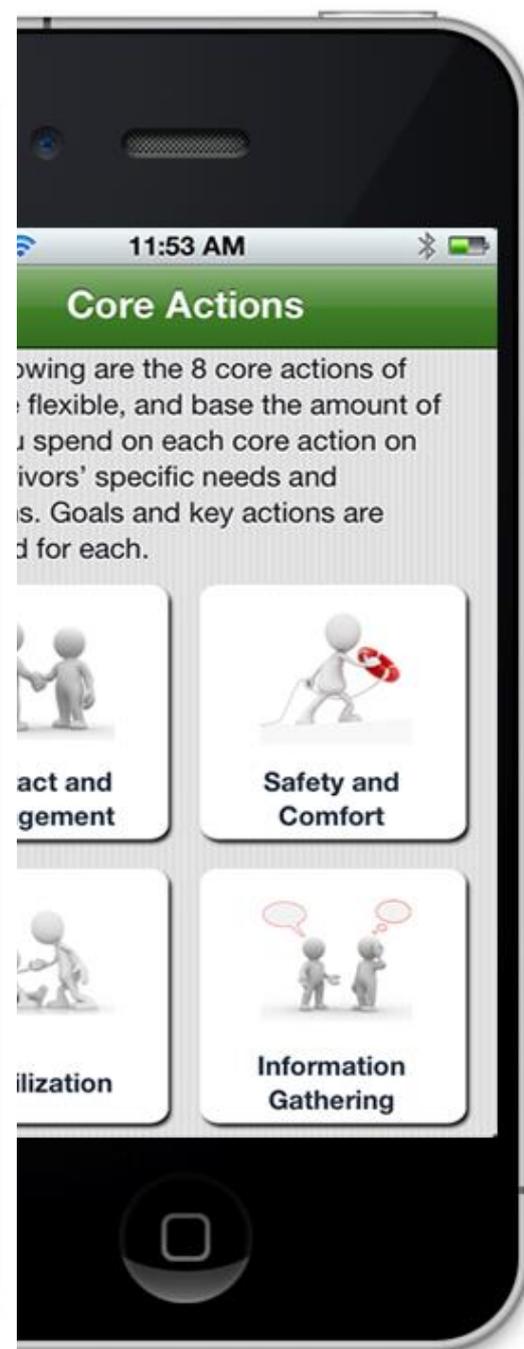
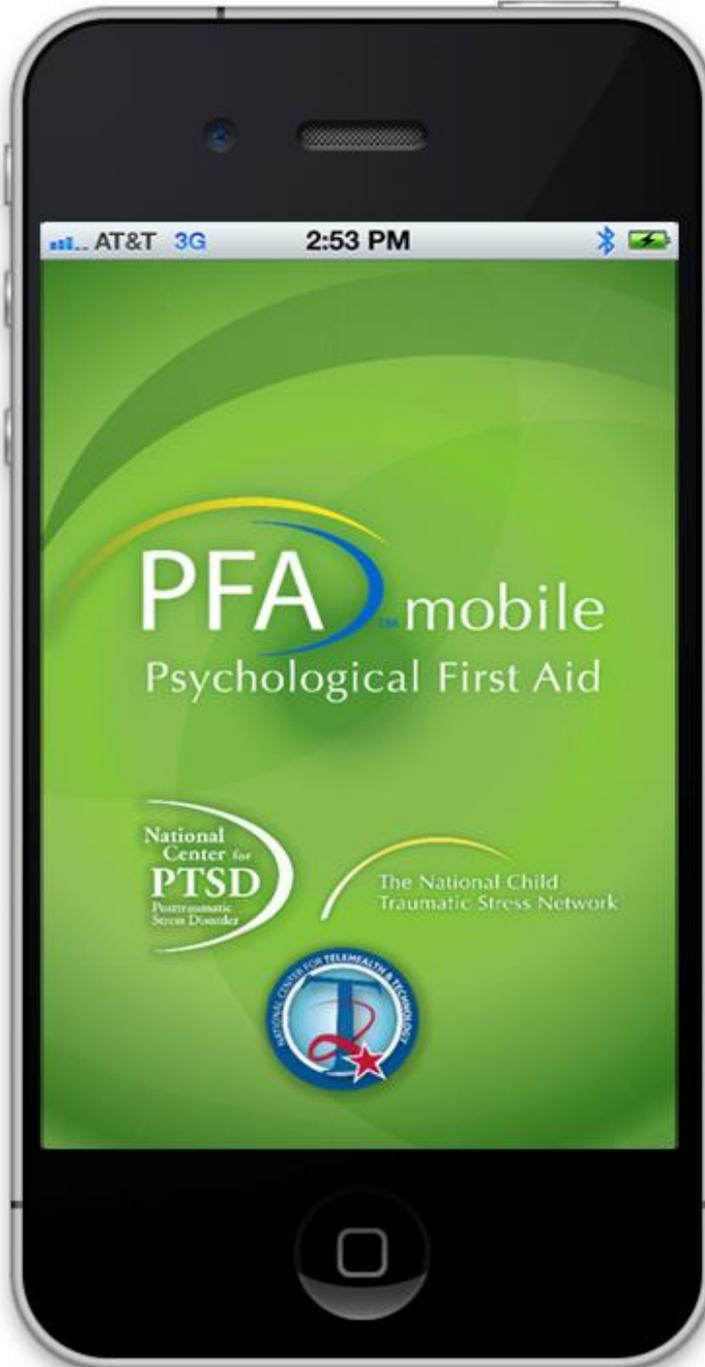


When to Refer



Responder Self-Care





NCTSN



**The National Child
Traumatic Stress Network**

www.NCTSN.org

But...

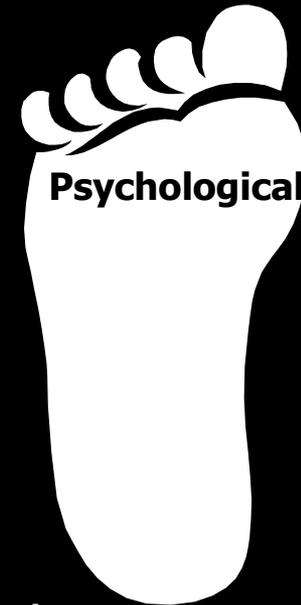
Why?

What is behind all of this?

Footprint of Disasters

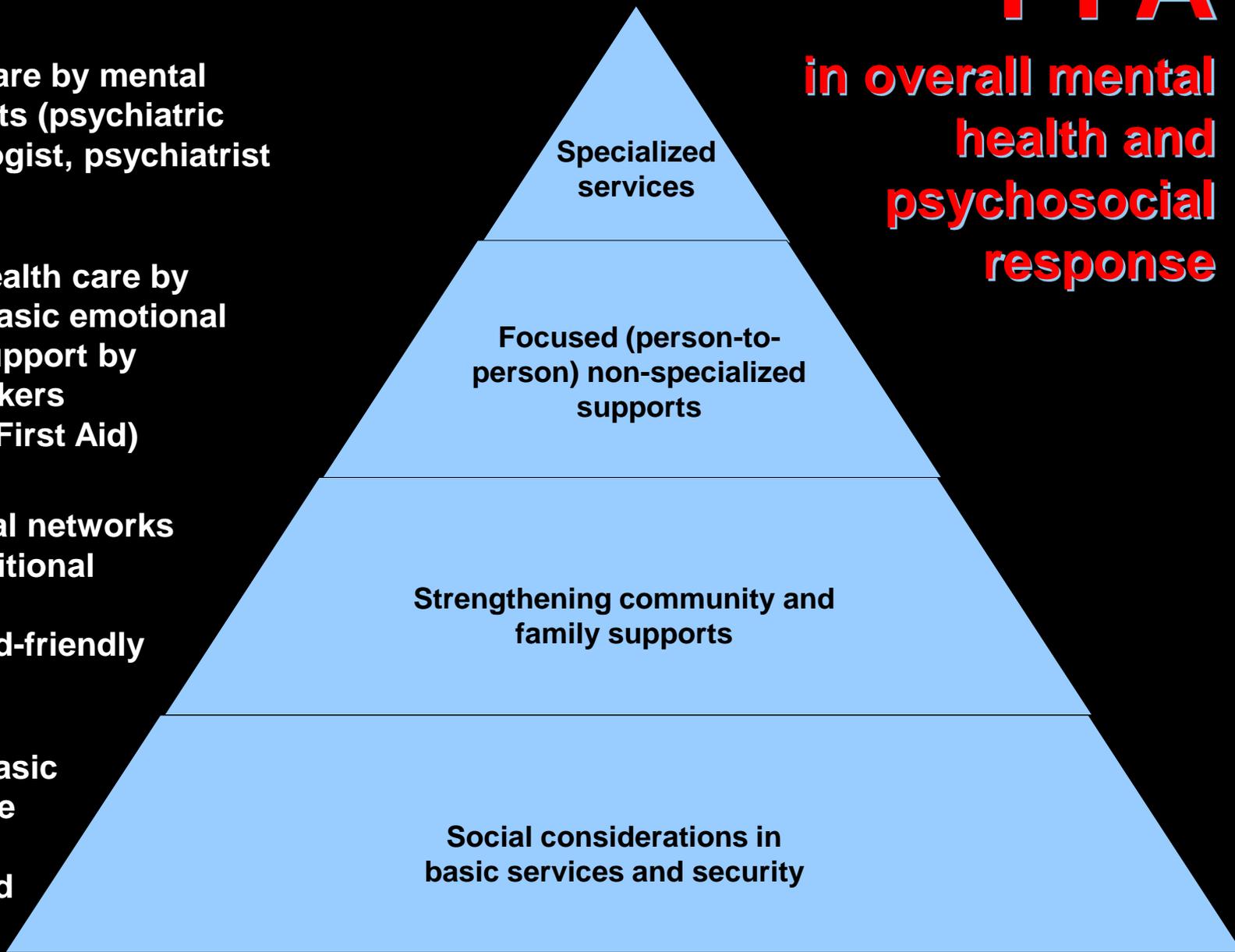
The psychological “Footprint” of a disaster is larger than the medical “Footprint”

