Innovations in Disaster Mental Health: Psychological First Aid

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PRACTICE

Psychological First Aid

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Psychological First Aid (PFA) consists of a systematic set of helping actions aimed at reducing initial post-trauma distress and supporting short- and long-term adaptive functioning. Designed as an initial component of a comprehensive disaster/trauma response, PFA is constructed around eight core actions: contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social supports, information on coping support, and linkage with collaborative services. PFA for children and adolescents focuses on these same core actions, with modifications to make them developmentally appropriate. Formal evaluation of the effectiveness of PFA is needed and it is hoped that development of a PFA Field Operations Guide will facilitate such evaluation.

Exposure to disaster and other traumatic experiences confronts survivors with immediate challenges and, for some, leads to development of enduring problems. Most psychological responses to trauma are relatively immediate, mild, and transient (Norris, Friedman, Watson, Byrne, Diaz, &

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Kaniasty, 2002), but significant percentages of traumatized individuals experience more intense stress reactions and some develop post-traumatic stress disorder and other mental health problems. Given the capacity of traumatic events to produce great immediate distress and sometimes overwhelm immediate coping abilities, disaster response encompasses efforts to support survivors in the immediate aftermath of disaster and to respond to their psychological needs.

Despite a widely recognized need to provide immediate help for trauma survivors, little is known about how best to assist individuals during the first hours and days after their experiences. In an effort to improve and promote formal evaluation of immediate care for survivors, the National Center for PTSD and the National Child Traumatic Stress Network recently collaborated to design a systematic set of helping actions called Psychological First Aid (PFA) intended for use by disaster mental health responders and others, including mental health counselors, who may be called upon to provide immediate support for trauma survivors. PFA is aimed at reducing initial post-trauma distress and supporting short- and long-term adaptive functioning. It is designed for delivery anywhere that trauma survivors can be found. Following a disaster, it can be offered in shelters, schools, hospitals, homes, staging areas, feeding locations, family assistance centers, and other community settings. The principles can also be applied immediately following traumatization in many non-disaster settings, including hospital trauma centers, rape crisis centers, and warzones. PFA is designed for simple and practical administration in field settings. The complete PFA manual can be downloaded at http://www.ncptsd.va.gov/pfa/PFA.html or http://www.nctsnet.org/nccts/nav.do?pid=typ_terr_resources_pfa. In this paper, we briefly review previous work on early intervention, describe the focus on evidence-informed intervention principles within PFA, outline the basic principles and practices of PFA, discuss adaptation of PFA for children and adolescents, identify key considerations in the evaluation of PFA, and indicate some future directions in development of this approach.

EARLY POST-TRAUMA INTERVENTION

To date, there are few published randomized controlled trials of interventions initiated in the first 14 days following disaster, mass violence, or other trauma. Difficulties in obtaining empirical support as well as lack of a conceptual framework have impeded the development of definitive recommendations. The current literature on the effects of disasters on mental health functioning suggests that: (a) people's reactions should not necessarily be regarded as pathological responses or even as precursors of

subsequent disorder; (b) many people will have transient stress reactions in the aftermath of mass violence, and such reactions may occur, occasionally, even years later; (c) rather than traditional diagnosis and clinical treatment, most people are likely to need support and provision of resources to ease the transition to normalcy; and (d) some survivors may experience great distress and require community and at times clinical intervention (Galea et al., 2003).

A number of reviews of the post-trauma intervention literature have concluded that there is no evidence that Critical Incident Stress Debriefing (CISD), a structured group model designed to explore facts, thoughts, reactions, and coping strategies following trauma, prevents long-term negative outcomes (Litz et al., 2002; Bisson, 2003; McNally, Bryant, & Ehlers, 2003; Watson et al., 2003). For example, in a recent large-scale randomized controlled trial (RCT) of a group debriefing intervention with active duty personnel, Litz and colleagues (2002) found that while soldiers rated their satisfaction with CISD as high and mental health outcomes at follow-up did not worsen as a result of CISD, there were no differences among the CISD, stress education, and survey-only conditions on any behavioral health outcome, including PTSD, depression, general well-being, aggressive behavior, marital satisfaction, perceived organizational support, or morale. Heart rate and blood pressure readings before and after the sessions did not indicate a change in physiological stress, and subjective ratings of distress did not change pre to post-session. There have been two randomized controlled trials (RCTs) of CISD that reported a higher incidence of negative outcomes in those who received CISD compared with those who did not receive an intervention (Bisson ; Mayou, Ehlers, & Hobbs, 2000).

While many of the CISD studies, particularly those showing negative outcomes, have methodological flaws, there are many possible theoretical explanations for both neutral and negative findings. For example, it is possible that CISD interventions with primary civilian survivors of disaster are too brief to allow for adequate emotional processing, that they increase arousal and anxiety levels, or that they inadvertently decrease the likelihood that individuals will pursue more intensive interventions. It is possible that future research will demonstrate that CISD may be useful for some populations, or has more subtle positive effects (e.g., increasing perceived social support). In the meantime, numerous reviews of the best-controlled studies have concluded that it cannot be endorsed as an intervention which prevents long-term distress or psychopathology, given the current state of the research (McNally, Bryant, & Ehlers, 2003; Rose, Bisson & Wessely, 2003; Gray, Maquen & Litz, 2004). Given the negative findings associated with CISD, as well as preliminary evidence that

increased arousal in the immediate phases post-trauma is linked to long-term pathology (e.g., Shalev, Sahar, Freedman, Peri, Glick, Brandes, Orr, & Pitman, 1998), there is concern that any intervention that focuses on emotional processing during this period may be contra-indicated. It has, therefore, been recommended that any one-session interventions that require emotional processing be more fully researched prior to recommending their routine practice post-disaster (Watson, 2004). In fact, there are particularly strong recommendations against their use in post-disaster settings involving mass trauma, due to the chaotic post-incident environment, need for attention to pragmatic material needs, possible cultural and bereavement issues, and multiple recovery trajectories based on complex variables (Watson et al., 2002).

While most empirical support for prevention of psychopathology and distress comes from short-term (4–5 session) cognitive-behavioral interventions (i.e., education, anxiety management training, imaginal exposure therapy, *in vivo* exposure, and cognitive restructuring) delivered within a month of trauma, cognitive-behavioral therapy (CBT) has not been empirically examined in the immediate aftermath (0–14 days) of trauma. Recent work with injury and accident victims has sought to evaluate services in the acute post-incident phase, but the interventions have generally been delivered more than 14 days post-trauma (Bisson, 2003; Bisson et al., 2004; Zatzick & Roy-Byrne, 2003; Zatzick et al., 2004).

