Understanding and Applying the Principles of Psychological First Aid - Prof. Phillip Held: TKBV-7365 - admin@strongstartraining.org - Wednesday, November 1, 2023 10:28 AM - 273 minutes

02:34:39 [W0] Dear colleagues and dear friends, I want to share with you a bit about the context of this lecture.
02:34:50 [W0] Series.
02:34:52 [W0] Two years ago, Professor Patricia Resick, with whom I trained over 20 years ago, reached out to me and introduced me to Leah Peskin from the Gavin Farrer Foundation.
02:35:04 [W0] And Leah's mission is to help create a better world for trauma survivors and improve access to evidence based therapy for PTSD.
02:35:15 [W0] And Leah introduced me to Dr. Katie Dondanville from the University of Texas and the director of the Strong Start Training Initiative, which is a grant funded implementation.
02:35:28 [W0] And dissemination program for evidence based psychological treatments and in the past two years, Dr. Katie Dondanville and Professor Jonathan Huppert from the Hebrew University and Jonathan Amster from the Ministry of Health.
02:35:46 [W0] And I have been working with Leah to build a project that will train therapists, supervisors and trainers in evidence based practice for PTSD.
02:35:58 [W0] Ironically, after some delays and many obstacles, the project was set to launch on October 27th and we were all excited about the project.
02:36:11 [W0] But then the events of October 7th hit us and realizing what had happened.
02:36:19 [W0] And I can say on the ninth, on the night of October 7th, I started asking myself how we would address many of the questions that this terrible national and personal trauma for many brought.
02:36:35 [W0] And I started sending emails around the globe.
02:36:39 [W0] And then came Katie and a bit like a fairy with her knowledge and abilities and connections and a lot of time with this learning community project to support Israeli therapists.
02:36:56 [W0] So Katie, I want to extend my deepest gratitude for making this lecture series on trauma, PTSD and traumatic loss possible.
02:37:06 [W0] I also want to thank Professor Philip Held and all the Speaker who agreed to come and donate their time and expertise to help us learn new skills to treat PTSD following this horrific terrorist attack.
02:37:21 [W0] And finally, I think that one of the horrors that many of the victims of this terrible event experience was that they were alone and help did not arrive.
02:37:33 [W0] And the fact that you are standing with us in these moments and that we are not forgotten reminds me the power of community, human connection and working together across borders for the greater good.
02:37:49 [W0] So thank you for being there for us, your support and solidarity with the people of Israel is deeply appreciated in Katie.
02:38:00 [W0] I want to thank you and give you the thank you for this opportunity.
02:38:10 [W0] I know how important this is and we are so grateful to be able to support in this way.
02:38:19 [W0] And we have a amazing experts, including Philip today, who are really eager to

share and support in any way that they can.
02:38:36 [W0] I want to introduce Dr. Philip Heldt, who will be presenting today on understanding and applying the principles of psychologic First aid.
02:38:51 [W0] Dr. Heldt is a licensed clinical psychologist and associate Professor in the Department of Psychiatry and Behavioral Sciences at Rush University Medical Center.
02:39:03 [W0] He is also the research director of the Road Home Program, a national center of Excellence for Veterans and their families, and the director of Treat Treatment Response, Efficacy Access and Timing Lab as a health service researcher, Dr. Held is passionate about innovating mental health care treatments, especially as it relates to PTSD and other trauma related disorders.
02:39:32 [W0] His research has been focusing on examining efficiency and effectiveness of evidence based treatments for PTSD and other trauma related disorders, such as substance use, mood and anxiety disorders.
02:39:50 [W0] And his goal is to develop briefer and more accessible treatments so many people can benefit from them, and that's exactly what we need.
02:39:59 [W0] So thank you, Dr. Held, for being here, and I'll turn it over to you to share your slides and to present today.
02:40:09 [W0] Yeah, thank you so much, Katie. Thank you, Danny. I'm.
02:40:12 [W0] I'm really excited to, to be here and be able to share this info nation with all of you on the call and on different platforms.
02:40:21 [W0] As I've learned since we are streaming in a number of different ways, I will be talking, as Katie mentioned, about psychological first aid, and initially I was expecting this presentation to be more interactive until I learned how many individuals we have on the call.
02:40:37 [W0] But the slides are all designed so that there are a lot of practical steps outlined for individuals on how to use the principles of psychology. First Aid.
02:40:48 [W0] A little bit about me.
02:40:50 [W0] Katie already shared much of this, but really my main research focus is on figuring out how can we take treatments for post-traumatic stress disorder or PTSD and accelerate them, which is also known as masked format so that they can be delivered in just one, 2 or 3 weeks of time, and then other interests of mine include how to use machine learning and artificial intelligence to identify by how individuals will respond to these treatments and then identify ways for individuals who are predicted to be non-responsive, to become responsive through novel interventions that are added to psychotherapy.
02:41:27 [W0] So I've been working in the trauma field for a long time, and I'm very privileged to get to talk to all of you today about an intervention for acute trauma that is referred to as psychological first aid.
02:41:40 [W0] And what we'll be doing today is we'll we'll take a little step back and discuss what is trauma, what are common responses to trauma.
02:41:49 [W0] And we'll talk specifically about the natural recovery process as well as barriers to recovery.
02:41:55 [W0] And we'll use that foundation then to discuss how psychological first aid and its steps prepare.
02:42:01 [W0] Look, listen and link can be used to help individuals who are going through these

