

LESSON 4-5

PSYCHOSOCIAL

Lesson: Psychosocial

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Intended Audience of Learners

A broad range of health professionals who may work with the older adult population.

Competencies

This lesson supports learning related to the following competencies, with regard to *psychosocial considerations for caring for geriatric populations during the disaster cycle*:

Core Competencies and Subcompetencies from Walsh L, Subbarao I, Gebbie K, et al. Core competencies for disaster medicine and public health. *Disaster Med Public Health Prep.* 2012;6(1):44-52. doi: 10.1001/dmp.2012.4.

Core Competency 7.0 "Demonstrate knowledge of principles and practices for the clinical management of all ages and populations affected by disasters and public health emergencies, in accordance with professional scope of practice."

Subcompetency 7.1 "Discuss common physical and mental health consequences for all ages and populations affected by a disaster or public health emergency."

Learning Objectives

At the end of this lesson, the learner will be able to:

- 4-5.1 Describe mental health issues and psychosocial problems common in older adults during disasters.
- 4-5.2 Provide an overview of evidence-supported interventions that can be used to support older adults during a disaster.

Estimated Time to Complete This Lesson

- 120 minutes for basic overview of mental health issues during the recovery phase.
- People who want to learn how to deliver interventions after disasters to affected populations should complete
 - Psychological First Aid training (6 hours)
 - Course can be accessed at <http://learn.nctsn.org/course/index.php?categoryid=11>

- Skills for Psychological Recovery online training (6 hours)
 - Course can be accessed
[at http://learn.nctsn.org/enrol/index.php?id=113](http://learn.nctsn.org/enrol/index.php?id=113)

Content Outline

(Please note that the content below applies only to the recovery phase)

Module 4: Caring for older adult populations during the disaster cycle: Preparedness, response, recovery, and mitigation

Lesson 4-5: Psychosocial

- I. Age in and of itself does not make a person vulnerable.
 - a. Some older adults may be a valuable resource during disasters. They can
 - i. Serve as volunteers in assisting responders and affected populations
 - ii. Offer knowledge and perspective of past disasters that inform current disaster-related activities
 - b. A constellation of factors makes it more or less difficult for older people before, during, and after disasters. These include
 - i. Impaired cognition, mobility, or senses
 - ii. Decreased social network or unavailable social support
 - iii. Limited finances
 - iv. Low literacy
 - v. Mental or medical problems, acute or chronic
 - c. The ability of people to adjust and cope after a trauma is mitigated by their capacity to access tangible support and assistance.
 - i. Older adults may have difficulty determining who to call for assistance and may be unsure about which organizations are available to provide help.
 - ii. Older adults may be unclear about what crisis counseling and therapy can and cannot do to help them recover from disasters.
 - d. Older adults at increased risk for adverse consequences include the following groups:
 - i. Those who are socially isolated
 - ii. Those who are frail
 - iii. Those with chronic illness
 - iv. Those who are cognitively impaired
 - v. Those with a history of exposure to an extreme traumatic stressor
 - e. Severity of trauma (i.e., the dose and duration of the traumatic stressor) is one of the best predictors for
 - i. Likelihood of developing post-traumatic stress disorder (PTSD)
 - ii. Severity of PTSD
 - iii. Chronicity of PTSD
 - f. A one-size-fits-all approach with older adults does not work for preparedness or recovery.
 - g. Disaster needs of older adults should be based on where they live, because

level of support will vary depending on setting and resources.