The brief CBT model may have elements that can be applied to immediate intervention, as research suggests that it results in prevention of PTSD and in decreased depressive symptoms when compared to repeated assessment, self-help, and education and support, and that benefits in psychological functioning are maintained nine months to four years later (Bryant, Moulds, & Nixon, 2003; et al., 2003). A number of RCTs have been conducted with individual survivors of motor vehicle accidents (including those with acute injuries), industrial accidents, and non-sexual assault who have been diagnosed with acute stress disorder (Bryant et al., 1998; Bryant et al., 1999; Bisson et al., 2004; Ehlers et al., 2003; Zatzick et al., 2004).

One of the difficulties of applying the brief CBT model to disasters and mass violence settings is that victims of accidents, assault, or injuries do not experience the disruption in the physical and social environment that is typical of mass trauma. Therefore further research is needed to determine whether the early provision of CBT-influenced interventions following mass violence or disaster is indicated earlier than 2 weeks post-trauma. Members of recent consensus efforts (Watson, 2004) agreed that the chaotic and stressful post-event environment may reduce the energy and effort needed to participate in CBT treatments (i.e., homework, emo-

tional, and time investment). They suggest that structured cognitive-behavioral interventions not be implemented until secondary stressors in the environment are under sufficient control to allow the individual to focus on the intervention (usually not sooner than three weeks post-incident) (Watson, 2004).

Recent efforts in acute intervention following disasters utilize cognitive-behavioral principles in community-based programs, such as the post-traumatic stress management (PTSM) program implemented following community stressors (i.e., suicide cluster, bus accident; Macy et al., 2004). The model is put into place within 24 hours, and involves a series of individual and group interventions designed to help people orient, stabilize, and improve coping skills (i.e., identification of access to support and resources, nonverbal and verbal processing of the trauma narrative, psychoeducation regarding the neurophysiology of traumatic stress and its impact on psychosocial functioning, and planning, problem-solving, and self-care). While this model has not been studied in a RCT, survey information indicates that the most useful parts of the program were providing direction to help communities heal and helping the communities come together to handle the crisis. Program creators recommend that this program can be overlaid on existing human services programs until a trained resource network is in place and stable.

Creative implementation strategies for CBT-based interventions include brief telephone (Greist et al., 2000; Mohr et al., 2000; Somer et al., 2004) and Internet interventions (Gega, Marks, & Mataix-Cols, 2004), which have proven helpful with a variety of mental health problems. One study employing a cognitive-behavioral telephone hotline intervention (e.g., relaxation breathing and challenging maladaptive thoughts) in Israel before the most recent American invasion of Iraq (see Somer et al., 2005) indicated decreased anxiety on several measures post-intervention. Similarly, a study by Gidron et al. (2001) reported reductions in PTSD symptoms at 3–4 month follow-up utilizing a CBT-based telephone intervention within the first 48 hours post-incident. Finally, Litz et al. (2004) have designed a cognitive-behavioral therapist-assisted Internet-based intervention designed to enable the treatment of large numbers of traumatized individuals, that uses a form of stress inoculation training for both secondary prevention of PTSD and treatment of the chronic disorder.

Because of the difficulty in applying the current literature base to interventions following disasters and mass trauma, a number of experts in the fields of trauma and disasters have identified the following five empirically-supported intervention principles to guide intervention practices following disaster and mass violence at the early to mid-term stages.

These principles are (a) promoting sense of safety, (b) promoting calming, (c) promoting sense of self- and community-efficacy, (d) promoting connectedness, and (e) instilling hope (Hobfoll et al., manuscript under review).

Promotion of a psychological sense of safety can reduce biological aspects of post-traumatic stress reactions (Bryant, 2006; McEwen, 1998; Friedman & McEwen 2004; Anotonovsky, 1979; Charney, 2004), and can positively affect cognitive processes that inhibit recovery, including a belief that "the world is completely dangerous" and exaggeration of future risk (Foa & Rothbaum, 1998; Ehlers, Mayou, & Bryant, 1998; Smith & Bryant, 2000; Warda & Bryant, 1998). Interventions include imaginal exposure and real-world, in-vivo exposure, which interrupt the process that links harmless images, people, and things to dangerous stimuli associated with the original traumatic threat (Bryant et al., 1998; Foa & Rothbaum, 1998; Gersons et al., 2000; Resick et al., 2002), "grounding techniques" such as reality reminders, to bring individuals to the relative safety of the present time, and instruction in contextual discrimination in the face of trauma and loss triggers (Hien et al., 2004; Najavits, 2002; Najavitz et al., 1998; Resick & Schnicke, 1992).

Promotion of calming can reduce trauma-related anxiety that can generalize to many situations (Harvey & Bryant, 2002; McNally, Bryant & Ehlers, 2003), as well as reduce high arousal, numbing, or emotionality which can interfere with sleep, eating, hydration, decision making, and performance of life tasks and lead to panic attacks, dissociation, PTSD, depression, anxiety, and somatic problems, if prolonged (Harvey, Bryant, & Tarrier, 2003; Shalev & Freedman, 2005). Interventions include therapeutic grounding (for those with re-experiencing symptoms), breathing retraining (Foa & Rothbaum, 1998), deep muscle relaxation, "normalization" of stress reactions to reduce anxiety associated with reactions (e.g., "I'm going crazy," "There's something wrong with me," "I must be weak"), and stress inoculation training (Bernstein & Borkovec, 1973; Foa & Rothbaum, 1998; Veronen & Kilpatrick,1983; Hembree & Foa, 2000; Meichenbaum, 1974; Rothbaum et al., 2000; Foa et al., 1991; Hickling & Blanchard, 1997; Kilpatrick et al., 1982; Rothbaum, 2001; Solomon, 2003).

Promotion of self-efficacy increases people's beliefs about their capabilities to manage the distressing events, principally through self-regulation of thought, emotions, and behavior (Benight & Harper, 2002; Benight et al., 2000; Benight et al., 1999). Interventions include reminding individuals of their efficacy, encouraging active coping and good judgment about when and how to cope, enhancing sense of control over traumatic stressors, and helping to "recalibrate" expectations and goals that were formed under "normal" circumstances (Follette & Ruzek, 2006; Baflo lu et al.,

2005). Individuals are also taught to problem-solve and set achievable goals, so they may reverse the downward spiral toward feelings of failure and inability to cope, have repeated success experiences, and help to reestablish a sense of environmental control necessary for successful disaster recovery (Baum, Cohen & Hall, 1993).