acute trauma responses.
02:42:08 [W0] We'll end the discussion today with focus on ethical considerations as well as the impact of trauma on ourselves being providers of various kinds.
02:42:19 [W0] We know that helping others can impact ourselves, and it's important to keep an eye on us as we are providing some of these services to others.
02:42:30 [W0] When we talk about trauma and when you think about trauma and depending on your training and the materials you're commonly used to, there are a number of different definitions.
02:42:40 [W0] But what we're trying to do is to take a relatively broad definition of trauma, which according to the American Psychological Association, refers to any disturbing experience that results in significant fear, helplessness, dissociation, confusion or other disruptive feelings intense enough to have long lasting negative effects on a person's attitude, behavior and other aspects of functioning.
02:43:05 [W0] And so specifically trauma can happen in a number of different ways.
02:43:08 [W0] We're not looking at any particular event.
02:43:12 [W0] This can be caused by human behavior such as war, rape, industrial accidents or incidents that are caused by nature, such as earthquakes or floods.
02:43:22 [W0] And this broad definition is one that we want to move forward with for this presentation, knowing that it applies very much to the current situation in Israel, but also to other incidences.
02:43:33 [W0] So hopefully this training can guide you all in responding to disasters and other critical events beyond the current situation as well.
02:43:42 [W0] So when we think about traumatic experiences, we're thinking about serious accidents, common bad or deployment related events, sexual or physical assaults, serious medical conditions.
02:43:53 [W0] And then we also have, as mentioned, natural disasters, human caused disasters such as terrorism as well as infectious disease outbreaks.
02:44:04 [W0] When you think about these types of traumatic experiences, they differ in some aspects in that some are interpersonal in nature, whereas others are not interpersonal, meaning it involves two individuals.
02:44:17 [W0] So natural disasters for example, or infectious disease outbreaks are not caused by humans.
02:44:22 [W0] And one of the things that the literature tells us is that events that involve interpersonal trauma tend to have a more serious negative impact on individuals.
02:44:33 [W0] So that is just something to keep in the back of your mind.
02:44:35 [W0] As we're going through this presentation today, trauma itself can be typed into two different stages.
02:44:43 [W0] We have an acute stage that usually refers to a single event that doesn't have to happen over a certain amount of time, but it's a single event, and that leads to most of the time, short term effects.
02:44:55 [W0] We can also see traumatic experiences that are chronic in nature.
02:44:59 [W0] So these are repeated incidences where someone is exposed to them for a prolonged amount of time.