- i. Community dwelling
 1. Senior communities, planned or naturally occurring
 2. Aging in place; may be surrounded by younger families in their community
 3. Homebound older adults
- ii. Special considerations with community-dwelling older adults
 1. Many older adults, especially those aged 85 and older, have chronic physical illnesses or disabilities that affect their ability to prepare and recover from a disaster.
 2. Many older adults may be a caregiver to a spouse who has a chronic physical illness or disability, which affects their ability to prepare and recover from a disaster.
 3. Community-dwelling older adults are less likely to complain, ask for support, and receive services or resources after a disaster.
 4. Older adults not affiliated with a community organization before the disaster are at risk for not receiving services.
 5. Older adults may be worried about who is trustworthy; those who will provide information need to be identified before a disaster.
 6. Many older adults may be concerned if the “help” provided will really be helpful.
 7. Homebound older adults may not possess the knowledge or information needed to make informed decisions and take adequate steps to prepare for disasters.
 8. Homebound older adults may not have the ability to access public or private transportation to purchase supplies or pre-enroll in special needs shelters.
 9. Formal and informal caregivers may need to provide assistance
 10. Impaired physical mobility, confinement to a bed or wheelchair, and vision or hearing problems further compound disaster-related stress.
 11. Outreach programs need to locate older adults who may not possess sufficient knowledge to access services or the physical ability to leave their homes and stand in line for assistance.
 12. Probability of home health aid service interruption is high; the home health aide may be dealing with personal or family issues after a disaster and may not be able to work.
 13. Homebound older adults with medical or mental health needs may require care in an assisted-living facility or nursing home during all phases of a disaster.
- iii. Institutionalized or facility-dwelling older adults include those who live in
 1. Nursing homes
 2. Assisted-living or residential care facilities (ALFs)
 3. Continuing care retirement communities

- iv. Special considerations with institutionalized or facility-dwelling older adults
 1. Nursing home residents may fare best during disasters if staff has taken part in planning and drills.
 2. Nursing home residents are provided with continuity of care whereas ALF residents may not have the same level of coverage and support.
 3. Level of disaster support to be provided is detailed in the ALF contract residents sign when moving to the facility and prior to a disaster.
 4. Institutions that are closed for an extended period of time force residents to receive shelter and care outside their community.
 5. Nursing home staff have relationships with their residents, which are not the same as those of hospital nurses with short-stay patients; the resident's social network is disrupted.
 6. Emergency relocation of persons with significant cognitive impairment presents a unique set of challenges and can result in increased morbidity and mortality.

II. Psychological reactions to disaster

- a. Normal psychological responses in the immediate aftermath of a disaster include the following:

- i. Shock
- ii. Fear
- iii. Denial
- iv. Numbness
- v. Anger
- vi. Sadness
- vii. Shame
- viii. Despair
- ix. Hopelessness
- x. Flashbacks
- xi. Grief
- xii. Relief to have survived the event that may be accompanied by feelings of elation
- xiii. The above psychological responses (i to xii) are subsyndromal presentations and:
 1. Do not meet DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders*, 5th edition) diagnostic criteria
 2. Are common
 3. Interfere with functioning and may be quite distressing
 4. Should be treated and not ignored

- b. Anxiety is different from fear. Fear is a response to danger. People may feel anxious without an actual threat. Sometimes people feel both anxious and excessively or unduly worried. Symptoms of anxiety include the following:
 - i. Fatigue
 - ii. Disturbed sleep
 - iii. Jumpiness, jitteriness, trembling
 - iv. Muscle aches, tension
 - v. Dizziness, lightheadedness
 - vi. Gastrointestinal upset
 - vii. Dry mouth, sensation of a lump in the throat, choking sensation
 - viii. Clammy hands, sweating
 - ix. Racing heartbeat, chest discomfort
 - x. Shortness of breath or the feeling of being smothered
- c. Depression - People can be anxious and depressed at the same time. Sadness does not always equal depression, and depression is not always marked by sadness. Symptoms of depression include the following:
 - i. Sleep changes, difficulty falling or staying asleep, sleeping more than usual
 - ii. Change in activity level, such as being tired, less energetic, nervous, or not able to sit still
 - iii. Appetite changes, e.g., lost appetite, food no longer tastes good, increased appetite and weight gain
 - iv. Sad feelings most of the day nearly every day, feelings of hopelessness or worthlessness
 - v. Troubled thoughts, e.g., difficulty making decisions, thinking about death or suicide, problems with concentration or attention
 - vi. Personality changes, e.g., irritable, lack of motivation, quick to lose temper, loss of pleasure in enjoyable activities
 - vii. Survivor guilt
 - viii. Suicidal ideation or behaviors
- d. Acute stress disorder is characterized by the development of severe anxiety, dissociative, and other symptoms that occurs within 1 month as a response to a traumatic stressor. Symptoms include the following:
 - i. Numbing, detachment, or absence of emotional responsiveness
 - ii. Being in a daze (i.e., reduction in awareness)
 - iii. Derealization
 - iv. Depersonalization
 - v. Inability to recall an important aspect of the trauma (i.e., dissociative amnesia)