Promotion of connectedness is based on research indicating that social support is related to better emotional well-being and recovery following mass trauma (Bleich, Gelkopf, & Solomon, 2003; Stein et al., 2004; Rubin et al., 2005; Litz, Gray, & Adler, 2002). Promoting social connectedness increases opportunities for knowledge essential to disaster response, and provides opportunities for a range of social support activities, including practical problem-solving, emotional understanding and acceptance, sharing of traumatic experiences, normalization of reactions and experiences, and mutual instruction about coping (Vaux, 1988; Norris, Friedman, & Watson, 2002). Interventions aim to identify those who lack strong support and who are likely to be more socially isolated, or whose support system might provide undermining messages (e.g., blaming, minimization), keep individuals connected, train people how to access support, and provide formalized support (deJong, 2002; Sattler et al., 2002). They also include specific strategies to address discordance among family members that may stem from differences in the type and magnitude of exposure to trauma, loss, and subsequent adversities, or differences between family members' personal reactions to trauma and loss reminders (Saltzman et. al., in press).

Instilling hope has been identified as a crucial component of post-disaster intervention because those who are likely to have more favorable outcomes after experiencing mass trauma are those who maintain optimism (because they can retain hope for their future), positive expectancy, a feeling of confidence that life and self are predictable, or other hopeful beliefs (e.g., in God, that there is a high probability that things will work out as well as can reasonably be expected) (Carver, 1999; Salmon, 1929; Solomon, 2003; Antonovsky, 1979; Smith, Pargament, Brant & Oliver, 2000; Crowson, Frueh, & Snyder, 2001; Ironson et al., 1997). Interventions include CBT approaches that identify, amplify, and concentrate on building strengths, normalize responses, indicate that most people recover spontaneously, highlight already exhibited strengths and benefit-finding, include guided self-dialogue (to envision a realistic, yet challenging, even difficult outcome), manage extreme avoidance behavior, control self-defeating self statements, and encourage positive coping behaviors (Bryant et al., 1998; Foa, Hearst-Ikeda, & Perry, 1995; Peterson & Seligman, 2003; Seligman et al., 2005; Foa & Rothbaum, 1998; Resick et al., 2002; Meichenbaum, 1974; McMillen, Smith, & Fisher, 1997)

Recently, a team from National Child Traumatic Stress Network and the National Center for PTSD (including Alan Steinberg, Melissa Brymer, Anne Jacobs, Chris Layne, Joe Ruzek, Patricia Watson, Eric Vernberg, and Robert Pynoos) in consultation with a diverse group of disaster response professionals has attempted to apply the research literature and embody many of these helping principles in developing a "Psychological First Aid" (PFA) Field Operations Guide (National Child Traumatic Stress Network and National Center for PTSD, 2005). The PFA guide has been designed, as far as possible, to be consistent with research evidence, applicable in field settings, tailored to the full developmental spectrum, and culturally informed. The guide has been reviewed by an expert panel of consultants, and has been designed to be flexible and targeted at practical assistance and skill-building related to the current concerns and needs identified by survivors themselves.

While PFA has not yet been systematically studied, experience in the field suggests that it will be acceptable to and well-received by consumers. It is, however, important to remain cautious in our estimation of what early interventions can accomplish in terms of prevention of long-term functional and symptomatic impact. It is unknown whether most early intervention activities are associated with significant improvements in functioning. There is a great need for both program evaluation and RCTs that will evaluate the effectiveness of Psychological First Aid principles in a number of contexts.

PSYCHOLOGICAL FIRST AID: PRINCIPLES AND PRACTICES

In working with survivors immediately after their potentially traumatic experiences, PFA providers must effectively enter the setting in which they will offer their services, and then flexibly adapt the principles of PFA to the specific situation. The paragraphs below describe some considerations regarding entry, as well as the core actions of PFA.

Entering the Setting

Providers may reach the scene when the incident is still occurring, in the very immediate aftermath, or in the first few days after an incident. PFA begins when a disaster mental health provider enters an emergency management setting in the aftermath of a traumatic event, and the effectiveness of PFA actions will depend in part upon how the provider enters the setting. Most important, such work should be conducted within the framework of an authorized helping organization with a structured Incident Command System. Because many survivors will take their cue from how others are reacting, especially if they see the other person as someone

who is a leader or who can help them (e.g., a first responder), it is important that the PFA provider demonstrate calmness and clear thinking. As much as possible, he or she must orient to the setting before entry, and learn as much as possible about the nature of the event, response leadership, organization policies and procedures, and available services.

Upon entering the helping environment, the PFA provider must observe how people are reacting and interacting in the setting, and begin to identify individuals who may need assistance. Signs of acute distress are many, but the helper may especially look for individuals who appear disoriented, confused, frantic or panicky, extremely withdrawn, apathetic or "shut down," extremely irritable or angry, or impulsive. In situations where there are many individuals who may need assistance, the provider will need to develop a set of priorities about who may need assistance or most benefit from contact and plan for how to be able to contact them within the time and situational constraints of the setting.

Individuals at special risk after a disaster include children, medically frail adults, those with serious mental illness, those with physical disabilities or illness, those with substance abuse problems, mothers with small children, and those exposed first hand to grotesque scenes or severe life threat. The prevalence of exposure to pre-disaster trauma may be higher among economically disadvantaged urban populations. As a consequence, minority and marginalized communities may have higher rates of pre-disaster trauma-related mental health problems, and are at greater risk following disaster. Mistrust, stigma, fear (e.g., fear of deportation), and lack of knowledge about disaster relief services are important barriers to providing services to these populations. Those living in disaster-prone regions are more likely to have had prior disaster experiences.

The "Core Actions" of PFA

PFA is constructed around eight core actions (see Table 1 for a summary). Most PFA contacts will involve providing most of the actions, depending on the context. The choice of actions and the amount of time spent on each will depend on the needs of the survivor and on the context of delivery. The actions are described below, along with key considerations related to their implementation.