- Greater number of individuals impacted
- Greater geographical impact



PFA

in overall mental health and psychosocial response



Specialized services

Focused (person-to-person) non-specialized supports

Strengthening community and family supports

Social considerations in basic services and security

Mental health care by mental health specialists (psychiatric nurse, psychologist, psychiatrist etc)

Basic mental health care by PHC doctors; Basic emotional and practical support by community workers (Psychological First Aid)

**Activating social networks
Communal traditional supports
Supportive child-friendly spaces**

Advocacy for basic services that are safe, socially appropriate and protect dignity

PFA Action Principles

Prepare	<ul style="list-style-type: none">• Learn about the crisis event.• Learn about available services and supports.• Learn about safety and security concerns.
Look 	<ul style="list-style-type: none">• Observe for safety.• Observe for people with obvious urgent basic needs.• Observe for people with serious distress reactions.
Listen 	<ul style="list-style-type: none">• Make contact with people who may need support.• Ask about people's needs and concerns.• Listen to people and help them feel calm.
Link 	<ul style="list-style-type: none">• Help people address basic needs and access services.• Help people cope with problems.• Give information.• Connect people with loved ones and social support.

3 Rs of Crisis & Disasters

1. **Readiness:** the level at which a school is prepared to respond to a crisis or to an emergency today.
2. **Response:** the sum total of the recourses and skills to take decisive and effective action when a crisis has occurred.
3. **Recovery:** process of restoring the social and emotional equilibrium of the school community.

Definition of Crisis

Everly & Mitchell, 1999

An Acute response to a critical incident wherein:

- Psychological homeostasis is disrupted
- Usual coping mechanisms fail to re-establish homeostasis
- Evidence of Functional Impairment

Goals of Crisis Intervention

- **Stabilization** of sign/symptoms of distress,
- **Mitigation** of signs/symptoms of distress,
- **Restoration** of Functional capabilities,
- **Follow-up** and/or **Referral**

5 Principles of Crisis Intervention

1. **Mobilize a crisis intervention team** in response to a significant critical incident, then actively implement the most appropriate crisis intervention tactics in response to observable signs or reported symptoms (evidence of need) of distress and/or dysfunction.

5 Principles of Crisis Intervention

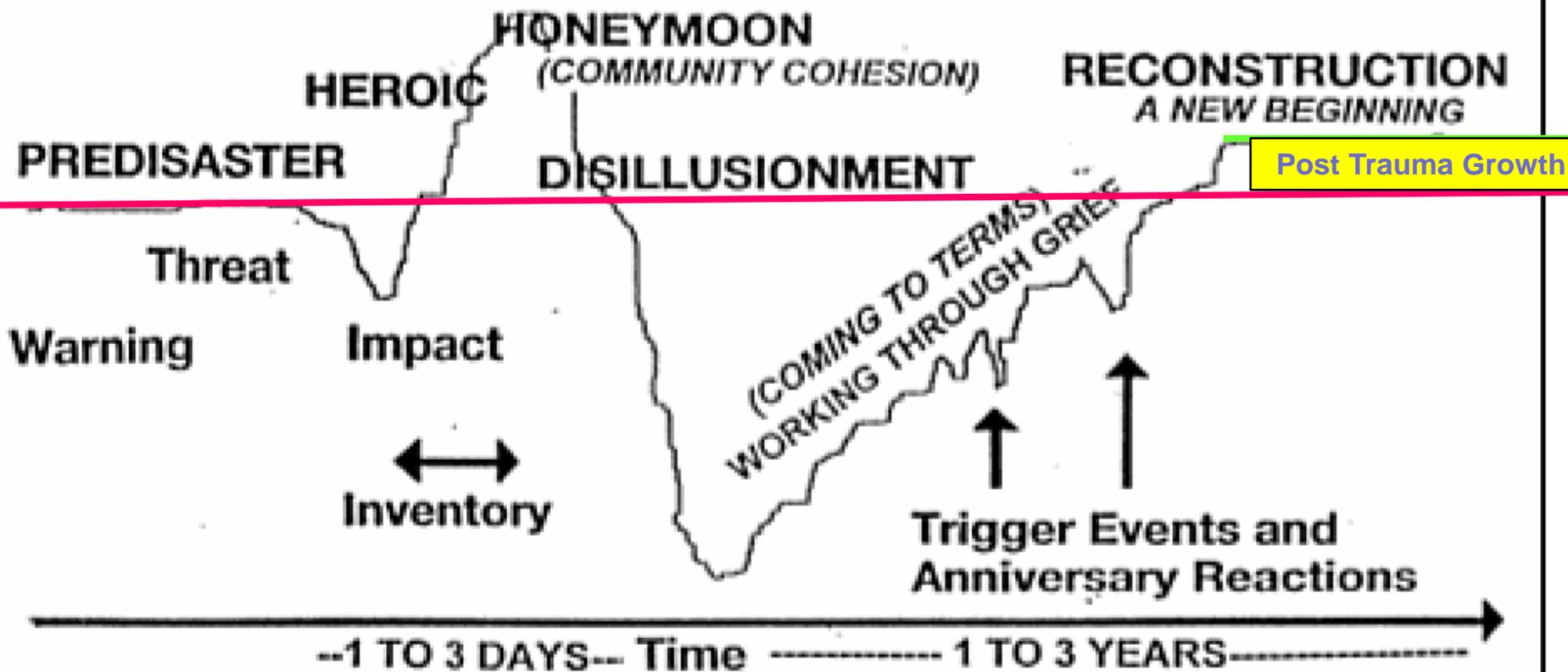
2. Not all signs and symptoms of acute distress are pathognomonic.
3. Tailor the crisis intervention to the needs of the individual(s).
4. Timing for crisis intervention is based upon psychological readiness, rather than actual passage of time. *(See Phases of Disaster by Faberow & Gordon, 1981)*

5 Principles of Crisis Intervention

5. Select the best crisis intervention strategies and tactics considering:
 - a. The specific event,
 - b. Specific population affected
 - c. Implemented at the best respective times

Phases of Disaster

Phases of Disaster



Phases of Disaster

Warning of Threat: Ranges from no advance notice (suicide bomber) to weeks (hurricane)

Impact: Actual onset of disaster Varies. BT has fuzzy beginning/end; bombing is precise

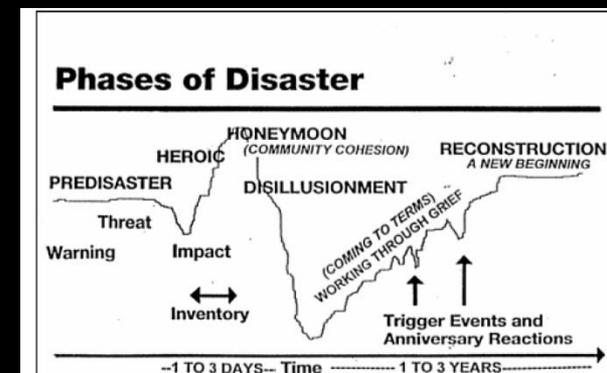
Rescue or Heroic: People watch out for, protect, even risk own safety to save strangers

Remedy or Honeymoon: People initially pitch in and collaborate for the collective good

Inventory: External resources begin to come online—people watch what goes where

Disillusionment: Resource allocation often seen as too little too late, poorly distributed

Reconstruction and Recovery: People move beyond self interests and start to rebuild