02:45:05 [W0] And then we'll also be discussing, especially toward the end of this, what secondary or vicarious trauma looks like, which is the indirect exposure through emotional engagement, for example.
02:45:16 [W0] From the provider perspective, these are interactions that we have with our clients or with the individuals that we are working with throughout providing psychological first aid and the toll this may have on us and what we can do about it.
02:45:30 [W0] One thing of note throughout this presentation is I'll be using a few terms interchangeably.
02:45:34 [W0] I'll be using the terms trauma disaster, oftentimes interchangeably, and also the words individual and survivor.
02:45:42 [W0] So just be aware of that.
02:45:44 [W0] As I go through this presentation, I want to now shift the focus to talk about common acute trauma responses and broadly, these can be grouped into cognitive symptoms that individuals may experience emotional symptoms, physical symptoms, behavioral symptoms and interpersonal symptoms.
02:46:04 [W0] So let's look at the cognitive symptoms first, key cognitive symptoms that you may notice in individuals who have experienced trauma responses might include disorientation or confusion in of thoughts or flashbacks to the event, feeling as though the event is happening again, Individuals may have a difficult time concentrating or may have memory gaps related to the trauma, and they may also become easily startled as a response to the traumatic experience in terms of emotional symptoms, individuals might experience intense fear or anxiety.
02:46:42 [W0] They might become very irritable or have mood swings that are noticeable to others or or they might also experience a sense of numbness or detachment at common other experiences in response to acute trauma are feelings of guilt or shame and questioning whether someone could have or should have done something different as well as expressing anger or aggressive behaviors.
02:47:07 [W0] So regarding the physical symptoms, these are oftentimes visible and sometimes lumped together in the form of being called a panic attack. But there's more to this.
02:47:18 [W0] Something that you might see is an individual hyperventilating or experiencing a shortness of breath, difficulty taking in air.
02:47:25 [W0] They might have increased heart rate or palpitations.
02:47:29 [W0] So really noticing feelings in their chest, feeling as though they're having a medical emergency, which they may or may not. And we'll be discussing the importance of intervening on this.
02:47:38 [W0] And checking in on individuals.
02:47:41 [W0] You may notice that some individuals experience trembling or shaking that is usually uncontrolled, while others may experience gastrointestinal distress, fatigue or exhaustion in terms of behavioral symptoms, individuals tend to try to avoid reminders of traumatic events following acute trauma exposure.
02:48:03 [W0] They may also end up withdrawing from social situations and beginning to isolate themselves.
02:48:09 [W0] Some individuals exhibit sleep disturbances or may have nightmares or night

terrors in response to the traumatic event.
02:48:19 [W0] Oftentimes we see an increase in hypervigilance.
02:48:21 [W0] So being on guard or being excessively alert about the situation and potential dangers that may be present.
02:48:29 [W0] And then also we're seeing individuals take an increased risk at times and become more impulsive.
02:48:37 [W0] And then finally, we're seeing some changes in response to acute trauma in interpersonal situations.
02:48:45 [W0] So individuals who've undergone acute trauma may experience difficulty trusting others.
02:48:51 [W0] They may have difficulties sustaining or staying in relationships.
02:48:55 [W0] They may emotionally withdraw from loved ones, even though they might still be present in the relationship.
02:49:00 [W0] They might be less available emotionally and we oftentimes see reduced intimacy or sexual interest as well as a tendency to be overprotective toward loved ones, oftentimes with the goal of keeping everybody around them safe, even in situations that are objectively more safe.
02:49:18 [W0] Where such overprotectiveness may not be needed.
02:49:22 [W0] It's important to note that all of these are simply examples.
02:49:27 [W0] It doesn't mean that an individual who undergoes acute trauma experience changes all of these symptoms or even symptoms in all of these categories.
02:49:36 [W0] So individuals may have some cognitive symptoms and some physical symptoms, but may not show any interpersonal symptoms, for example.
02:49:43 [W0] So the combination of how individuals experience trauma in terms of their symptoms is very unique.
02:49:53 [W0] It's important to note that everybody experiences trauma differently.
02:49:57 [W0] So even some even though some traumas are shared or two individuals might be undergoing the exact same traumatic experience, that doesn't mean that their outcomes or their symptoms as a result of this are the same. It's quite the opposite.
02:50:13 [W0] We know that every individual processes trauma reactions very differently and therefore also has different outcomes following the traumatic experiences we usually classify experiences of trauma or stressful situations in terms of no or minimal functional impact.
02:50:32 [W0] So this means, for example, that an individual may be slightly more irritable than they were prior to the acute trauma.
02:50:42 [W0] A second category is moderate functional impact.
02:50:45 [W0] This might look like feeling disconnected from others or being increasingly absent from work.
02:50:53 [W0] So we're noticing that the trauma has had an impact on their ability to function and then the category, the last one is severe functional impact, where we're really looking at individuals who are no longer able to complete activities of daily living.
02:51:08 [W0] So they're no longer able to take care of themselves like they used to prior to the traumatic event.
02:51:13 [W0] And that may not just be due to physical symptoms or injuries.