Contact and Engagement

In most disaster response environments, PFA providers will be challenged to rapidly establish contact and develop a positive relationship with survivors. There will be little opportunity to "get to know" people. Many affected persons will not seek help from providers, and some may not want or need contact. This means that the provider will need to use

Table 1. Core Actions and Goals of Psychological First Aid

1.	Contact and Engagement Goal: Respond to contacts initiated by affected persons, or initiate contacts in a non-intrusive, compassionate, and helpful manner.
2.	Safety and Comfort Goal: Enhance immediate and ongoing safety, and provide physical and emotional comfort.
3.	Stabilization (if necessary) Goal: To calm and orient emotionally-overwhelmed/distraught survivors.
4.	Information Gathering: Current Needs and Concerns Goal: Identify immediate needs and concerns, gather additional information, and tailor PFA interventions.
5.	Practical Assistance Goal: To offer practical help to the survivor in addressing immediate needs and concerns.
6.	Connection with Social Supports Goal: To reduce distress by helping structure opportunities for brief or ongoing contacts with primary support persons or other sources of support., including family members, friends, and community helping resources.
7.	Information on Coping Support Goal: To provide the individual with information (including education about stress reactions and coping) that may help them deal with the event and its aftermath.
8.	Linkage with Collaborative Services Goal: To link survivors with needed services, and inform them about available services that may be needed in the future.

judgment in when and how to initiate contact. Providers should introduce themselves with first or full name (and title, if appropriate) and describe their response role. Importantly, they should ask for permission to talk with the survivor. The initiation of contact is likely to be better received if the provider focuses on identifying and helping meet the immediate needs of the person.

Safety and Comfort

Practical help must start with ensuring immediate physical safety, providing physical and emotional comfort, and promoting a psychological sense of safety. Some individuals may be unsafe themselves or may present a threat to others, as a result of physical contamination or behavioral or psychological instability. If there are indications that persons may hurt

themselves or others (e.g., expresses intense anger towards self or others, exhibits extreme agitation), PFA providers should seek assistance from a medical or security team. Attending to physical safety also means being alert to medical concerns (including pre-existing medical problems) requiring attention. It may be important to protect survivors from elements of the situation that may increase their sense of danger: from unnecessary exposure to additional trauma and trauma reminders, from possible violators of their privacy (e.g., reporters, onlookers, or attorneys), from exposure to the suffering of others, or from inaccurate or re-traumatizing information via media. Because disasters or terrorist incidents are often unexpected, shocking, and confusing, sense of safety and control can sometimes be strengthened by providing the survivor with accurate information, about what to do next, what is being done to assist them, what is currently known about the unfolding event, available services, and self and family care. But as with other elements of PFA, helpers should use judgment as to whether and when to present information. Does the individual appear able to comprehend what is being said, is he or she ready to hear the content of the messages, and are other things more important right now? Broadly, many of the actions of PFA can contribute to sense of safety, including being connected with family members, offered immediate practical resources, and linking with other affected persons.

Stabilization

When survivors are emotionally overwhelmed, it may be important to attempt to calm them and reduce their distress. Of course, it is not necessary to stabilize most expressions of strong emotion, which are normal and to be expected following a trauma, not indicative of problems or of a need for more than supportive contact. But for individuals whose reactions interfere with their ability to comprehend the situation or respond to guidance, stabilization may be needed. Such individuals would include those who are unresponsive to questions, crying uncontrollably, hyperventilating, or experiencing intense uncontrollable physical reactions (e.g., shaking). In such situations, the Psychological First Aid provider has several options, including enlisting the aid of family or friend (if they are available) in comforting the distressed person, taking him or her aside to a quiet place, or speaking quietly with the person while family/friends are nearby. When intervening, it will be important to try to address the person's primary immediate concern or difficulty. Options for stabilizing distressed persons include giving them a few minutes alone, simply remaining present, helping them focus on specific manageable feelings, thoughts, and goals, or "grounding" techniques like asking them to orient to the present environment and describe some things they can see. If none of

these interventions aids in emotional stabilization, consultation with mental health colleagues and/or psychiatric consultation for medication may be indicated.

Information Gathering: Current Needs and Concerns

Because of its focus on immediate assistance for the survivor, information gathering in the context of PFA focuses most prominently on identifying immediate needs and concerns. Therefore, most discussion will focus on such things as concerns about immediate post-disaster circumstances and ongoing threat, separation from or concern about the safety of loved ones, physical illness and need for medications, and the nature and severity of experiences during the disaster. However, the provider is also looking for information as to whether there is a need for immediate referral, additional services, or a follow-up contact. Information that may be relevant includes such things as pre-existing social support network, alcohol and drug use, and prior mental health treatment. The PFA provider will need to use judgment about how to gather information, how much information to gather, and to what extent to ask questions, while remaining sensitive to the needs of the person.

Practical Assistance

Assisting survivors with current or anticipated problems is a central part of PFA. Ongoing adversities and continuing problems resulting from a disaster can add significantly to the stress level of the survivor, distract from self-care, and help maintain distress reactions. Problem-solving important problems can be helpful. As noted above, most PFA interactions are built around discussion of immediate needs. In such discussions, the PFA provider can clarify the need, help the survivor specify the problem, and discuss what can be done to address the need or concern. If helpful ideas are generated, it is important to follow through in making an active response (e.g., by helping the person set an appointment with a needed service or helping them complete paperwork).

Connection with Social Supports

Assistance with re-establishing contacts with primary support persons or other sources of support (e.g., family members, friends, community helping resources) is an important PFA action. An immediate concern for most affected persons is locating and contacting their loved ones. The provider should take practical steps to enable the person to make contact (in person, by phone, by e-mail) with persons important to the survivor. If individuals are disconnected from social support, it will often be helpful to encourage them to make use of immediately available sources of social

support (i.e., PFA providers, other relief workers, other affected persons). The provider may also help educate survivors about the importance of social support, and how to be supportive to others. For individuals who have a history of relative social isolation, it will be important to help the person choose specific ways to be involved with other people. Anyone who might benefit can be encouraged to get involved in a support group with others who have had similar experiences.

Information on Coping Support

Although PFA is not focused on treatment of psychological problems, the PFA contact provides an important opportunity to influence coping behaviors of the survivor, by providing brief education about the unfolding disaster itself, stress reactions, and coping. Disaster-related information might focus on what is currently known about the event, what is being done to assist survivors, and available services. Coping-related information that may be helpful includes information about post-disaster reactions and how to manage them, self-care and family care, and coping. PFA providers should use judgment as to when to present information, and provide the type of information that is most pertinent and useful. The most useful information provides assistance in addressing immediate needs, reducing distress, addressing current concerns, and supporting positive coping efforts.