- vi. Recurring images, thoughts, nightmares, illusions, or flashbacks of the traumatic event
- vii. Reliving the traumatic event
- viii. Becoming distressed at reminders of the traumatic event
- ix. Avoiding stimuli (i.e., people, places) that lead to remembering or re-experiencing the traumatic event
- x. Trouble sleeping
- xi. Irritability
- xii. Difficulty concentrating
- xiii. Inability to sit still or to stop moving
- xiv. Constantly tense or on guard
- xv. Startled too easily or at inappropriate times
- e. PTSD –The DSM-5 diagnostic criteria includes a history of exposure to a traumatic event that meets specific stipulations (i.e., direct exposure, witnessing, indirectly, repeated) and persistence of symptoms for more than one month from each of four symptom clusters: intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity. Symptoms include:
 - i. Intrusion symptoms
 - 1. Recurrent, involuntary, and intrusive memories.
 - 2. Traumatic nightmares.
 - 3. Dissociative reactions (e.g., flashbacks) that may occur on a continuum from brief episodes to complete loss of consciousness.
 - 4. Intense or prolonged distress after exposure to traumatic reminders.
 - 5. Marked physiologic reactivity after exposure to trauma-related stimuli.
 - ii. Avoidance
 - 6. Trauma-related thoughts or feelings.
 - 7. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).
 - iii. Negative alterations in cognition and mood
 - 8. Inability to recall key features of the traumatic event.
 - 9. Persistent negative beliefs and expectations about oneself or the world.
 - 10. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
 - 11. Persistent negative trauma-related emotions.

12. Markedly diminished interest in (pre-traumatic) significant activities.
 13. Feeling alienated from others (e.g., detachment or estrangement).
 14. Constricted affect: persistent inability to experience positive emotions.
 - iv. Alterations in Arousal and Reactivity
 15. Irritable or aggressive behavior
 16. Self-destructive or reckless behavior
 17. Hypervigilance
 18. Exaggerated startle response
 19. Problems in concentration
 20. Sleep disturbance
 - f. Complicated Bereavement - feelings worsen over time and last longer than 6 months after the death
 - i. Intense sorrow and pain at the thought of a loved one; focus on little else but the loved one's death
 - ii. Extreme focus on reminders of the loved one or excessive avoidance of reminders
 - iii. Intense and persistent longing or pining for the deceased
 - iv. Problems accepting the death
 - v. Numbness or detachment
 - vi. Bitterness about the loss
 - vii. Feeling that life holds no meaning or purpose
 - viii. Irritability or agitation
 - ix. Lack of trust in others
 - x. Inability to enjoy life or think back on positive experiences with the loved one
- III. Post-disaster assessment
- a. Assessment is conducted not to generate a clinical diagnosis but to address the needs of 3, functionally discrete subgroups of disaster survivors:
 - i. Those who are well-functioning and not in need of immediate assistance
 - ii. Those who are acutely distressed and exhibiting a temporary reduction in functionality
 - iii. Those who are or who will become dysfunctional and not able to execute basic activities of daily living
 - b. The first and third groups are distinguished by a history of behavioral health issues, current level of impairment following the disaster, and lack of available