02:51:17 [W0] This may also be to psychological impact of the trauma.
02:51:20 [W0] And this is oftentimes associated with loss of job or impacts to family functioning where it's noticeable when we think of when the trauma impacts individuals.
02:51:35 [W0] That also differs.
02:51:36 [W0] Again, each individual reacts uniquely to a trauma.
02:51:40 [W0] Some individuals may notice symptoms come on immediately following the traumatic event, whereas other individuals have a delayed onset of their symptoms.
02:51:49 [W0] So they may come out of an acute trauma response, seemingly fine, and weeks, months or even years later, as they're processing what happened may begin to develop symptoms.
02:52:00 [W0] As we recently conducted a study looking at combat veterans who engaged in war activities, and a lot of these individuals experienced what is called morally injurious events.
02:52:13 [W0] And what we noticed in interviewing these individuals was that a lot of them described not having any noticeable symptoms despite knowing what they were doing, was violating their morals and deeply held beliefs until much later, until they returned from deployment, until years after.
02:52:30 [W0] And it usually had to do with them having more time to process what went on during the situation.
02:52:37 [W0] All of that is to say, just don't assume that someone's trauma experience is the exact same as the person next to them or someone else who has undergone a similar situation.
02:52:47 [W0] We're all different.
02:52:52 [W0] In addition, trauma can really disrupt how we view the world, how we view ourselves, how we view others.
02:52:59 [W0] We oftentimes refer to this as cognitive schemas.
02:53:02 [W0] So these are maps, mental maps that we create of of the world, of others and ourselves.
02:53:11 [W0] There are three specific schemas that I want to address as part of this because they become increasingly relevant for psychological first aid.
02:53:18 [W0] The first one is the schema of safety.
02:53:22 [W0] We refer to this because it impacts someone's belief that they are able to remain free from harm or danger.
02:53:30 [W0] So I have the ability to keep myself and others safe, for example, and this schema helps me evaluate risk of certain situations and associated decision making.
02:53:43 [W0] So if I recognize that a situation is potentially dangerous, I have the ability to make a decision to act in a certain way to keep myself and others safe.
02:53:55 [W0] What happens when we experience a traumatic event or what can happen is that it shatters our schema of safety and leads to feelings of vulnerability and hyper arousal.
02:54:04 [W0] So I might have the sense that I need to be continuously on guard, always be on the lookout for danger because it might be lurking literally everywhere.
02:54:13 [W0] And so my my system is constantly on overdrive.
02:54:18 [W0] Why this is important for psychological first aid or PFA, is that restoring a sense of safety is critical in order for us to move forward with psychology, ethical first aid.
02:54:31 [W0] If an individual does not feel safe, there's there's very little that will sink in when

we're trying to link them with resources or when we're trying to listen to them, because again, they're trying to protect themselves and do not tend to engage with conversation happens with helpers.
02:54:50 [W0] The second schema that we want to talk about is trust.
02:54:53 [W0] It's the expectation that others will act in a reliable, fair and predictable manner.
02:54:59 [W0] And this is really the basis of all social interactions and attachment relationships that we have when we undergo a traumatic experience.
02:55:09 [W0] What can happen is that the trust that we once had in individuals, whether they were close to us or humanity itself, begins to diminish.
02:55:19 [W0] And this can cause interruptions in our ability to function interpersonally with individuals.
02:55:24 [W0] We're close to or others and might lead to isolation or withdrawal and so forth.
02:55:31 [W0] Because I now may believe that the other individuals can no longer be trusted in terms of psychological first aid or PFA.
02:55:40 [W0] It's really important that we begin to establish rapport with individuals and that we begin to rebuild that trust because trust and especially social support that is directly tied to the ability to trust others is one of the key areas that humans need in order to recover from acute traumatic situations.
02:56:02 [W0] The last schema we want to discuss is power or control.
02:56:06 [W0] It's the belief in one's own agency and ability to influence outcomes.
02:56:11 [W0] In other words, the belief that that I have the ability to make a change or make a difference or that I can do certain things, it enables us with goal setting, decision making and problem solving and what happens when we experience what can happen when we experience traumatic events is that we might perceive as though we no longer have control over situation means things or people that we used to have control over before.
02:56:40 [W0] And as a result, some of us may end up feeling helpless, as if there is nothing we can do in order to change the situation in terms of psychological first aid, it's really important that we try to help individuals see what all they have done and can do to support their own recovery so that we help them regain the ability to feel empowered and that we help them regain their self efficacy.
02:57:06 [W0] All of this will then facilitate individual's ability to cope more adaptively with the acute trauma situation as well as the symptoms that have resulted from it.
02:57:19 [W0] Keeping the schemas in mind is is important because they truly impact how individuals might out react to a trauma and how we engage with them in psychological first aid.
02:57:33 [W0] So when we take a deeper dive into the sense of safety, we talked about a lot of these, but the key here is that individuals whose sense of safety is impacted by trauma, they may shift their focus toward threat detection.
02:57:48 [W0] They tend to be more on guard looking for constant threat.
02:57:52 [W0] So their ability to be present in the moment and have conversations with individuals with helpers can be influenced by that as well, because their system, their biological system is looking for these threats in the environment, not allowing them to stay engaged in conversations from a behavioral standpoint, the sense of safety, if it is disrupted, can lead to avoidance of people, places or situations.