Stress reactions may be alarming for survivors. Some will be frightened or otherwise distressed by their own responses to an event; some may view their reactions in negative and distressing ways (e.g., my reactions mean "There's something wrong with me" or "I'm weak"). Therefore, individuals may benefit from information that explains the reactions that they are experiencing, and that clarifies that these reactions are typical and expectable. PFA providers must take care to avoid pathologizing survivor responses, and avoid use of terms like "symptoms." Of course, it is also important to inform survivors that if their reactions continue to interfere with their ability to function adequately for over a month, psychological services should be considered.

It may also be appropriate and helpful to discuss ways of coping and to distinguish between positive and negative coping actions. Positive coping actions are those that help to reduce anxiety, lessen other distressing reactions, and improve the situation. They include such things as talking to another person for support, getting adequate rest, exercising, and engaging in positive distracting activities. On the other hand, negative coping actions may worsen problems. These problematic ways of coping include using alcohol or drugs, withdrawing from family or friends, or working too many hours.

In some situations, PFA providers will have time to discuss ways of coping in more detail, and in such situations, if the survivor is receptive, it may be useful to introduce the person to simple relaxation, anger management, or sleep improvement skills. It may also be possible to provide simple feedback on negative beliefs related to the event that can cause distress. The PFA provider can listen for such negative beliefs, and help survivors identify alternatives to their beliefs. And the provider can also address substance abuse, if warranted, by educating the individual about the connections between stress reactions and drinking/drug use, discussing safe patterns of use, and/or making a referral for substance abuse counseling.

Linkage with Collaborative Services

Because many survivors will need additional assistance following a PFA contact, the contact is used to help link survivors with needed services. If the survivor is interested in additional services, the PFA provider should do whatever is necessary to insure effective linkage with the services (e.g., walk the survivor over to an agency representative). When making a referral, the provider should summarize the discussion with the person about their needs, describe the option of referral (including how it may help), and give written referral information relevant handouts.

In major disasters, it is a challenge to provide continuity in care and some survivors can feel as if they're being shuttled between care providers. In most cases, continuing contact between affected survivors and the PFA provider will not be possible because the affected persons will go to other sites for continuing services and helpers will rotate out of the setting. But PFA should include ways of attempting to create a psychological sense of continuity of care, by providing, if feasible, continuing contact information so that the affected person can find the PFA provider if they wish to re-connect, and introducing the survivor to other mental health, health care, family service, or relief workers so that they know several helpers by name. When leaving a response site, it is important to let the survivor know this, ensure a direct "hand-off" to another provider, and orient the new provider to what he or she needs to know about the person.

ISSUES IN PFA APPLICATION

PFA is designed to fit into a larger, more comprehensive disaster/trauma response intervention whose components collectively address a broad spectrum of disaster-related problems and associated needs. The

components of this more comprehensive, integrated system collectively share the goals of reducing stress, promoting safety, and maintaining (or recovering, where necessary) adaptive functioning in those exposed to disasters and other trauma. Given that survivors of disasters and other traumatic events may experience a range of needs, both within the acute post-disaster phase and in the persisting aftermath of disaster, it is helpful to conceptualize PFA and other intervention programs as being both *horizontally* and *vertically stratified.*

Horizontal stratification involves efforts to develop integrated broad-spectrum supportive services in the acute aftermath of disaster. PFA is one of a variety of coordinated intervention services—including social services, medical services, housing, and perhaps pastoral care—that are offered concurrently, as needed, to promote recovery in the first hours, days, and weeks following disaster or other trauma. From this perspective, PFA has two overriding goals. The first goal is to provide a "direct beneficial effect" by promoting safety, comfort, stabilization, practical assistance, connection with others, and practical information that facilitate survivors' abilities to adaptively cope with acute stresses and acute stress reactions. A second major goal of PFA is indirect in nature, and is centered on successfully linking survivors (based on information gathered during the PFA intervention regarding current and anticipated needs) to other available services. PFA and the other collaborative services with which it is linked are thus designed to provide survivors with continuity in care across multiple domains of current need, depending on survivors' particular individual circumstances, and associated strengths and needs.

In contrast, *vertical stratification* involves efforts to interlink PFA with a sequence of other more specialized mental health services over time. As noted above, available evidence suggests that the majority of individuals exposed to traumatic stress do not generally develop persisting mental distress or mental disorders (McFarlane & Yehuda, 1996). Thus, conceptual frameworks, risk identification methods, and intervention programs are needed to identify those at-risk for persisting severe distress and dysfunction, and to furnish them with appropriate interventions at specific points in time when they are needed in the short, intermediate, and long-term aftermath of a disaster. For example, interventions can variably (a) identify populations of individuals at-risk for exposure to specific traumatic stresses, (b) focus on preventing the traumatic stress where possible *before it occurs*, (c) promote stress resistance in those likely to be exposed *before it occurs*, (d) promote resilient (quick or expeditious) recovery among those adversely affected *shortly after it has occurred*, and (e) promote long-term protracted recovery in adversely affected subgroups that

do not show resilient recovery, with the goal of preventing persisting severe distress and functional impairment (Layne, Warren, Watson, & Shalev, in press).

What Services are Needed and When Should They be Delivered?

From this perspective, a critical issue in promoting continuity of mental health care with respect to short, intermediate, and long-term post-disaster intervention involves identifying and linking subgroups of individuals with "specialized" needs to timely "specialized" mental health services. In keeping with this goal, efforts are underway to develop and interlink PFA with more specialized services that can be offered, either concurrently or at later points in time (when acute distress reactions begin to subside in those at lower risk), to higher-risk subgroups who may benefit from more specialized therapeutic assistance and professional support. Specifically, we are currently developing Secondary Psychological Assistance, which is designed to serve as a follow-up to PFA for specific subgroups of individuals who need additional or sustained psychological support. Although in its early stages, Secondary Psychological Assistance will contain additional interventions focused on psychoeducation, developing and practicing coping skills, and a greater focus on promoting calmness, connectedness, self- and collective efficacy, and hope (see Hobfoll et al., manuscript under review). This form of intervention would require additional training beyond that related to PFA, and would be capable of being implemented in a variety of settings.