Typical Reactions

- Physical
- Cognitive
- Behavioral
- Emotional
- Spiritual

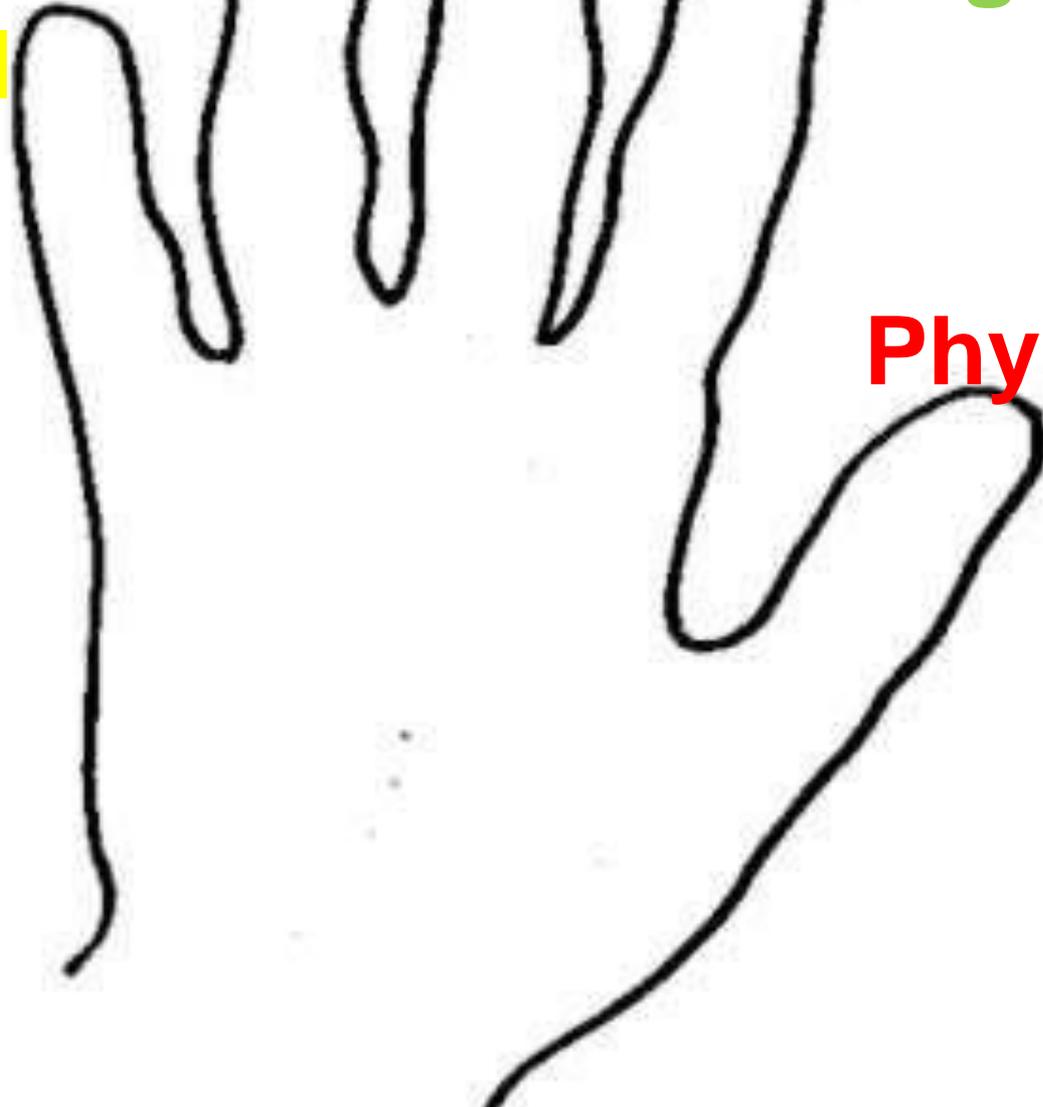
Emotional

Behavioral

Cognitive

Spiritual

Physical



Typical Reactions

Spiritual

- Anger at God
- Uncharacteristic religious involvement
- Withdrawal from place of worship
- Loss of Meaning or purpose
- Faith practices seem empty
- Sense of isolation from God
- Questioning basic beliefs
- Angry at clergy

Cognitive

- Memory Problems
- Poor concentration
- Poor attention span
- Slowed problem solving
- Difficulty making decisions
- Difficulties with calculations

Behavioral

- Excessive silence
- Sleep disturbances
- Unusual behaviors
- Changes in eat/sleep/people habits
 - Withdrawal from contact
 - Change in work habits

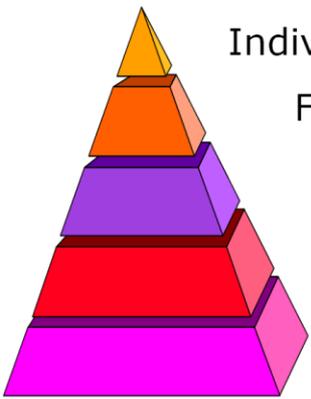
Emotional

- Guilt
- Loss of emotional control
- Feeling lost/overwhelmed
- Anxiety/Fear
- Depression
- Grief

Physical

- Headaches
- Chest pains
- Muscle tremors
- Difficulty Breathing
- Gastrointestinal distress
- Elevated blood pressure