02:58:19 [W0] And also individuals oftentimes tend to rely on safety behaviors.
02:58:23 [W0] So seeking constant reassurance or compulsively checking certain things like their home locks, their doors and so forth, and unfortunate.
02:58:33 [W0] We also, if I don't feel safe, it sometimes very difficult for me to engage in social situations and maintain relationships because I never know what would happen in these.
02:58:42 [W0] And so as a result, I may end up isolating from individuals because being by myself, I have more control over my sense of safety.
02:58:50 [W0] And so what we sometimes see is that the circle of social relationships decreases as the sense of safety decreases In terms of trust, we may notice that individuals may come to expect betrayal, that once trust is broken from one individual through an acute trauma situation, they might expect that trust will always be broken with individuals. Individuals will always betray me.
02:59:20 [W0] Might be believes that individuals present with and as a result emotionally they might become more guarded and the more guarded I am, the more difficult it is for me to establish intimate and authentic relationships with other people because I don't really share much of myself.
02:59:35 [W0] I keep a lot of this to myself, which then prevents me from forming meaningful, deep relationships that are also associated with healing in terms of our sense of power and control.
02:59:51 [W0] Our shift, our focus tends to shift from other from our own ability to influence events, to sort of an external power that influences events.
03:00:03 [W0] Again, it leads to this sense of helplessness, the sense of I'm ineffective, there's nothing I can do to change the situations further feeding that loop of of being helpless and so what happens with individuals who are feeling less powerful, less in control, they may have an increased sense of fear and anxiety because things can happen to them.
03:00:28 [W0] And there is an a more of an awareness of these types of situations that may present a danger or other threats of which they're not in charge.
03:00:38 [W0] It might also lead to excessive dependance on or extreme distancing.
03:00:44 [W0] So individuals may step away from situation.
03:00:47 [W0] Again, isolating themselves more and having a more difficult time to maintain relationships.
03:00:52 [W0] Because in a relationship, oftentimes it is about two people or more people interacting with one another, which allows or requires an individual all to give away or give up some of the control they used to initially have.
03:01:09 [W0] The nice thing is that even though some of these schemas can change and even though individuals might have symptoms following acute trauma responses, as we as human beings all have the ability, the innate ability, so we're born with it to recover from adversity and from traumatic events.
03:01:28 [W0] And that's what we call the natural recovery process.
03:01:31 [W0] We all have this built into our system and there are a number of studies that make this very clear of what this looks like. I forgot the citation here.
03:01:40 [W0] This is from Dr. Barbara Rothbaum and colleagues from the early 90s, and they evaluated individuals who have experienced rape or non sexual assaults and they evaluated

what percentage of individuals in the study experienced PTSD at different time points from one week to one month, two months, three months, six months and 12 months.
03:02:05 [W0] You can see here in the red bar represented for rape victims that approximately 90% of individuals met the criteria for PTSD one week following the rape.
03:02:18 [W0] And yet, as you look over time, you look at one month, two months, three months, six months, all the way out to 12 months, you notice that the percent of individual with PTSD drastically decreases and goes down to approximately 30%, 12 months after the initial rape.
03:02:36 [W0] The important thing to know here is that this was a purely observational study. These were not individuals who underwent treatment.
03:02:43 [W0] These were individuals who were simply assessed over time.
03:02:46 [W0] And what this shows is that the symptoms that they experienced decreased naturally over time.
03:02:54 [W0] We see the same for non sexual assaults with an even more drastic recovery rate.
03:03:00 [W0] And the key takeaway here is that even without intervention for a number of individuals, symptoms are not necessarily lasting.
03:03:11 [W0] A similar study by Pietrzak and colleagues in 2014, which surveyed about 40,000 police who responded to the World Trade Center attacks, found something fairly similar.
03:03:22 [W0] So they evaluated individuals over time.
03:03:25 [W0] Over the course of several years, and then grouped their PTSD, their post-traumatic stress symptoms in terms of their severity.
03:03:34 [W0] And what they identified is that when you look at these trajectories, especially the bottom trajectory, I don't know if you can see my mouse, but the bottom trajectory, which is called the resistance trajectory, that made up 77.8% of individuals.
03:03:50 [W0] So despite responding to something that was extremely traumatic, the vast majority of individuals never developed substantial symptoms of post-traumatic stress.
03:04:00 [W0] They also identified that individuals who immediately following their response to the World Trade Center attacks, expressed moderately severe symptoms of post-traumatic stress, ended up recovering.
03:04:12 [W0] And that makes up the 8.4%.
03:04:15 [W0] And if you look at this over time, over the course of several years, at the end of the study, 86% of individuals did not meet criteria for PTSD.
03:04:24 [W0] Again, pointing to the fact that despite going through something extremely traumatic, individuals may not necessarily develop long term consequences in terms of their mental health.
03:04:34 [W0] We have the ability to innately recover.
03:04:39 [W0] And then a final study by Bonanno and colleagues, which looked at 3000 deployed US military personnel over the course of six years, showed again something very similar here.
03:04:49 [W0] The story will sort of repeat itself that the vast majority of individuals, 83%, remained non symptomatic in about 8% who presented with initially moderate post-traumatic stress symptoms ended up recovering by the end of the six year period.