- social support. Those who have any of these risk factors are referred for a follow-up evaluation with a behavioral health specialist.
- c. Stepped care model of treatment
 - i. Moving from intervention (i.e., psychological first aid) to formal treatment (e.g., cognitive behavioral therapy), there is an escalation in the intensity of care for those who need assistance with recovery.
 - ii. A stepped care framework matches presenting needs with the least intensive therapy that is still expected to provide significant and beneficial outcomes and is adjusted or increased in steps according to lack of effect or failure of lower-intensity therapies.
 - iii. Trauma exposure is a risk factor for a wide range of psychiatric disorders.
 - d. Special considerations when assessing older adults
 - i. Use of a cognitive screen is recommended when assessing an elderly person who appears confused or too quiet.
 - ii. Screen for cognitive impairment such as dementia or delirium.
 - iii. Assessment of trauma and related symptoms should be routine.
 - iv. Older adults may fail to report or may minimize traumatic experiences.
 - v. Older adults may want to focus on physical rather than emotional symptoms.
 - vi. Suicide assessment is particularly important because older males are at greater risk for death by suicide.
 - e. Special considerations when providing psychological intervention or treatment to older adults
 - i. Allow for extra time to listen to concerns.
 - ii. Maintain eye contact with the older adults and be at eye level.
 - iii. Normalize reactions and responses.
 - iv. Do not appear to doubt or disbelieve the person's account of what happened.
 - v. Do not inquire about details of the traumatic episode at this time.
 - vi. Do not ask questions or make statements that suggest that you hold the person responsible for this incident such as, "What were you doing in a place like that?"
 - vii. Older adults may fail to report or minimize traumatic experiences.
 - viii. Older adults may focus on physical rather than emotional symptoms.
 - ix. Older adults may be less familiar with therapy, and more time may be needed to educate them and develop a treatment plan.
 - x. Older adults have many life examples and experiences to draw on during therapy.
 - xi. Use their language.

- xii. Periodically inquire about their satisfaction with the therapy process and rate of progress.
 - xiii. Consider offering therapy at a slower pace.
 - xiv. Use personal examples and life review
 - xv. "Say it, show it, do it."
 - xvi. Repeat and simplify complex ideas if it would be beneficial.
 - xvii. Consider having older adults use a notebook to organize their thoughts and as a reminder of therapy.
 - xviii. Consider scheduling shorter, more frequent, and best-time-of-day sessions.
 - xix. For older adults with sensory impairment, consider using assistive devices for hearing or visual impairments.
 - xx. Confirm that the older adult can read and/or write.
 - xxi. Consider using materials with large print.
 - xxii. Record sessions if it would be beneficial.
 - xxiii. For older adults with physical impairments, consider offering shorter sessions for fatigue or pain.
 - xxiv. Attend to environmental barriers (e.g., wheelchair navigation, rug, low chair).
 - xxv. Offer flexibility in the meeting place.
 - xxvi. Use older adults' strengths.
 - xxvii. If beneficial use life review to point out strengths and accomplishments
 - xxviii. Restructure "mistakes" as learning opportunities and situations in which the older adults did the best they could.
- f. Psychological first aid
- i. After disasters, psychological first aid is the early intervention of choice for the American Red Cross, the Medical Reserve Corps, and state departments of health.
 - ii. *Early intervention* has been defined as "...any form of psychological intervention delivered within the first four weeks following mass violence or disasters" (National Institute of Mental Health, 2002).
 - iii. Psychological first aid is typically an undocumented, short-term intervention that is administered in response to a disaster near the location where it occurred.
 - iv. If evidence exists of continuing flashbacks, dissociation, or derealization experiences, then the survivor is likely to require more intensive psychological care by a behavioral health specialist (Marmar, Wiss, & Metzler, 1997).