Efforts are also underway to provide subgroups manifesting signs of persisting distress and dysfunction with specialized therapeutic support in the mid- to long-term aftermath of disasters. Several protocols have been developed and implemented to provide these levels of support. These include a mid-level Enhanced Services 10- session manual (Saltzman et al., 2005). This intervention protocol focuses heavily on psychoeducation and coping skills-building to promote survivors' abilities to contend with post-disaster adversities and persisting distress and anxiety reactions, while keeping the risks for iatrogenic (negative) effects at a minimum. Last, for subgroups at high risk for persisting severe distress and dysfunction, highly specialized therapeutic protocols are needed. These include Trauma/Grief-Focused Therapy (Saltzman, Layne, Steinberg, & Pynoos, 2006) which combines psychoeducation and skills-building with explicit therapeutic exercises designed to decrease mental distress, facilitate adaptive grieving among the bereaved, promote adaptive coping, and facilitate adaptive developmental progression. Taken together, PFA, Secondary Psychological Assistance, and other more specialized therapeutic interventions may provide a range of mental health support for

groups with varying levels of need, across different time periods, spanning from the acute post-disaster phase, to a year or longer following the event. It is expected that a decreasing proportion of individuals will progressively require increasingly specialized and intensive interventions, with many individuals benefiting from PFA, less requiring secondary psychological assistance, and fewer requiring mid-level and specialized therapeutic interventions.

Who Should or Can Appropriately Deliver PFA?

These different types and levels of support clearly require different qualifications and levels of training in prospective support providers. With adequate training and ongoing support (including ongoing access to expert mental health consultation and supervision), mature individuals from a variety of backgrounds, including paraprofessionals, may provide PFA. Given this assumption, efforts are underway to adapt PFA for allied professions, including medical professionals, school personnel, and members of the clergy. It is clear that members of different professions may differ with respect to their capacities to competently carry out various interventions or to work with specific groups of exposed individuals (e.g., helping to console and support an acutely distressed traumatically bereaved survivor); thus, referral networks and "back up" consultation services are of great importance to ensure quality and continuity of care and to minimize the risk of adverse effects.

PFA FOR CHILDREN AND ADOLESCENTS

It is estimated that more than 5 million children are exposed to a severe traumatic event yearly in the United States (Pfefferbaum, 1997); thus, it is likely that providers of crisis services will encounter youth in their work. Children and adolescents are often perceived as being especially vulnerable during disasters or other traumatic events, for good reason. Physically they may be less able than adults to escape from dangerous situations; they are more susceptible to injury; and youth may suffer disruptions in their developmental trajectories (Cieslak & Henretig, 2003; Pynoos & Nader, 1988; Silverman & La Greca, 2002). Furthermore, the needs of youth are at risk for being overlooked following a major disaster for two main reasons. First, adults in their environment may be overwhelmed with their own recovery process, and second; some children try to protect their caregivers by suffering silently (McDermott & Palmer, 1999; Schonfeld, 2002; Silverman & La Greca, 2002). The needs of children and adolescents at the scene of a disaster and in the days

immediately following an event are great, as are the questions of how best to provide for those needs.

Unfortunately, little research exists to guide providers in the best manner of approach (La Greca, Silverman, Vernberg, & Roberts, 2002; Stein, Tanielian, Vaiana, Rhodes, & Burnam, 2003). The way in which crisis intervention for youth is addressed varies greatly. Sometimes children are mentioned with regard to the way that their injuries and deaths affect first responders (Leach, 1995). Often, relatively brief guidelines for working with children are included in larger crisis intervention manuals (e.g., DeWolfe, 2000). There are even examples in which children are classified along with emotionally overwhelmed adults as "challenging individuals" (e.g., American Academy of Experts in Traumatic Stress, 2006). While there are numerous attempts to address the issue of working with children and adolescents following a disaster, examples of how to integrate these specialized interventions into a larger manual remain scarce. PFA not only draws upon the available research to guide crisis intervention with youth, but that information is integrated into each core action section of the guide.

Strengths of Child and Adolescent PFA

In creating the PFA manual, an attempt was made to remain mindful of the research on how trauma affects developmental issues (Silverman & La Greca, 2002) and how developmental stages influence the ways in which individuals may react to trauma (Vogel & Vernberg, 1993). This information on working with children and adolescents is integrated throughout each section of the Field Operations Guide. Basic guidelines for communicating with youth are provided at the beginning of the guide to help providers who may not have much prior experience in working with a wide variety of developmental levels. Just as dialogue examples are given for communicating PFA to adults, separate dialog boxes are provided with language and concepts appropriate for communicating with children and adolescents. The interventions can be provided to individuals or within the family context. While the PFA provider may implement services specifically for children, the focus is on supporting and empowering caregivers, not supplanting them. The separation of children from their caregivers is an occurrence that is not often addressed in early interventions; yet it has long been recognized as a severely distressing event (Bowlby, 1973). The PFA guide outlines ways to help children and adolescents cope while efforts are being made to reunite them with caregivers.

While child and adolescent interventions are integrated into the same eight core actions of PFA that are provided for adults, modifications were

made to make these interventions developmentally appropriate for all ages. The modifications generally took one of three forms. First, the language used in the PFA provider scripts found in the dialogue boxes was modified to better fit children's level of understanding. In some cases the script for adults was deemed appropriate for adolescents, while in other instances a separate script was created for this age group. Second, efforts were made to outline activities for children that can be conducted with an individual child or a group of children. Recommendations for appropriate toys or games that have been observed to promote positive coping and distraction from further traumatic stimuli are listed. Third, specific developmental concerns and needs are addressed for various stages of childhood and adolescence. This is accomplished both through providing information on post-traumatic stress reactions to caregivers and through interventions to help youth recognize what needs they may have following a disaster.

Providing PFA through Caregivers

PFA can be delivered through the parents and other caregivers with little or no direct contact with the children or adolescents. A review of the disaster response literature indicates that providing information and support to caregivers is one of the most effective ways to serve children (Norris, Friedman, & Watson, 2002). By providing services to caregivers, PFA serves to help reestablish the adult protective shield for youth and help alleviate their distress (Pynoos & Nader, 1988). The interventions in the PFA guide are respectful of the family and social systems in which survivors exist and reflect the research indicating that these support systems serve as a protective factor (Galante & Foa, 1986). Thus, the interventions often include drawing on natural family resources and working to strengthen the family system following a traumatic event. This is an important aim to note because the intent is to help survivors regain control in their lives, not foster dependence on temporary supports such as the PFA provider. In providing safety and comfort to survivors, PFA providers are instructed in ways to help keep families safe physically and emotionally with interventions such as keeping children and adolescents near calm adults and peers. PFA providers share information with parents about family care, including the need to limit exposure to disaster images via media and to discuss the event with children and adolescents. Developmental differences in children and adolescents' understanding of death and how that may influence their grieving are also outlined for various ages to help parents support their children's coping. Likewise, in aiding emotional stabilization of children and adolescents when necessary, PFA providers are instructed to first ensure that caregivers are effectively

coping, and then provide support to the caregivers to help stabilize their children.