03:05:07 [W0] So again, approximately 91% didn't meet criteria for PTSD at the end of treatment.
03:05:13 [W0] Speaking to the fact that even without intervention, some individuals can recover from traumatic or adverse experiences.
03:05:23 [W0] Philip, I want to point out there's a question in the chat. Don't know if you saw it.
03:05:26 [W0] It says, Is there a natural healing process from chronic or recurring trauma when it finally stops?
03:05:34 [W0] Yeah, that's a very interesting question.
03:05:36 [W0] So all of these studies actually look at more acute traumatic events.
03:05:40 [W0] There are long term studies that look at individuals who've who've had chronic post traumatic stress symptoms such as repeated sexual assault throughout childhood.
03:05:51 [W0] Some of those individuals show a decrease in symptoms, but primarily the data here are looking at more of the acute period.
03:05:59 [W0] So not something that individuals have lived with for a long time.
03:06:02 [W0] Usually once it establishes itself, it requires some more formal intervention that will be discussed as part of the additional workshops that you're getting through this lecture series.
03:06:12 [W0] In terms of actual PTSD and other types of treatments.
03:06:18 [W0] There's a couple of questions that look to be related to this slide in the Q&A. Do you want me to read them?
03:06:25 [W0] Yeah, sorry, I haven't pulled it up, so if you can, that would be fantastic.
03:06:28 [W0] Yeah.
03:06:29 [W0] It says with regard to delayed versus immediate response, its symptoms, are there groupings of symptoms more common in acute versus delayed onset?
03:06:42 [W0] Yeah, that's a great question.
03:06:43 [W0] So in terms of acute trauma responses, we oftentimes see physiological symptoms come up relatively quickly.
03:06:50 [W0] So there's a change in the hyperarousal symptoms that individuals have, whereas other symptoms such as avoidance behaviors or changes in how people view the world or how they're ending up feeling, those tend to lag behind a little bit, behind the more physiological immediate reactions that look like severe anxiety.
03:07:13 [W0] And the last question is, do we know who's expected to develop later symptoms? Do we know anything about that group?
03:07:23 [W0] So that's a wonderful question.
03:07:26 [W0] We don't, as a field know all that much about who is and isn't going to develop symptoms later on.
03:07:32 [W0] There are some risk factors where this presentation is actually going to go that we want to keep an eye out for, but the field is not currently at a place where we know exactly what put someone at drastic risk for developing any of the long term mental health consequences.
03:07:47 [W0] We have some pretty good ideas, but there's much more work that needs to be done in the field to really help us identify this.
03:07:53 [W0] But yeah, the risk factors are actually coming next because that's what we want