- v. If disaster-related distress persists in the days and weeks after a disaster, crisis counseling is indicated.
- vi. Make a referral if the survivor has
 1. A problem that is beyond your capability or level of training
 2. Difficulty maintaining contact or communicating (e.g., does not appear to be oriented to time, place, person, or situation)
 3. An acute or chronic medical or mental health problem or condition that needs immediate attention
 4. A medication need
 5. Difficulty performing daily functions or needs assistance with activities of daily living
 6. Desire for additional counseling (e.g., some older adults may want to speak with a religious figure or counselor)
 7. Suspected or discovered elder abuse, neglect, or criminal activity
 8. Threatens to harm himself or herself, you, or others or there is a concern for the safety of the survivor, others, or yourself
- g. Crisis counseling
 - i. In the weeks and months after an event, those who require or desire more assistance with psychological recovery are offered crisis counseling.
 - ii. A small but significant number of people receive formal psychotherapy after mass casualty events.
 - iii. Crisis counseling programs are managed by a designated state agency (i.e., department of health or child and family welfare) and are delivered at a variety of nontraditional sites (i.e., schools, homes, mental health clinics, community centers) located in the affected community.
 - iv. Crisis counseling services are delivered by laypeople who have attended a training workshop.
 - v. The goal of crisis counseling is to help survivors cultivate adaptive coping skills and recover to their pre-disaster state of functioning.
 - vi. Crisis counselors do not make diagnoses and no records of the sessions are kept.
 - vii. Crisis counselors meet survivors where they are in the recovery process and tailor their treatment accordingly.
 - viii. People who need more intense treatment are referred to licensed clinicians who can deliver formal behavioral health care.
 - ix. Make a referral if the survivor has
 9. Ongoing difficulties with coping

10. Severe stress reactions that are not lessening in intensity
 11. A worsening of a preexisting medical, emotional, or behavioral health problem
 12. Requested traditional psychotherapy or more intense services
- h. Traditional psychotherapy with an evidence base
- i. Cognitive-behavioral therapy approaches
 13. Behavior therapy
 14. Cognitive-behavioral therapy
 15. Rational-emotive therapy
 16. Problem-solving therapy
 17. Dialectical-behavior therapy
 18. Acceptance and commitment therapy
 19. Mindfulness-based cognitive therapy
 - ii. Acceptance and commitment therapy
 - iii. Prolonged exposure therapy
 - iv. Cognitive processing therapy
 - v. Eye movement desensitization and reprocessing
- i. Treatment considerations with older adults
- i. Older persons with mental health problems are responsive to psychotherapies, group therapies, counseling, and psychotropic medications when necessary.
 - ii. Education to decrease misattribution of somatic symptoms and increase acceptance of mental health treatment should be provided.
 - iii. Avoid negative inquiries and labels.
 - iv. Echo the older adult's words or concerns.
 - v. Normalize, but don't minimize.
 20. "Because most people have had difficult experiences at some point during their life, I routinely ask about past events."
 21. "You are not alone."
 - vi. Validate, validate, and validate.
 22. "Many people have had these experiences and are deeply affected by them. They often feel angry, embarrassed, and fearful for some time afterwards. It is an understandable reaction to a very frightening experience."
 23. "That must have been very frightening."
 - vii. It is appropriate to express care and concern.
 1. "I am sorry that this has happened to you."
 - ii. Trauma survivors frequently decline referrals; this may be especially true of older adults.
 - iii. Most people who have been traumatized just want to forget about it, hoping it will go away without intervention or treatment.
 - iv. Older adults may not realize the connection between trauma and

PTSD.

- v. Older adults may not realize the toll trauma may have taken upon their emotional and physical health (e.g., depression, PTSD, chronic pain syndromes).

IV. Coping

- a. Provide information about stress reactions and coping to reduce distress and promote adaptive functioning.
 - i. Provide basic information about stress reactions.
 - ii. Review basic information on ways of coping.
 - iii. Teach simple relaxation techniques.
 - iv. Assist with anger management.
 - v. Identify what the survivor has done in the past to cope.
 - vi. Encourage adaptive coping behaviors and discourage maladaptive coping behaviors.
 - vii. Help the survivor identify and consider different coping options.
 - viii. Identify and acknowledge the survivor's individual coping strengths.
 - ix. Discuss the negative consequences of maladaptive coping behaviors.
 - x. Facilitate a sense of personal control over coping and adjustment.

V. Social support

- a. Assist with the transition from formal (i.e., Red Cross) to informal (i.e., friends and family) social support systems.
- b. Help survivor develop a social network diagram to identify family, friends, and neighbors if needed.
- c. Locate local community programs.