Impact Pyramid



Individual victims

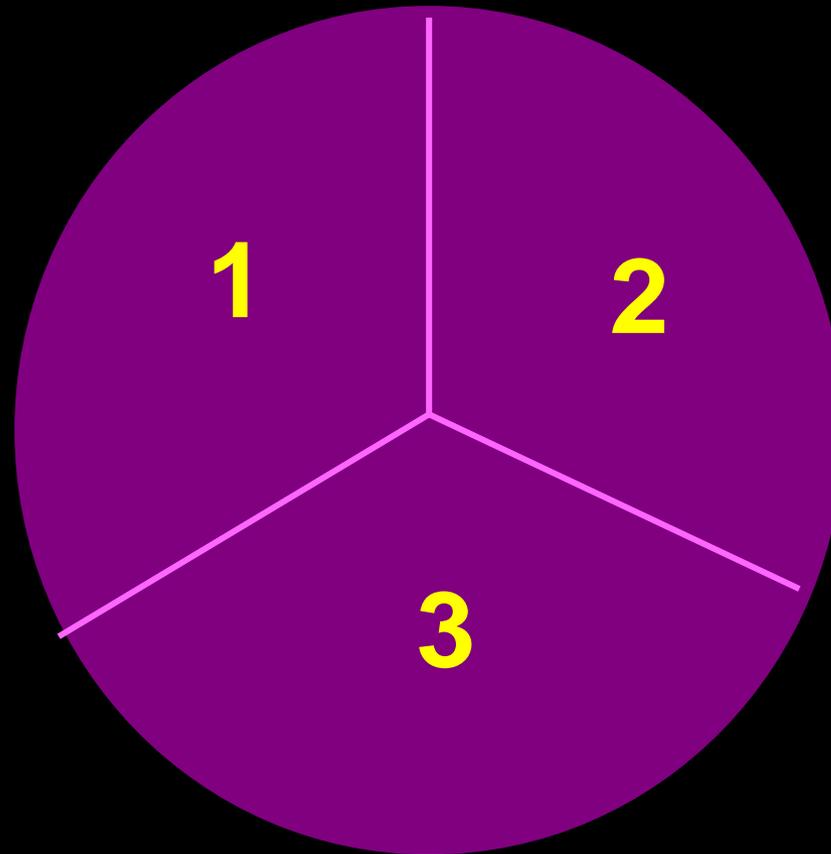
Families and social networks

Rescue workers, medical care providers, their families and social networks

Vulnerable populations and impacted businesses

Ordinary people and their communities

“1/3 Rule” - Theoretical



8%

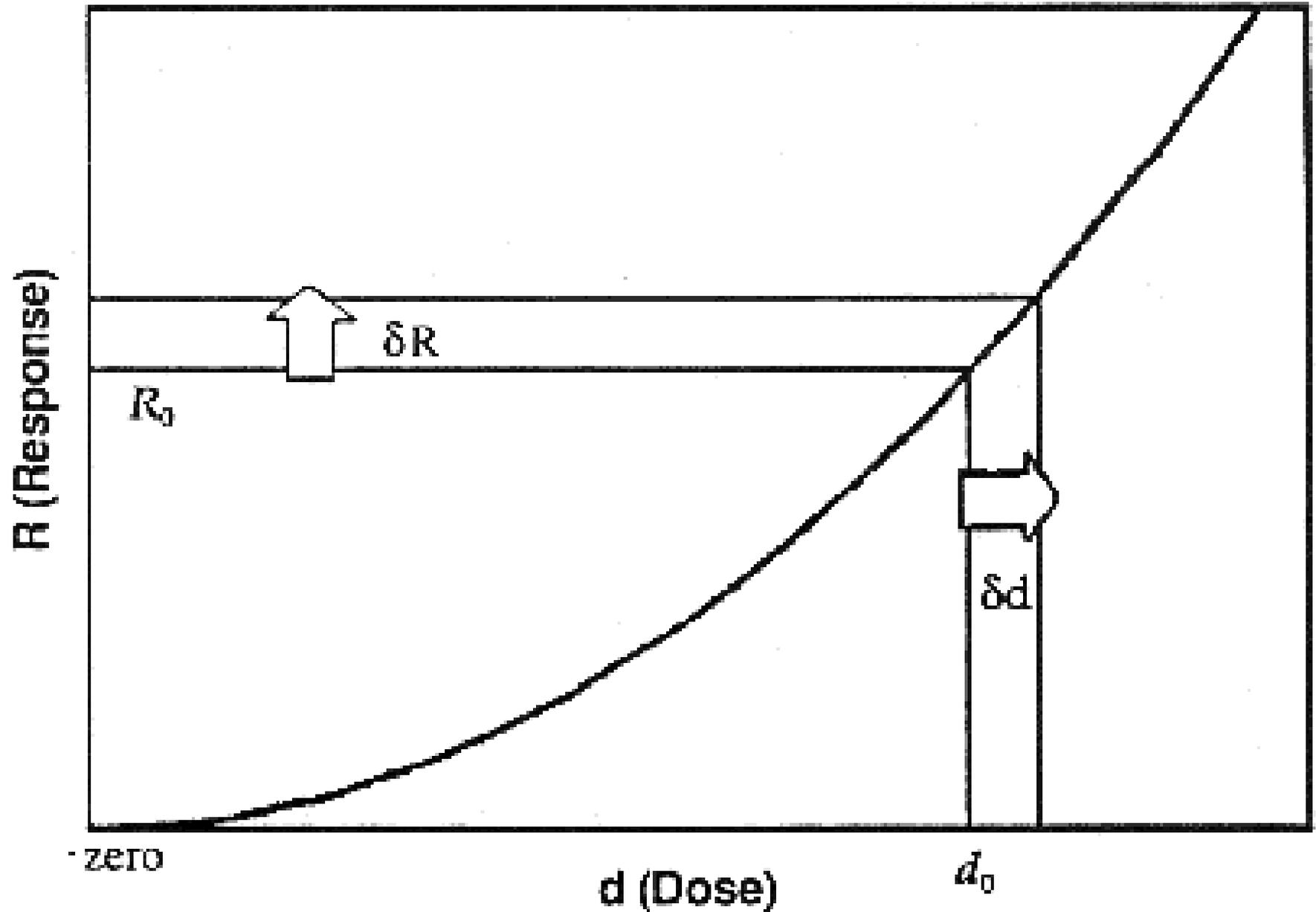
Imprint of Horror

“Dose Anchors”

- Visual
- Auditory
- Olfactory
- Kinesthetic
- Gustatory
- Temporal



Dose Response



Relationship

Number of people affected

Many

Few

Mild/Few

Severity or number of symptoms

Severe/Many

Examples of mild reactions:
• Insomnia
• Worry
• Feeling upset

Examples of moderate reactions:
• Persistent insomnia
• Anxiety

Examples of severe reactions:
• PTSD
• Depression



Department of Health and Human Services

Centers for Disease Control and Prevention

Factors Influencing Reactions

1. Prior experience with the same or similar event
2. The intensity of the disruption
3. The length of time that has elapsed between the event occurrence and the present
4. Individual feelings that there is no escape, which sets the stage for panic
5. Emotional strength of the person



Risk Factors for Mental Disorders

- Academic failure and scholastic demoralization
- Attention deficits
- Caring for chronically ill or dementia patients
- Child abuse and neglect
- Chronic insomnia
- Chronic pain
- Communication deviance
- Early pregnancies
- Elder abuse
- Emotional immaturity and dyscontrol
- Excessive substance use
- Exposure to aggression, violence and trauma
- Family conflict or family disorganization
- Loneliness
- Low birth weight
- Low social class
- Medical illness
- Neurochemical imbalance
- Parental mental illness
- Parental substance abuse
- Perinatal complications
- Personal loss – bereavement
- Poor work skills and habits
- Reading disabilities
- Sensory disabilities or organic handicaps
- Social incompetence
- Stressful life events
- Substance use during pregnancy

Protective Factors for Mental Disorders

- Ability to cope with stress
- Ability to face adversity
- Adaptability
- Autonomy
- Early cognitive stimulation
- Exercise
- Feelings of security
- Feelings of mastery and control
- Good parenting
- Literacy
- Positive attachment & early bonding
- Positive parent–child interaction
- Problem-solving skills
- Pro-social behavior
- Self-esteem
- Skills for life
- Social and conflict management skills
- Socioemotional growth
- Stress management
- Support of family & friends



Chronic Stressors In Disaster

- Family Disruption
- Work Overload
- Gender Differences
- Bureaucratic Hassles
- Financial Strain

Peritraumatic Stress Symptoms

- Dissociation
 - Depersonalization, derealization, fugue states, amnesia
- Intrusive Re-Experiencing
 - Flashbacks, terrifying memories or night mares, repetitive automatic re-enactments
- Avoidance
 - Agoraphobic-like social withdrawal
- Hyperarousal
 - Panic episodes, startle reactions, fighting or temper problems
- Anxiety
 - Debilitating worry, nervousness, vulnerability or powerlessness
- Depression
 - Anhedonia, worthlessness, loss of interest in most activities, awakening early, persistent fatigue, and lack of motivation
- Problematic Substance Use
 - Abuse or dependency, self-medication
- Psychotic Symptoms
 - Delusions, hallucinations, bizarre thoughts or images, catatonia

Highest Risk for Extreme Peritraumatic Stress

- Life-Threatening danger, extreme violence, or sudden death of others;
- Extreme loss or destruction of their homes, normal lives, and communities;
- Intense emotional demands from distraught SURVIVORS (rescue workers, counselors, caregivers);
- Prior psychiatric or marital/family problems;
- Prior significant loss (death of a loved one in the past year)

Cardena & Spiegel, 1993; Joseph et.al., 1994; Kooperman, et.al., 1994&5; La Greca et.al., 1996; Lonigan, et.al., 1994; Schwarz & Kowalski, 1991; Shalev, et.al., 1993

Medical Triage



CONTAMINATED

Personal Property Receipt*
Evidence Tag *413730*

Destination _____
Via _____ *413730*

TRIAGE TAG *413730*

S L U D G E
Salivation Lacrimation Urination Defecation G.I. Distress Emesis

AUTO INJECTOR 1 2 3 4 5

Yes No	Gross Decon
Yes No	Secondary Decon
Solution	
<input type="checkbox"/>	Blunt Trauma
<input type="checkbox"/>	Burn
<input type="checkbox"/>	C-Spine
<input type="checkbox"/>	Cardiac
<input type="checkbox"/>	Crushing
<input type="checkbox"/>	Fracture
<input type="checkbox"/>	Laceration
<input type="checkbox"/>	Penetrating Injury

BIOLOGICAL AGENT

CHEMICAL AGENT

RADIOLOGICAL AGENT

Age _____

Male Female

Other: _____

VITAL SIGNS

Time	B/P	Pulse	Respiration

Time	Drug Solution	Dose

MORGUE
Pulseless/Non-Breathing *413730*

IMMEDIATE
Life Threatening Injury *413730*

DELAYED
Serious, Non Life Threatening *413730*

MINOR
Walking Wounded *413730*

EVIDENCE

413730 DEFT

Psychological Triage

- Criterion Based
- Experiential Based

Psychological Triage

PsySTART™ Behavioral Health Triage System **Field Triage**

CLIENT NAME _____

HOME (Pre-event) _____

ARC WORKER (Name/ID#) _____

ARC DMH CONTACT (Name/Telephone) _____

Saw/heard death or serious injury of others? YES NO

Felt they (or loved one) almost died? YES NO

Received physical injury or self/loved one is physically ill? YES NO

Received medical treatment (self/loved one)? YES NO
If yes, describe: _____

Death of family member, friend, schoolmate, pet? YES NO
If yes, list: _____

Separated from family member? YES NO

Child separated from parent? YES NO

Family member missing? YES NO
If yes, list: _____

Home not livable? YES NO
Circle one: Destroyed Damaged Unknown

Expresses thought/intent to harm self? YES NO

Expresses thought/intent to seriously harm others? YES NO

Note to ARC Worker:

- If any RED items are checked above, contact site supervisor and DMH immediately
- If any YELLOW or ORANGE items are checked, contact DMH as soon as possible and indicate triage items from above

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PsySTART™ Behavioral Health Triage System

	YES	NO
Saw/heard death or serious injury of others?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Felt they (or loved one) almost died?	<input type="checkbox"/>	<input type="checkbox"/>
Received physical injury or self/loved one is physically ill?	<input type="checkbox"/>	<input type="checkbox"/>
Received medical treatment (self/loved one)?	<input type="checkbox"/>	<input type="checkbox"/>
Death of family member, friend, schoolmate, pet?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Separated from family member?	<input type="checkbox"/>	<input type="checkbox"/>
Child separated from parent?	<input type="checkbox"/>	<input type="checkbox"/>
Family member missing?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Home not livable?	<input type="checkbox"/>	<input type="checkbox"/>
Expresses thought/intent to harm self?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Expresses thought/intent to seriously harm others?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

 If yes, contact DMH as soon as possible.

 If yes, contact site supervisor and DMH immediately.