to look out for.
03:07:56 [W0] Also, when we do psychological first aid to try to nip them in the bud as early as we possibly can to set someone up on some of these recovery oriented trajectories
03:08:14 [W0] was that a Katie? I didn't have the Q&A open.
03:08:17 [W0] We can move forward and I'll I'll keep looking for questions and yeah, I appreciate you chiming in because I didn't have this have this up.
03:08:27 [W0] Okay. there we go.
03:08:29 [W0] So whoever asked the question about what do we know about who will and will not develop these symptoms, that was perfectly timed because that's exactly what we're going to be talking about next.
03:08:40 [W0] So as I mentioned, the field of trauma really doesn't have a full understanding of what makes someone a very likely or not very likely to develop PTSD.
03:08:51 [W0] However, we know that factors such as behavioral avoidance, maladaptive cognitions and lack of social support present individuals with increased difficulties with recovery.
03:09:03 [W0] So if I'm avoiding certain trauma reminders, if I view myself as unable to handle challenging situations and if I don't have any support from friends, family or other organizations, I'm at increased risk for recovery.
03:09:20 [W0] Now, this is not a 1 to 1 equation.
03:09:22 [W0] So just because all these factors might be present in me, that doesn't mean I won't recover.
03:09:27 [W0] It just puts me at a slightly higher risk for developing longer term symptoms.
03:09:33 [W0] And so when we think about psychological first aid, we want to keep an eye on our individuals engaging in any of these or have any of these characteristics and see if we can intervene early to put them on the path of recovery.
03:09:49 [W0] Speaking about the role of avoidance a little bit further avoidance behaviors are usually very well intentioned.
03:09:56 [W0] If I've just gone through something that is extremely traumatic to me as a human being, I have the drive to avoid pain and seek pleasure.
03:10:06 [W0] If something is dangerous, I want to avoid this.
03:10:09 [W0] And so in the short term, this avoidance can be very adaptive.
03:10:12 [W0] It might reduce exposure to distressing stimuli or dangerous situations, but it also might help me minimize my discomfort.
03:10:21 [W0] So my emotional reactions may be buffered by avoidance.
03:10:25 [W0] There's a big downside to this, however, because avoidance is self-reinforcing, nursing and research has shown over time that the long term impact of avoidance can be harmful because it increases by itself. So what do we mean by this?
03:10:42 [W0] Imagine I've undergone something that is extremely traumatic and I'm in my house and I'm feeling fairly safe.
03:10:49 [W0] But going outside reminds me of that traumatic situation.
03:10:53 [W0] So the more I begin to think about having to go outside, the more my anxiety decreases and I might begin to have thoughts about bad things happening. This is going to happen again.
03:11:05 [W0] I might get injured, others might get injured.

03:11:07 [W0] And so as my anxiety builds and I feel increasingly uncomfortable, it might seem like a better option for me to just maybe I'll stay at home for a little bit longer.
03:11:17 [W0] And so instead of going out of my door, I might go back into my house, sit back on the couch, and I'll notice that my anxiety decreases.
03:11:25 [W0] And so by doing so over time, over and over, I'm teaching my body that going outside leads to anxiety.
03:11:32 [W0] And the best way to avoid anxiety is by staying home, because this is so comfortable.
03:11:37 [W0] However, individuals tend to get hung up in this pattern, and that is something that we want to look out for is are they using avoidance behaviors?
03:11:46 [W0] And the key here is that when we're talking about avoidance behaviors, this is avoidance of objectively safe situations.
03:11:53 [W0] So if there is true danger or there is a scenario that would put someone at true risk, you should not go into those situations.
03:12:02 [W0] Those are situations that should be avoided unless it is part of your your job and you're required to to do these types of things.
03:12:10 [W0] But then hopefully also with the right precautions.
03:12:12 [W0] So we're talking about objectively safe situations when we're talking about the role of avoidance.
03:12:18 [W0] Philip, we have another question in the chat and the Q&A in in what sense can psychology of first aid be applied to an event that's ongoing?
03:12:33 [W0] so thinking about the current context and, the, the adaptive human response of fear and anxiety and hypervigilance, yeah, excellent question.
03:12:52 [W0] We'll get there in the second half of this presentation.
03:12:56 [W0] I'm sort of tempted to not give a sneak peek just yet, but wait till we get there because we'll be talking about it in, in detail of what do I do both as an individual going through it, but also as a helper, like how do I identify guy who needs help and what are specific strategies that I can engage in with those individuals to help them regain some of that sense of safety?
03:13:17 [W0] Even in ongoing traumatic situations?
03:13:21 [W0] So if folks are okay with this and can hang on for for a little bit longer, we'll have a big section on what psychological first aid actually looks like.
03:13:30 [W0] Hope that's okay with everybody. All right.
03:13:34 [W0] We talked about cognitions already.
03:13:38 [W0] It's the change in how someone believes as a result of the trauma that we want to pay particular attention to.
03:13:44 [W0] And and one of the other aspects that I wanted to point out is we've talked about behavioral avoidance.
03:13:50 [W0] Just a second ago.
03:13:52 [W0] There's also something like cognitive avoidance, which is the attempt to not think about situations.
03:13:57 [W0] And unfortunately, what happens when we're trying not to think about situations is oftentimes the exact opposite.