VI. Barriers to care include the following:

- a. Substance abuse
- b. Low socioeconomic status
- c. Language and cultural barriers
- d. Severe mental illness
- e. Emotional pain
- f. Self-blame
- g. Shame
- h. Problem recognition
- i. Symptom misattribution
- j. Readiness to change
- k. Belief that talking about it will make it worse
- l. Belief that providers can't be trusted or past negative reporting experiences
- m. Some people may be reluctant to accept assistance from government agencies or find completion of the paperwork required to receive aid daunting.
- n. Some people may turn to religious leaders, family members, informal social networks, or their personal physician for relief from their distress.

- o. Symptoms associated with PTSD, depression, and anxiety may motivate some older adults to ask for medication from their physician.

Case Vignette

Margaret is an 84-year-old grandmother. Her husband died several years before the tornado struck her small Midwest town. Her son and his family were forced to move from the town after their home was destroyed. As a result of the storm, 2 of her closest friends moved into an assisted-living facility in a neighboring town. It's been a month since the tornado and Margaret feels sad and lonely most of the day. She stopped attending the senior group at her church and is becoming increasingly isolated. She no longer drives and is having her meals delivered by a local hot lunch program.

What are your main concerns with Margaret?

How will you proceed?

Margaret just informed you about the detail of the tornado.

How do you respond?

What do you do and say?

Consider the following issues:

- Elicit Margaret's view of her problems.
- Allow time for discussion and questions.
- Respect Margaret's choices and promote efficacy and self-control over her life.
- Work as equal partners to address Margaret's problems.
- Recognize the importance of client activation from the beginning.
- Develop a treatment plan together with concrete goals, strategies, and a timeline.
- Provide education about the problem.
- If beneficial, explain the causes of symptoms.
- Explain what happens if symptoms go untreated.
- Assess the interaction of the problem with other illnesses.
- Provide written, video, and verbal education.
- Provide education about treatment.
 - o Treatment options (medication/therapy, type of therapy)
 - o Treatment rationale (why it works)
 - o Treatment strategies (how it works)
 - o Treatment timeline (how long, how often, when start to improve?)
- Foster a strength-based approach (as opposed to deficit-oriented) focusing on skills building and future-oriented goals.
- Establish rapport and trust (e.g., provide emotional safety).

- Remember the goal is not for Margaret to disclose any or all details but rather to feel safe, develop trust, and ultimately become more functional.
- Be aware that rural communities may have a smaller pool of local talent and fewer resources to support incoming temporary crisis counseling programs.
- Help to restore Margaret's sense of control.
- Encourage networking and reestablishing contact with informal and formal support, providers, and clergy.

Suggested Learner Activities for Use in and Beyond the Classroom

1. Invite learners to work as partners or in a small group to review a case study (using the resources provided at the end of this lesson or using a case study the educator/trainer is already familiar with). Ask them to identify key issues and concerns, generate potential solutions, describe facilitators and barriers to services, and develop a treatment/action plan to facilitate recovery. Groups should report back to the full class for further discussion.
2. Invite learners to work as partners or in a small group to develop a peer-to-peer program using older adults to assist vulnerable older adults (i.e., homebound, mobility impaired) in accessing crisis counseling and behavioral health services after a disaster. Ask them to identify key issues/concerns, generate potential solutions, describe facilitators and barriers to services, and develop a plan to facilitate recovery. Groups should report back to the full class for further discussion.
3. Ask learners to independently complete the Social Network List and develop a Social Network Map (see [Skills for Psychological Recovery Field Guide for forms and instructions](#)). Using the completed list and map, ask learners to identify strengths and weakness within their social network, consider what they might do to address any weaknesses and to exploit their strengths, and to share their impression of the social network exercise. Ask learners to consider the value of using this exercise with an older adult, to identify potential issues that might result during the process, and to develop approaches to address those concerns.
4. Ask learners to identify all the mental health services that are available for mental health care and substance abuse within a 20-mile radius from their home. Learners can use a telephone book or the Internet to locate available local services. Next, ask learners to determine if public transportation is available from their home to 2 different types of mental health service providers that are located in 2 different areas of their community. Have the learner note how long it would take them to walk from their home to the bus or train, the frequency of public transportation, the cost of transportation, and the estimated time from home to the mental health service

provider. Identify the challenges and develop a brief plan for enhancing access and providing disaster mental health services (i.e., crisis counseling, psychotherapy) to distressed, older adult survivors after an event.