DMH Contact: _____

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**Merritt Schreiber, Ph.D., Coordinator
Terrorism and Disaster Branch,
National Center for Child Traumatic Stress**

Psychological Triage

- **Neuromuscular “Freezing”** *Levine, 1997, Lee, Vaillant, Torrey, & Elder, 1995*
- **Severe time distortion** *Fontana & Rosenheck, 1993*
- **Psychogenic analgesia** *Fontana & Rosenheck, 1993*
- **Traumatic psychogenic amnesia** *Fontana & Rosenheck, 1993*
- **Dissociation, depersonalization, and/or derealization** *Marmar, Weiss, Schlenger, et.al., 1994; Weiss, Marmar, Metzler, & Ronfeldt, 1995; Koopman, Classen & Speigal, 1994; Holen, 1993; Shalev, et.al 1996*
- **Manifestations of sympathetic nervous system dysfunction** *Everly, 1989, Brewin, Andrews, Rose & Kirk, 1999*
- **Manifestations of enhanced parasympathetic arousal** *Everly, 1989; Lee, Vaillant, Torrey, & Elder, 1995*
- **Guilt reactions, including “survivor guilt”** *Holen, 1993; Peterson, Prout & Schwarz, 1991*
- **Helpless, hopeless ideation** *Seligman, 1975*
- **Suicidal / Homicidal ideation**

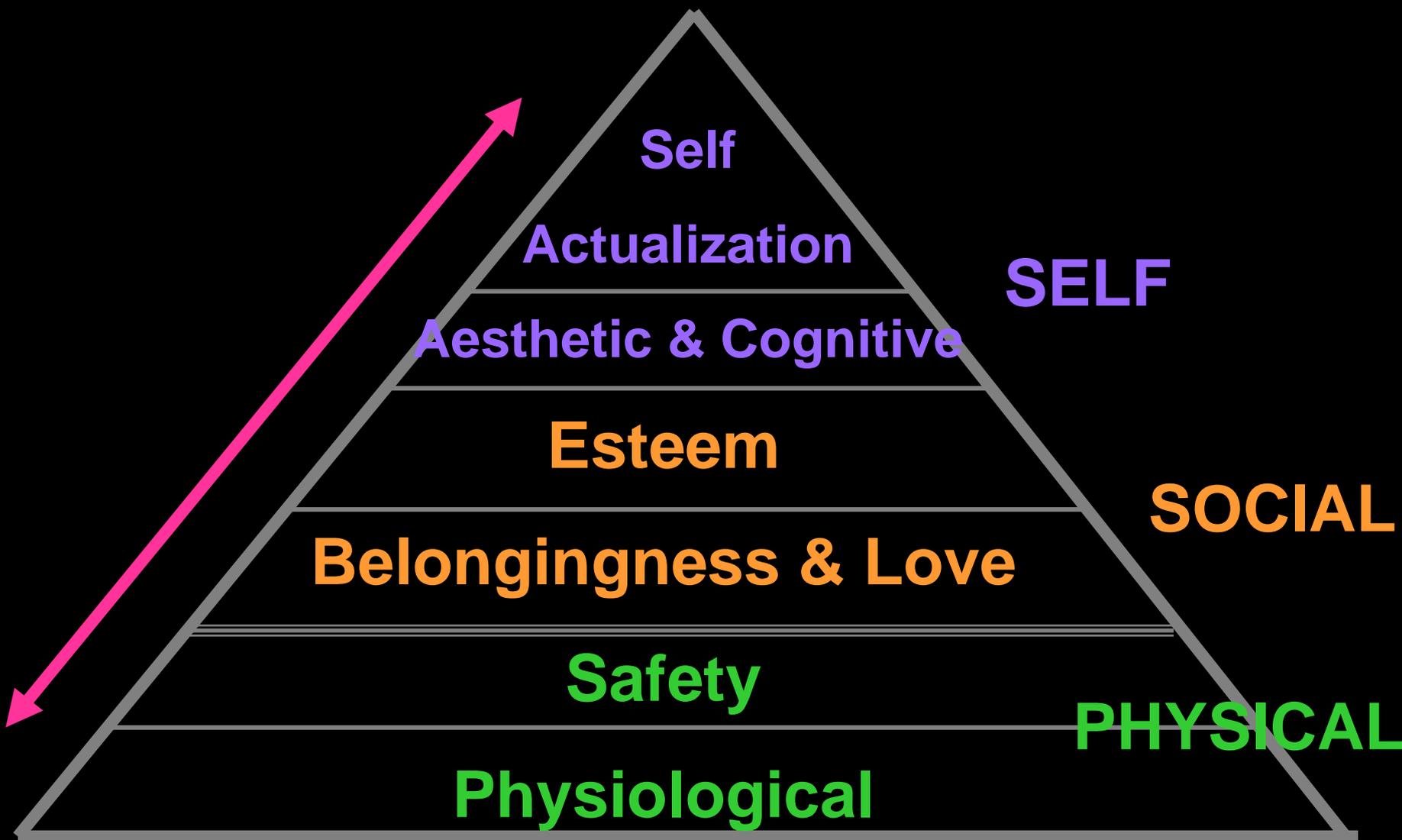
At-Risk Groups

- Middle Age
- Elderly
- Lower Socioeconomic Status
- Cultural / Racial Differences
- Institutionalized Persons
- People in Emotional Crisis
- People Requiring Emergency Care
- Human Service and Disaster Relief Workers

IMPORTANT

Hierarchy of Needs

Abraham Maslow



IMPORTANT

Hierarchy of Needs

Abraham Maslow



Basic Principles of Emergency Care

1. Provide for **basic survival needs** and comfort (liquids, food, shelter, clothing, heat/cool),
2. Help survivors **achieve restful and restorative sleep**,
3. Preserve an **interpersonal safety** zone protecting basic personal space (privacy, quiet, personal effects),

Basic Principles of Emergency Care

4. Provide nonintrusive **ordinary social contact** (sounding board, judicious use of humor, small talk about current events, silent companionship)
5. Address immediate physical **health problems** or exacerbations of prior illnesses,
6. Assist in **locating** and verifying the personal safety of **separated loved ones/friends**,

Key Concepts in Disaster Mental Health - 1

1. No one who sees a disaster is untouched by it.
2. There are two types of disaster trauma: Individual and Collective
3. Most people pull together and function during and after a disaster, but their effectiveness is diminished.
4. Disaster stress and grief reactions are a normal response to an abnormal situation.

Key Concepts in Disaster Mental Health - 2

5. Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.
6. Disaster relief procedures have been called, “the second disaster”.
7. Most people do not see themselves as needing mental health services following disaster and will not seek out such services.

Key Concepts in Disaster Mental Health - 3

8. Survivors may reject disaster assistance of all types.
9. Disaster mental health assistance is often more “practical” than “psychological” in nature.
10. Disaster mental health services must be uniquely tailored to the communities they serve.
11. Mental Health staff need to set aside traditional methods, avoid the use of labels, and use an active outreach approach.

Key Concepts in Disaster Mental Health - 4

12. Survivors respond to active interest and concern.
13. Interventions must be appropriate to the phase of disaster.
14. Support systems are crucial to recovery.

Tasks of Mourning

1. To Accept the Reality of the Loss

It can be very difficult to believe that "it" really happened but making this important step is crucial to our walk through grief.

2. To Experience the Pain of Grief

It has been said that to get to the other side of grief we can't walk around it, that we must walk through it. Allowing ourselves to feel what we are feeling, to cry when we must, and to feel the pain of sorrow are important.

3. To Adjust to an Environment in Which the Deceased is Missing

In our acceptance of the reality of our loss, we must develop new skills and interests to fill the void. Whether it is learning car maintenance routines or learning how to cook, we begin taking responsibility for ourselves as new single people.

4. To Withdraw Emotional Energy and Reinvest it in Other Activities; Memorialize the Relationship.

While they were living, much of our energy may have been focused on our loved one. Now that they are gone, we must direct that energy into new places—new interests, new friends. Perhaps we will re-prioritize other relationships, such as our children and grandchildren, our jobs. Remember to direct some of that energy toward taking good care of yourself.

Transition

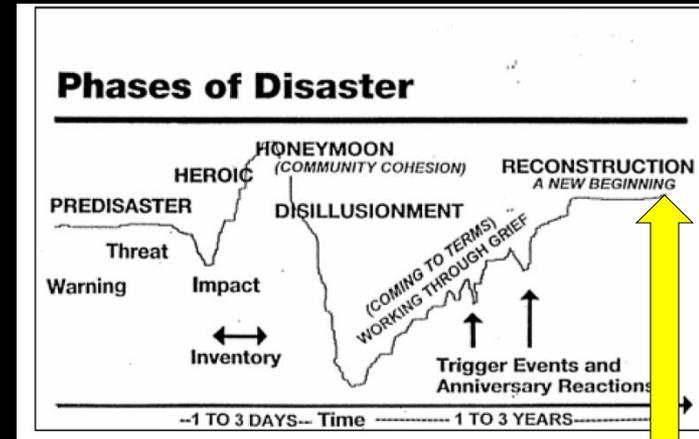
1. An *ending*, involving loss and letting go

- Disengagement
- Disidentification
- Disenchantment
- Disorientation

2. A period of *confusion* or *distress*,

3. A period of *working through* and making sense of feelings,

4. A new *beginning*.



Post Trauma Growth

Psychological Tasks for Recovery

- Acceptance of the disaster and losses,
- Identification, labeling, and expression of emotions,
- Regaining sense of mastery and control
- Resumption of age-appropriate roles & activities. (ADLs)

Initial Emergency Mental Health Interventions

1. Protect
2. Direct
3. Connect

Diane Myers, RN MSN



How to Help

Interventions to Providing Assistance:

- Utilize their available Support System,
- Establish a realistic perception of disaster recovery,
- Predict future problems,
- Provide opportunities to vent their fears, frustrations, grief, etc
- Reinforce the use of appropriate present coping strategies or developing new ones to prevent recurrence of the same problems

Disaster Mental Health Interventions

- Rapid Assessment & Triage
- Crisis Intervention
- Supportive Listening
- Problem-Solving Immediate Issues
- Education About Disaster Stress
- Debriefing & Community Meetings
- Information & Referral

Follow-Up and/or Referral

Follow-Up:

- 1 Week
- 1 Month
- 6 Months
- 1 Year

Referral:

- Physical Healthcare Professionals
- Mental Healthcare Professionals
- Spiritual Healthcare Professionals

Suicide Intervention

- **Clarify:** “Do you want to die or end the pain?”
- **Contradict:** Suicide creates more problems
- **Delay:** Postpone acting on suicide thoughts
- **Refer:** **ALWAYS** assist to a higher level of care

Never leave them alone.