Information-gathering in PFA primarily focuses on obtaining information about the family through the caregivers. Focus is placed on specific concerns about the developmental impact of the disaster, including disrupted milestones from toilet training to high school graduations. Practical assistance can be given to help caregivers prioritize and meet the most pressing needs of their family. When individuals would benefit from greater social support, ways of enhancing their access to family members are outlined. A number of activities that adults can participate in with children are also suggested. Information on coping includes specific information on how post-traumatic stress reactions may be manifested in children's behavior and how to respond to these behavioral changes. Emphasis is placed on helping families re-establish their routines, helping youth engage in healthy self-care, and promoting understanding of the diverse emotional reactions that each family member may experience. Discussions of ways for families to respond to interruptions or delays in important developmental events are provided. Finally, handouts are available for the PFA provider to share with caregivers with information about their children's behavior and reactions to the disaster, how to respond to these behaviors, and examples of specific things to do or say. These handouts are available for parents of various age groups, including preschool-age children, school-age children, and adolescents. Information on how to link the family with collaborative services and examples of how to end the session with each family member are also provided.

Providing PFA Directly to Children and Adolescents.

There are several reasons why the PFA provider might work directly with children and adolescents. Typically, adolescents and even younger children appreciate being addressed directly by adults. Particularly for adolescents who are working to establish greater independence, this can be a respectful stance for the PFA provider to take. It is important for the PFA provider to make contact with a caregiver first and obtain permission to work directly with the youth. In some cases, the caregivers may not be coping well enough to adequately attend to their children's needs at the moment. The PFA provider can then temporarily provide services that the children immediately need and enhance the caregivers' coping until they are able to attend to their children. Finally, there are some instances in which children may be separated from their caregivers or their caregivers may have died in the disaster. The PFA guide addresses specific interventions for these youths while they are waiting to be

reunited with family members. Whenever possible, it is important for the PFA provider to make contact with the caregivers and inform them of any interactions the provider had with their children.

The first core action, Contact and Engagement, contains scripts illustrating how to introduce oneself to a parent and child and gather information about their immediate needs. Care is taken in describing what type of stance and body language one should use, such as getting down on the child's eye level, in order to make contact with children in a sensitive, non-threatening manner. Special issues in enhancing Safety and Comfort for children and adolescents are discussed in the second core action of PFA. Separate scripts are provided to help the PFA provider communicate basic information to adolescents and children using developmentally appropriate language. Suggestions are presented regarding toys that help promote self-soothing with children and ways to instruct children about self-care through play. When children are exposed to the extreme, emotional reactions of other survivors, scripts are provided in order to help the PFA provider explain what the children observed and enhance a sense of safety. Alternately, tips for talking with emotionally-overwhelmed children and adolescents are outlined. Great care is taken in the PFA guide to describe how to promote safety and social support among youth in the event that they are separated from their parents. Ideas for creating a comforting physical space that shields children from further traumatic images are discussed. Various activities that require few, if any, materials are listed. Adolescents and older children are encouraged to help engage younger children in activities or are otherwise encouraged to engage in active coping strategies. Scripts are provided to help the PFA provider to encourage discussion of ways to seek support and talk with others about their feelings or needs. In providing information on coping, the basic relaxation techniques used with adults are modified to be appropriate for children and adolescents. Ways to turn these exercises into games for children are discussed. The PFA provider is also given examples of how to talk with youth regarding specific developmental issues or goals that were waylaid by the disaster. Finally, just as scripts were given to show how to introduce oneself to children and adolescents, scripts are provided to help the PFA provider end the session with children.

EVALUATING PSYCHOLOGICAL FIRST AID

We view the process of evaluating PFA as a multi-step endeavor that is currently in a very early stage. Although much is known about risk and resilience following trauma exposure, there has been relatively little systematic research on the effects of various approaches to responding to the

mental health needs of survivors in the immediate aftermath of disasters. This is especially true when considering interventions for a broad cross-section of civilian populations that range in age from the very young to the very old, as opposed to specialized groups such as emergency responders or military personnel. Many barriers exist to conducting research on intervention strategies in community settings in the immediate aftermath of disasters and it is doubtful that the most rigorous methodologies used to evaluate mental health interventions (i.e., randomized clinical trials) will ever be feasible. However, we believe it is possible to generate other streams of evidence and to move closer to the goal of measuring the impact of PFA on meaningful indicators of survivor adaptation and functioning following disasters. In this section, we describe key issues in evaluating PFA and provide an overview of research strategies.

The Need for Evaluation

There has been an undeniable increase in efforts to incorporate mental health considerations into disaster relief efforts in the United States and other industrialized countries over the past several decades. Research has played a significant role in creating a greater awareness and understanding of the social and psychological effects of trauma, and a number of interventions have been developed with the goal of preventing or lessening the impact of disasters on survivors' lives. Although we have increasingly good information about the many factors that influence risk and resilience following disasters, it has been difficult to demonstrate at a scientific level that mental health efforts soon after a traumatic exposure have had a measurable impact on survivors' adjustment. This is not meant to imply that there have been no positive effects of post-disaster mental health efforts. Rather, it has been extremely difficult to carry out research that evaluates these efforts in a systematic manner.

There are at least two major problems arising from this relative lack of information. First, policy makers may eventually question the value of mental health components of disaster response plans and allocate fewer resources for this aspect of rescue and recovery efforts. Second, decisions about the types of early mental health interventions that should be incorporated into disaster response efforts will continue to rely on incomplete scientific evidence. This leaves open the possibility of utilizing inert or even harmful intervention models.