Readings and Resources for the Learner

- Required Resources
 - Recovering from disaster. Federal Emergency Management Agency website. <http://www.ready.gov/recovering-disaster>. Updated February 12, 2013. Accessed January 16, 2015.
 - Coping with disaster. Federal Emergency Management Agency website. <http://www.ready.gov/coping-with-disaster>. Updated February 12, 2013. Accessed January 16, 2015.
 - Natural disasters. US Environmental Protection Agency website. <http://epa.gov/naturaldisasters/index.html>. Updated May 8, 2013. Accessed January 16, 2015.
 - Figure 1. Family tree of [mental health services] terms in use in the field of collaborative care: a national agenda for research in collaborative care. Agency for Healthcare Research and Quality website. <http://archive.ahrq.gov/research/findings/final-reports/collaborativecare/collab3fig1.html>. Published June 2011. Accessed February 4, 2015.
 - *Psychological First Aid: Field Operations Guide*, 2nd ed. National Center for PTSD and National Child Traumatic Stress Network. http://www.nctsn.org/sites/default/files/pfa/english/1-psyfirstaid_final_complete_manual.pdf. Published 2006. Accessed February 4, 2015.
 - *Psychological First Aid: Field Operations Guide for Nursing Homes*, 2nd ed. Disaster Preparedness for the Elderly Collaborative Workspace. <http://elderlydisaster.pbworks.com/f/PFA%202nd%20Ed%20Manual%20Flyer%20FINAL.pdf>. Accessed February 4, 2015.
- Supplemental Resources
 - Stay in touch in crisis situations: elder care locator. National Association of Area Agencies on Aging website. <http://www.eldercare.gov/eldercare.net/public/Resources/Brochures/docs/InTouch-Brochure2.pdf>. Accessed February 4, 2015.

Learner Assessment Strategies

1. Learners work as partners or in a small group to review a case study and identify key issues and concerns (i.e., elder abuse, family crisis, depression, dementia), generate

potential solutions, describe facilitators and barriers to services and care, and develop a treatment/action plan to address areas of concern after a disaster.

Readings and Resources for the Educators

- Required Resources
 - National Center for PTSD
 - PTSD coach online. US Department of Veterans Affairs. National Center for PTSD website. <http://www.ptsd.va.gov/public/treatment/cope/index.asp>. Updated June 25, 2014. Accessed January 20, 2015.
 - Effects of disaster: risk & resilience factors. US Department of Veterans Affairs. National Center for PTSD website. http://www.ptsd.va.gov/public/types/disasters/effects_of_disasters_risk_and_resilience_factors.asp. Updated January 3, 2014. Accessed January 20, 2015.
 - SAMHSA
 - Oriol W. *Psychosocial Issues for Older Adults in Disasters*. Substance Abuse and Mental Health Services Administration. <https://store.samhsa.gov/shin/content/SMA11-DISASTER/SMA11-DISASTER-03.pdf>. Accessed January 20, 2015.
 - Office of the Assistant Secretary for Preparedness and Response
 - Disaster behavioral health fact sheet. US Department of Health and Human Services. Office of the Assistant Secretary for Preparedness and Response website. <http://www.phe.gov/Preparedness/planning/abc/Documents/disaster-behavioral-health.pdf>. Accessed January 20, 2015.
 - Disaster behavioral health: current assets and capabilities. US Department of Health and Human Services. Office of the Assistant Secretary for Preparedness and Response website. <http://www.phe.gov/Preparedness/planning/abc/Documents/dbh-assets.pdf>. Accessed January 20, 2015.
- Supplemental Resources
 - None

Sources Cited in Preparing Outline and Activities Above

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- National registry of evidence-based programs and practices. Substance Abuse and Mental Health Services Administration website.
<http://www.nrepp.samhsa.gov/AboutNREPP.aspx>. Updated December 24, 2014. Accessed January 20, 2015.
- Warchal JR, Graham LB. Promoting positive adaptation in adult survivors of natural disasters. *Adultspan Journal*. 2011;10:34-51.