Bring Cognition to Chaos

Information

Understanding

A

B

C

**Antecedent
Event**

Beliefs

**Culminating
Reactions**

Violation of World View(s)

Event Samples

- Death
- Bullying
- Other

*“It is unethical to NOT tell
people about
Compassion Fatigue.”*

Charles Figley, Ph.D.
Florida State Univ.

Compassion Fatigue
is
a normal response
to
listening to
traumatized people

“Universal Vulnerability”-J.Mitchell

Signs of Helper Stress

Individual

- Post trauma reactions
- Chronic fatigue and apathy
- Hostility toward team members and clientele
- Family and relational problems
- Gradual and profound changes:
 - Appearance
 - Deportment
- Spiritual depletion

Are Mental Health Professionals at Risk for Compassion Fatigue?

(Wee & Myers, 2002)

- Review of studies of 1st Responders following major incidents show range of 9-50% rates of traumatic stress
- 50% of British soldiers involved in body handling during Gulf War showed evidence suggestive of PTSD
- 64.7% disaster mental health workers showed mild to moderate rates of PTSD

DO: Prior to Exposure

- Awareness of vulnerability & limitations
- Building self protection skills
- Realization of need for support
- Plan for routine self care
- Support system in place
- Ongoing work on personal issues
- Limits on demands
- Evaluation of each exposure re: readiness

DO: During Crisis Incidents

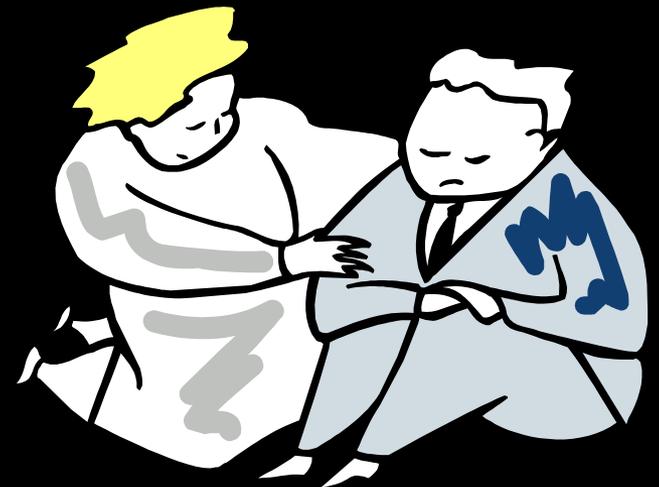
- Maintain optimal structure
- Monitor “inner process”
- Maintain awareness of personal issues, investments
- Monitor and regulate emotional distance
- Utilize support
- Get help when necessary

DO: Following Exposure:

- Review incident with peer & supervisor
- Monitor emotional reactions
- Debrief according to self care plan
- Eat, sleep, exercise moderately and well
- Work at putting incident into narrative format
- Find creative expression for deep processing
- Process experience with professional

Caring for the Caregiver

- Before, During & After an Event
- Compassion Fatigue
- Practice what you teach
- “You will Walk with a limp”



Post Action Staff Support

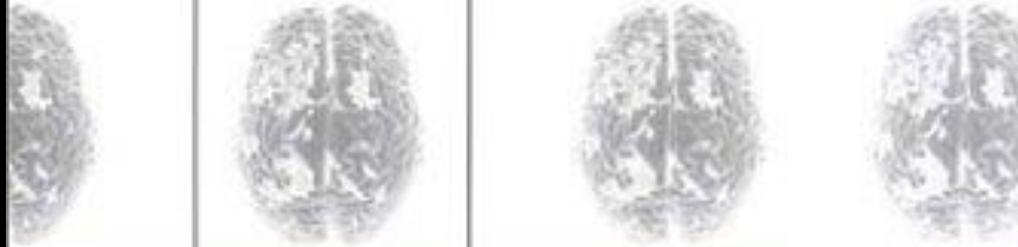
Review
Response
Remind

Psychological First-Aid

- Protect survivors from further harm,
- Reduce physiological arousal,
- Mobilize support for those who are most distressed,
- Keep families together and facilitate reunions with loved ones,
- Provide information and foster communication and education,
- Use effective risk communication techniques

Resources

**Understanding
Trauma-Related Disorders from a
MIND-BODY Perspective**



**DOES STRESS
DAMAGE THE
BRAIN?**

J. DOUGLAS BREMNER

Acute Traumatic Stress Management

ACUTE TRAUMATIC STRESS MANAGEMENT™

ATSM

ADDRESSING EMERGENT PSYCHOLOGICAL NEEDS
DURING TRAUMATIC EVENTS

MARK D. LERNER, PH.D.
RAYMOND D. SHELTON, PH.D.

FOREWORD BY



CHIEF RAYMOND E. CRAWFORD
CHIEF OF DEPARTMENT
NASSAU COUNTY POLICE DEPARTMENT, NEW YORK

A TRAUMATIC STRESS RESPONSE PROTOCOL FOR ALL EMERGENCY RESPONDERS

10 Stages of ATSM

1. Assess for Danger/Safety for Self/Others
2. Consider the Mechanism of Injury
3. Evaluate the Level of Responsiveness
4. Address Medical Needs
5. Observe & Identify
6. Connect with the Individual
7. Ground the Individual
8. Provide Support
9. Normalize the Response
10. Prepare for the Future



NCTSN



**The National Child
Traumatic Stress Network**

www.NCTSN.org

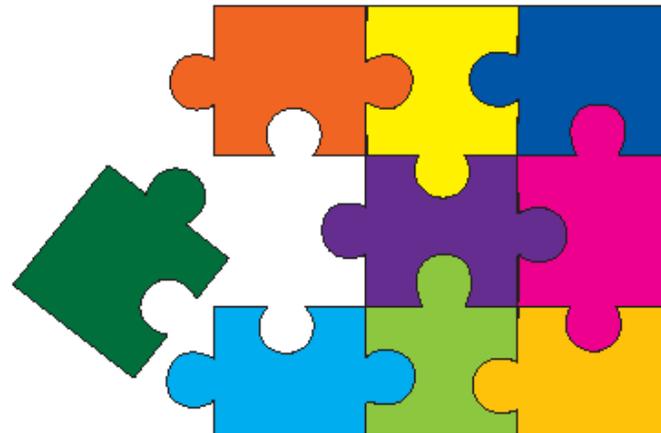
**International
Critical
Incident
Stress
Foundation**

ICISF.org

*Responding to School Crises:
An Integrated, Multi-Component
Crisis Intervention Approach*

Kendall Johnson, Ph.D., N.B.P.T.S.
Barbara J. Ertl, C.T.S., FAAETS
George S. Everly, Jr., Ph.D., F.A.P.M.
Jeffrey T. Mitchell, Ph.D.

Building Community Resilience for Children and Families



TDC
Trauma and Disaster Center
University of Children, Youth & Services Center

NCTSN 
The National Child
Traumatic Stress Network

This work was funded by the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the US Department of Health and Human Services (HHS).

Helping Children and Youth Who Have Experienced Traumatic Events



National Children's Mental Health Awareness Day—May 3, 2011

Many Children and Youth Experience Traumatic Events

Childhood exposure to traumatic events is a major public health problem in the United States. Traumatic events can include witnessing or experiencing physical or sexual abuse, violence in families and communities, loss of a loved one, refugee and war experiences, living with a family member whose caregiving ability is impaired, and having a life-threatening injury or illness. It is estimated that 26% of children in the United States will witness or experience a traumatic event before the age of 4 years.¹ According to the Centers for Disease Control and Prevention (CDC), almost 60% of American adults say that they endured abuse or other difficult family circumstances during childhood.² Research has shown that exposure to traumatic events early in life can have many negative effects throughout childhood and adolescence, and into adulthood. The Adverse Childhood Experiences (ACE) study found a strong relationship between traumatic events experienced in childhood as reported in adulthood and chronic physical illness such as heart disease, and mental health problems such as depression.³ The annual financial burden to society of childhood abuse and trauma is estimated to be \$103 billion.⁴ This short report discusses the prevalence of exposure to traumatic events among children and youth participating in two SAMHSA initiatives, the problems that trauma can cause, and available treatments that can help children and youth recover.