Specifying the PFA Intervention Model

Defining core principles and techniques for PFA in a manualized format represents an important step in the long-term goal of evaluating the effectiveness of this approach for meeting immediate mental health needs

of trauma survivors. Development of a relatively detailed Field Operations Guide for service providers allows assessment of fidelity to the PFA intervention model during training of disaster mental health personnel and in field applications. It is not possible to conduct an adequate evaluation of the effectiveness of PFA without having clear guidelines for what providers are being asked to do (or not do). It will be important to assess whether PFA providers are able to employ these skills in analog settings, such as disaster preparedness drills and training exercises, and PFA offers a specific set of skills that can be measured systematically. Similarly, study of the actions of PFA-trained mental health responders in field settings can be undertaken through records generated as part of providing PFA, observational methods, and post-deployment surveys of providers and survivors. Aside from demonstrating the feasibility of implementing PFA in field settings, this opens the possibility of demonstrating a link between specific actions by responders and the subsequent adjustment of survivors.

In addition to specifying responder interventions, it is critical to articulate a clear rationale for the various components of PFA. Ideally, each action recommended in PFA (or other post-disaster mental health interventions) is consistent with well-supported scientific explanations based on current knowledge of the factors that affect human stress reactions and coping efforts. This level of conceptual linkage allows an ongoing evaluation of the validity of assumptions that underlie PFA, drawing on full range of scientific inquiry on the impact of trauma on human functioning. In other words, if the assumptions for PFA actions are well articulated, it should be possible to modify PFA in the future if one or more of these assumptions is found to be inaccurate or incomplete. It may also be possible to test individual components of PFA in more controlled settings to determine whether recommended actions have their intended effects. For example, the PFA guide gives specific advice to providers on techniques for stabilizing and calming survivors who are emotionally overwhelmed. The impact of these techniques on observable indicators of stress reactions could potentially be evaluated in settings in which highly distressed individuals are routinely encountered, such as emergency departments or fire rescue settings.

Specifying Outcomes

It is important to recall the purposes of PFA, which include reducing initial distress caused by traumatic events and fostering better short- and long-term adaptive functioning of survivors. Each of these outcomes is multidimensional and should be operationalized and measured robustly. For example, the impact of PFA on initial distress could be assessed using

self-reports of survivors soon after PFA is delivered and an initial self-assessment of distress could be obtained as part of the PFA process itself. Survivors who have received PFA could also be asked their perceptions of the usefulness of specific techniques used during the PFA contact in the following days or weeks. Although self-reports are susceptible to social desirability effects, this information at least gives insight into the acceptability and perceived benefits of PFA techniques for survivors. Certainly, these self-reports must be supplemented by other indicators, such as observation of behavioral indicators of distress during and after PFA encounters. Again, it may be difficult or impossible to measure these behavioral indicators in many settings where PFA is delivered, but evidence on this point from more controlled settings would be invaluable in testing the utility of specific actions and techniques incorporated in PFA.

In terms of gauging whether PFA has an impact on adaptive functioning, we believe it will be important to identify and measure dimensions of functioning that are directly targeted by PFA. For example, some components of PFA focus on helping survivors with decision-making, such as prioritizing needs and making a plan to address the most pressing of these needs. Evaluation should attempt to measure whether decision-making was addressed in the PFA contact and the extent to which survivors judge that the interventions helped them organize their thoughts and make immediate decisions. Even more valuable would be indicators that survivors took some action to follow through on decisions made as a result of the PFA contact. To make this type of measurement possible, the Field Guide provides a written tool to give the survivor a brief summary of priorities set and actions recommended during the PFA contact. When a follow-up contact is made, it should be possible to review this summary, discuss whether the survivor followed these earlier recommendations and whether or not they were helpful, and facilitate further decision-making. In this way, the procedures and tools used to deliver PFA also provide a means for evaluating whether PFA contacts are helping survivors with decision-making in the acute aftermath of traumatic events.

Other indicators of functioning may examine a longer time frame and assess whether PFA has helped survivors move more rapidly towards recovery. For example, it should be possible to gauge whether PFA helps survivors connect to important services more quickly, such as enrolling children in schools and seeking housing or employment more quickly or effectively. Similarly, PFA emphasizes the importance for survivors of seeking and utilizing social supports more effectively (both family or friendship networks and community support systems). It should be possible to track survivors' levels of connection to support systems over time. Again, this tracking serves a dual purpose by providing a context for addi-

tional problem-solving and support by disaster relief systems and also giving a valuable source of evaluative information.

As a final example, another emphasis for PFA is to provide greater continuity and connectedness between survivors and disaster assistance systems. This may be reflected in the indicators of functioning discussed above, but also should be assessed more directly. Survivors could be asked at several points in time to describe or rate how much their experience with the disaster response system has been well-coordinated versus fragmented.

Clarifying Evaluation Design Issues

As noted earlier, the unpredictability of disasters and the understandable priority given to practical matters in the aftermath of catastrophic events makes it extremely unlikely that PFA can be evaluated in a randomized control trial. The more feasible strategies involve measuring the types of mental health interventions offered in the first few days and weeks after disasters or other traumatic events and looking for connections between the form and intensity of interventions and indicators of distress and adaptive functioning in survivors. Undoubtedly, there will be variability within and between communities in the types of assistance offered. Many of the indicators of survivors' post-disaster adjustment described above could be measured regardless of whether or not PFA is utilized as an intervention model. Measuring these indicators could provide a naturally-occurring quasi-experimental design for comparing functioning for survivors who receive PFA with those who receive services from systems using other approaches.

There is also a great deal to be learned by systematically measuring the "dose" of PFA offered to survivors and their subsequent adjustment. One of the strengths of PFA is the high level of specification of the intervention model coupled with the flexibility to match components of the intervention to the survivor's most immediate needs and circumstances. Integrating a written record of the survivor's immediate needs and of the PFA provider's actions and recommendations into the basic intervention protocol should prove invaluable in moving closer to the long-term goal of measuring the effectiveness of PFA at a scientifically credible level.

CONCLUSIONS

Psychological First Aid represents a systematization of eight core helping actions suitable for delivery in the first hours and days following exposure to disaster and other traumas. The core actions of PFA are contact and engagement, safety and comfort, stabilization, information gathering,

practical assistance, connection with social supports, information on coping support, and linkage with collaborative services. The PFA Field Operations Guide describes these actions in detail, along with modifications necessary for their application with children and adolescent survivors. It is designed to inform and provide detailed guidance for those, including mental health counselors, who may be called upon to provide initial support to trauma survivors. At present, there is little empirical evidence that any immediate intervention offered within hours of trauma can prevent development of mental health problems. However, PFA has been designed to be consistent with current traumatic stress research and theory, and it is hoped that systematization of current thinking about very early intervention within the PFA Field Operations Guide will stimulate research on the effectiveness of the approach.

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