SAMHSA's Children's Mental Health Initiative and National Child Traumatic Stress Initiative

The Substance Abuse and Mental Health Services Administration (SAMHSA) addresses the needs of children and youth exposed to traumatic events through many of its programs. Two programs are highlighted in this report. The **Comprehensive Community Mental Health Services for Children and Their Families Program** (Children's Mental Health Initiative, or CMHI), established by an act of Congress in 1992, funds grantee agencies to apply the system of care approach, a conceptual and philosophical framework for systemic reform of children's mental health services. A "system

of care" is an organizational philosophy and framework that is designed to create a network of effective community-based services and supports to improve the lives of children and youth with or at risk of serious mental health conditions and their families. Systems of care build meaningful partnerships with families and youth, address cultural and linguistic needs, and use evidence-based practices to help children, youth, and families function better at home, in school, in the community, and throughout life.

The Donald J. Cohen National Child Traumatic Stress Initiative (NCTSI) is a national initiative that aims to raise the standard of care and improve access to services for children and youth throughout the United States who have experienced trauma. SAMHSA developed the National Child Traumatic Stress Network (NCTSN), a network of grantees from academic, clinical, and community entities that collaborate to develop, disseminate, and provide training on evidence-based practices; integrate trauma-informed treatment and practices into all child-serving systems; and promote and deliver effective community programs for children and families exposed to traumatic events.

Exposure to Traumatic Events and Behavioral Health

*"Children who suffer from child traumatic stress are those children who have been exposed to one or more traumas over the course of their lives and develop reactions that persist and affect their daily lives after the traumatic events have ended."*⁵ In CMHI, 84% of children and youth experienced at least one traumatic event before entering services. Among those children and youth receiving treatment for trauma exposure through NCTSN, the most common traumatic experiences reported were the traumatic loss of a loved one (48%), witnessing domestic violence (47%), and living with a family member whose caregiving ability is impaired (44%). Exposure to multiple types of traumatic events was common: 40% of children and youth in NCTSN had experienced four or more traumatic event types.



Foreword

Did you know that research has found that remarkable things can happen if parents and caregivers spend at least 15 minutes of undivided time a day listening and talking with their children? Research also tells us that children really do look to their parents and caregivers for advice and help about difficult choices and decisions.

The document in your hands right now and other companion materials about bullying are part of 15+ Make Time to Listen... Take Time to Talk, an initiative developed by the Substance Abuse and Mental Health Services Administration, part of the U.S. Department of Health and Human Services, to promote healthy child development and to prevent youth and school-based violence.

The initiative builds on both the value children place on the advice they get from important adults in their lives and the benefits of those special 15 minutes each day. The listening and talking theme, however, also can be adapted by teachers, counselors, and other adults who are involved in the lives and futures of children.

Whether focused on bullying – as in this part of the initiative – or on general principles of healthy development and behavior, the messages exchanged between children and their parents and caregivers in just these 15 minutes or more a day, can be instrumental in building a healthier and safer future for children as individuals, family members, and active and engaged participants in the life of their communities.

— about —

Welcome to...

"Make Time to Listen... Take Time to Talk... ABOUT BULLYING" interactive conversation starters. Schools, adults and children can use these cards to start conversations about bullying and how to prevent it.

There are no "right or wrong" answers, just statements that make us think about the issue of bullying and ways to prevent and/or stop it. The cards are listed under different headings so that there is flexibility in how the questions can be asked to lead to meaningful dialogue about bullying prevention and interventions. The basis of the conversation starters are to help start meaningful dialogue about the critical issue of bullying and the prevention of bullying.

There are no rules. Everyone is a winner if we begin to talk and listen to one another, but you can't be a winner if you don't answer the questions honestly. No one is looking for problems, but if bullying is an issue at school, home, or in your community, then this is a safe way to start to understand and hopefully resolve the problem.

Go ahead, get started and remember that these are only conversation starters and you don't have to finish all the cards to continue talking. Use your own judgment on how many questions to ask, when, and for how long. If you or your child feels uncomfortable talking about the issue, you may choose to stop for a while and continue the discussion at a later time. If major problems do arise, please seek the help of a mental health professional.

— about —

CMHS-SVP-0051 Printed 2009

Listen - Learn - Respect

These cards are to be used to start conversations about bullying and bullying prevention.

Feel free to adapt the questions to your own conversational styles.

The questions are designed to generate open and honest discussions. Please be careful to respect any concerns or sensitive issues raised by the answers.

Again, if problems do arise, please read the additional materials provided by this project, take a break and talk about the issue later, or seek the help of a mental health professional.

— about —

General Questions

What does "bullying" mean to you?

15+ MINUTES TO LISTEN & TALK



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

General Questions

Do you ever feel lonely at school or left out of activities? Let's talk about what happens and what you feel.

15+ MINUTES TO LISTEN & TALK



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

General Questions

What is lunch time like at your school? Who do you sit with, what do you do, and what do you talk about?

15+ MINUTES TO LISTEN & TALK



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov



AMERICAN ASSOCIATION OF SUICIDOLOGY
SUICIDAL BEHAVIOR AMONG LESBIAN, GAY, BISEXUAL, AND
TRANSGENDER YOUTH FACT SHEET

Suicidal Behavior among LGBT Youth

- Many studies have found that LGBT youth attempt suicide more frequently than straight peers. Garafalo et al. (1999) found that LGBT high school students and students unsure of their sexual orientation were 3.4 times more likely to have attempted suicide in the last year than their straight peers. Eisenberg and Resnick (2006) found LGBT high school students were more than twice as likely as their straight peers to have attempted suicide.
- Safren and Heimberg found that among youth who had attempted suicide, almost twice as many LGBT youth as their straight peers said that they had really hoped to die.
- Little research has been done about transgender individuals, but in one study of adults and young adults 30.1 percent of transgender individuals surveyed reported having ever attempted suicide (Kenagy, 2005). For US adults overall, 4.6 percent of adults and young adults report having ever attempted (Kessler et al., 1999)
- Numerous studies confirm that LGBT youth have higher rates of suicidal ideation than their straight peers; for example, the Massachusetts Youth Risk Behavior Survey found that youth who self-identified as LGBT or reported any same-sex sexual contact were more than three times more likely to report having seriously considered suicide in the last year (Massachusetts Department of Education, 2006)
- Because no reliable data exists, we do not know whether LGBT youth die by suicide more frequently than their straight peers. Sexual orientation and gender identity data are not included on death certificates so aggregated national death data do not include this information. In addition, many LGBT youth do not disclose this information to family members and friends; as a result, sexual orientation and gender identity often do not show up in psychological autopsy interviews

Risk and Protective Factors among LGBT Youth

I. Teacher Guidelines for Crisis Response

Reprinted from *A Practical Guide for Crisis Response in Our Schools*
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 Tel. (516) 543-2217 • Fax (516) 543-6977 • <http://www.aets.org>

What is a crisis and what is crisis response?

A crisis is an event of limited duration that is typically unpredictable and overwhelming for those who experience it. This situation may be volatile in nature and, at times, may involve threat to the survival of an individual or groups of individuals. Moreover, a crisis state may result upon exposure to drastic and tragic change in an individual's environment which has become common and familiar to them. This alteration in the status quo is unwanted, frightening, and often renders a person with a sense of vulnerability and helplessness. Ultimately, with successful intervention, the equilibrium is restored between the environment and the individual's perception of their world as a safe and secure place. Examples of crises that can potentially have a large scale effect on the students, faculty and administrators in a school building or district include: an accident involving a student or faculty member, a suicide or death of a student or faculty member, severe violence (e.g., gang fight), hostage taking, fire at school or a natural disaster (e.g., hurricane).

Crisis response, as it pertains to the school environment, is a proactive, organized and well thought out plan to a crisis situation that has adversely affected many individuals in a school district, including students, faculty and administrators. The primary goals of crisis response are 1) to prevent a chaotic situation from escalating into a potentially catastrophic one, 2) to help those affected by the crisis to return, as quickly as possible, to pre-crisis functioning, and 3) to decrease the potential long-term effects of the crisis on functioning.

Why a Crisis Response Plan?

Research conducted over the past 10 years has revealed that schools are increasingly more prone to crisis situations that adversely affect large numbers of students and faculty. The rise in adolescent suicide, increased assaults on teachers, high levels of substance abuse among students and increased violence in the schools are some of the reasons cited. Research has also indicated that today's school districts need to contend with reactions to new types of trauma/disasters. For example, hostage taking, sniper attacks, murders, terrorist activities and bomb scares were almost nonexistent in the schools 30 years ago, but today occur with greater frequency.

Thus, it is strongly recommended that school districts need to be prepared for a crisis situation that can potentially affect the functioning of their students, faculty and administrators. Lerner (1997) comments:

"There are two kinds of beach front homeowners on the south shore of Long Island: those who have faced serious erosion, and those

who will. Similarly, there are two kinds of schools: those that have faced a serious crisis situation, and those that will."

Research has emerged over the past ten years supporting a proactive approach to a crisis, as opposed to one that is reactive in nature. Such an approach is much better in dealing effectively with a large scale crisis situation. A reactive approach is spontaneous, and not fully thought out, planned, or practiced, and can result in the response that is less effective in meeting the immediate, and possibly the long-term needs of the students, faculty and administrators.

In summary, a proactive approach to a crisis is one that is organized, planned and practiced and more likely results in a response that can have a dramatic effect on reducing the short and long-term consequences of the crisis on the individuals in a school district.

What types of behaviors/reactions can teachers expect from their students after a crisis situation has occurred?

The manner in which people react to crisis situations is dependent upon a number of variables including personal history, personality variables, severity and proximity of the event, level of social support and the type and quality of intervention. While no two people respond to situations, including crisis situations, in exactly the same manner, the following are often seen as **immediate** reactions to a significant crisis:

- shock, numbness,
- denial or inability to acknowledge the situation has occurred,
- dissociative behavior—appearing dazed, apathetic, expressing feelings of unreality,
- confusion,
- disorganization,
- difficulty making decisions, and
- suggestibility.

It is important to note that most children will recover from the effects of a crisis with adequate support from family, friends and school personnel. Their response to a crisis can be viewed as "a normal response to an abnormal situation." While the emotional effects of the crisis can be significant and can potentially influence functioning for weeks to months, most children will evidence a full recovery.

Following are descriptions of responses likely to be observed in children:

- **Regression in Behavior:** Children who have been exposed to a crisis often exhibit behaviors that are similar to children



Youth Suicidal Behavior Fact Sheet

Prevention of Youth Suicides and Suicidal Behavior

Youth suicidal behavior is a significant problem. Yet *youth suicide is often preventable*. The extent of suicidal behavior — including thoughts of and planning for suicide, nonfatal suicide attempts, and suicide deaths — is shown below. Saving the lives of youth at risk involves a diverse range of interventions including effective assessment and treatment of those with mental disorders, promotion of mental health and help-seeking, early detection of and support for youth in crisis, training in life skills, and reduction of access to lethal means of harm.

Data and demographics – USA Suicides

The following data are for 2009, for youth aged 10 to 24:

- **NUMBER OF SUICIDES:** 4,630 died by suicide
- **A LEADING CAUSE OF DEATH:** Suicide was the third leading cause of death for 10- to 24-year-olds.
- **SUICIDE RATES:** Rates of suicide are highest for older youth. For youth aged 20 to 24, 12.5 per 100,000 youth died by suicide. For youth aged 15 to 19, 7.8 per 100,000 died, while for youth aged 10 to 14, 1.3 per 100,000 died.
- **GENDER:** Male youth die by suicide over four times more frequently than female youth.
- **RACE:** Native American/Alaska Native youth have the highest rate with 17.4 suicides per 100,000. White youth are next highest with 7.5 deaths per 100,000.
- **METHODS:** The majority of youth who died by suicide used firearms (45 percent). Suffocation was the second most commonly used method (40 percent).

(Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. [cited January 2012]. Available from www.cdc.gov/ncipc/wisqars)

Data – Suicide thoughts, plans, and attempts

The national Youth Risk Behavior Survey found that among high school students:

- 6.3 percent self-reported having attempted suicide one or more times in the previous 12 months. Attempts were reported more frequently by female students (8.1 percent vs. 4.6 percent for males) and Hispanic females reported attempts more than other racial and ethnic groups (11.1 percent).
- 1.9 percent reported having made a suicide attempt in the previous 12 months that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse.
- 10.9 percent reported having made a plan for a suicide attempt in the previous 12 months.
- 13.8 percent reported having seriously considered attempting suicide in the previous 12 months.

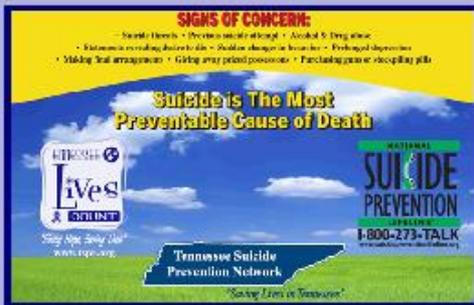
(Centers for Disease Control and Prevention. *Youth Risk Behavior Surveillance – United States, 2009*. Surveillance Summaries, June 4, 2010. *MMWR* 2010; 59 (No. SS-5).)



"Saving Lives is Treasures"

YOUTH SUICIDE PREVENTION & EARLY INTERVENTION TRAINING

The Tennessee Lives Count Youth Suicide Prevention Early Intervention Juvenile Justice Project (TLC/JJ) is a statewide early intervention/prevention project to reduce suicides/attempted for youth (ages 10-24).



Our goal is to train "Gatekeepers" across the state how to recognize the warning signs of suicide in youth and young adults, and how to intervene and save a life.

"Gatekeepers" are those who serve at-risk youth, including educators and other school personnel, youth group facilitators, parents involved in the foster care system and/or the juvenile justice system, the staff of universities and hospitals, as well as any community organization in which youth/young adults are involved.

The objective is to provide participants with:

- general knowledge of the societal view of suicide by addressing myths, facts, attitudes and opinions
- adequate knowledge of the steps that they can follow to prevent a suicidal person from completing suicide
- resources from which they can refer a suicidal person once they have intervened and prevented a suicidal attempt.

TENNESSEE LIVES COUNT (TLC/JJ) PROJECT

Phone: 615.297.1077

Email: TLC@tspn.org

Fax: 615.269.5413

Website: www.tspn.org/tlc



There is no charge for this training. CEUs and contact hours are available.

Funded by:

The Tennessee Lives Count Juvenile Justice Project (TLC/JJ) is funded by a grant (#2U79SM057400-04) to the TDMHDD from SAMHSA, U.S. Department of Health and Human Services (HHS) made possible by the Garrett Lee Smith Memorial Act of 2004. The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

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Tennessee Suicide Prevention Network

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"Saving Lives in Tennessee"

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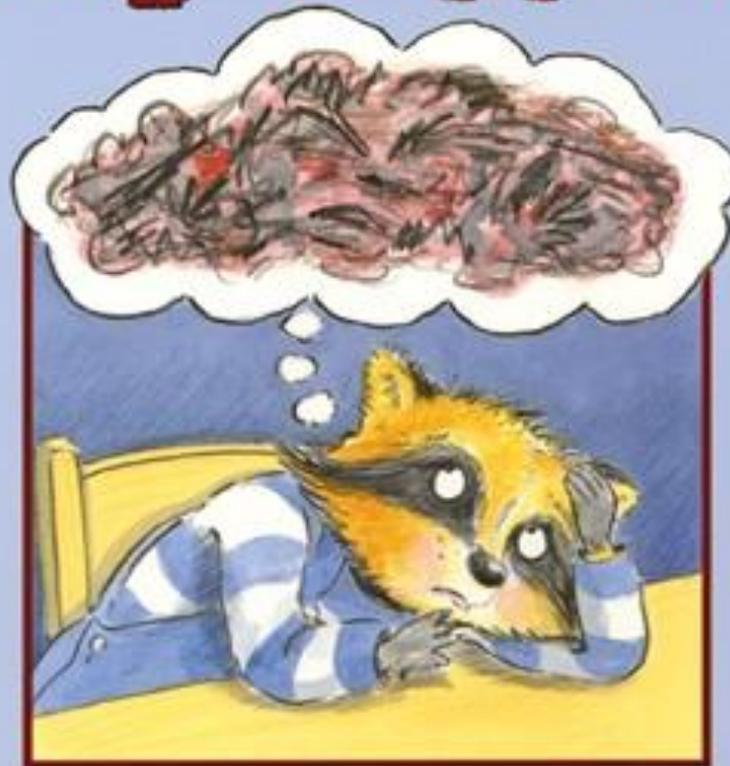
Resources & Training >

Target Populations >

Crisis/Need Help Now >

This application was developed by the
Tennessee Suicide Prevention Network
the statewide public-private partnership charted with
implementation of the Tennessee Strategy of Suicide Prevention.
More information about TSPN is available at www.tspn.org

A Terrible Thing Happened



By Margaret M. Holmes Illustrated by Cary Pillo

Survivor Psalm

I have been victimized,
I was in a fight that was not a fair fight,
I did not ask for the fight,
I lost.

There is not shame in losing such fights, only in winning.
I have reached the stage of survivor and am no longer a
slave of victim status.

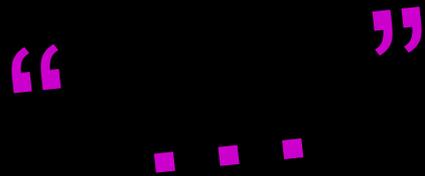
I look back with sadness rather than hate,
I look forward with hope rather than despair.
I may never forget, but I need not constantly remember.
I was a victim,
I am a survivor.

Frank Oshberg, M.D. & Gift From Within

Questions



Comments



Suggestions

Aha Moments

- What did you learn today?
- What did you realize?
- What are you going to do?

Goals

- Have a better overall understanding of psychological impact of crisis:
 - Principles
 - Effects
 - Interventions
- Know when to call for assistance,
- Know how to self-care,
- Access further training and education.

Agenda

- Disaster Mental Health Core Concepts
- Psychological First Aid
- Caring for the Caregiver
- Resources

...and just one more thing...

Thank You!

**Thank you for your
participation!**

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