03:14:03 [W0] So the harder we try not to think about something, the more we end up thinking about it, which can help, which can lead to us spiraling as well.
03:14:13 [W0] So more specifically, what does the role of cognitions look like?
03:14:17 [W0] In a few concrete examples?
03:14:18 [W0] Us Imagine I've experienced a traumatic event and what's going through my mind is this happened because I just wasn't prepared.
03:14:26 [W0] And if that's running through my mind over and over, this happened because I wasn't prepared.
03:14:30 [W0] This happened because I wasn't prepared, I might begin to blame myself and experience self-blame.
03:14:36 [W0] Similarly, if I have thoughts of if I go outside, I'll die.
03:14:40 [W0] And that is what's running through my mind over and over. I might be hypervigilant.
03:14:45 [W0] I might be really on guard because I might die any second.
03:14:48 [W0] If I go outside.
03:14:51 [W0] Similar things go for trust.
03:14:52 [W0] If I trust people, they'll hurt me again, which might lead to social withdrawal.
03:14:57 [W0] And then if I'm not, I'm not capable of handling these situations which might lead to feelings of depression.
03:15:03 [W0] So keeping an eye out on how we and others think following a traumatic event can be a guide to what sort of symptoms we or others might develop following a traumatic experience.
03:15:16 [W0] So again, this is not a 1 to 1 relationship, so I may have these thoughts and not have any self-blame, hypervigilance, social withdrawal or depression.
03:15:23 [W0] It's just one of those things that puts me at greater risk for it in terms of social support, which is the third factor that puts someone at risk.
03:15:32 [W0] At least the lack of social support is what put someone at risk. There are different types of social support.
03:15:38 [W0] We have the emotional comfort.
03:15:40 [W0] So just the fact of being with someone can be validating for us.
03:15:44 [W0] They can help listen to our problems.
03:15:46 [W0] They might express empathy or we might be the ones actively listening to others and providing empathy, thereby creating an emotional bond.
03:15:55 [W0] Social support can also help us with cognitive restructuring, so it might help us reframe or problem solve and it might provide some practical aid, such as others might be able to have resources that I can benefit from, vice versa.
03:16:08 [W0] And so through this connection, we're able to help one another.
03:16:12 [W0] And there is a strong literature on social support as one of the biggest correlates of post-traumatic stress symptoms following trauma exposure, showing that the more social support individuals tend to have, the more likely they are to have lower symptoms down the road.
03:16:32 [W0] So overall, to facilitate recovery, what we want to increase is adaptive cognitions approach behaviors for safe situations and social support.

03:16:41 [W0] And we want to decrease maladaptive cognitions avoidance behaviors in isolation, withdrawal, and we do this.
03:16:47 [W0] And so I think this is where we're getting into the earlier question of what is psychological first aid.
03:16:52 [W0] Actually look like via psychological first aid, a definition I really like is from the World Health Organization, which says that psychological first aid is a humane and supportive response to a fellow human being who is suffering and who may need support.
03:17:09 [W0] It's an acute intervention of choice when responding to psychological needs of children, adults and families affected by disaster or traumatic experiences.
03:17:21 [W0] So it really gets at the nature that this is one human or multiple humans helping other humans.
03:17:27 [W0] So building that social support and also pointing to the fact that this is an acute intervention.
03:17:32 [W0] So we want to use this in the midst of trauma or immediately following traumatic or disaster events.
03:17:39 [W0] This is not an intervention for individuals who have developed chronic symptoms as a result of traumas that have occurred a while ago.
03:17:49 [W0] And so thinking about all of you and why you are well suited for psychological first aid, as far as I understand, most of the individuals who are listening to this webinar are mental health providers or have knowledge in the mental health space, and this puts you ahead of of a lot of other folks who are learning about psychological first aid for the first time.
03:18:09 [W0] So first also because you if you're local to the situation, you have knowledge of what the actual situation is.
03:18:16 [W0] This is different compared to someone coming into a new context and having to learn about the situation.
03:18:21 [W0] You also acutely aware of challenges that might exist in terms of resources or challenges that individuals might face due to the circumstances on the ground.
03:18:30 [W0] And you fully understand the culture that is in the context in which you are operating.
03:18:36 [W0] And then with your mental health training, you come with skills of either basic therapy or counseling skills.
03:18:42 [W0] You might have advanced skills and also you probably connected with other resources in your area.
03:18:48 [W0] So these are maybe other mental health providers.
03:18:50 [W0] These might be medical providers, these might be individuals who can provide financial or other type of assistance.
03:18:56 [W0] And so these connections will also come in really handy as you're learning about psychological first aid.
03:19:03 [W0] This slide is a little overwhelming on purpose because when you think about psychological first aid principles, there are these eight principles that are outlined that are supposed to be followed.
03:19:14 [W0] And yet we know when we undergo a traumatic experience or we're helping in the face of a disaster thinking through all of these things and remembering it can be a whole lot.

03:19:24 [W0] And so really when thinking about psychological first aid, there's a simpler way of thinking about the action principles of what do I need to do in order to provide psychological first aid?
03:19:35 [W0] And we can break this down into four concrete steps.
03:19:39 [W0] These steps are prepare.
03:19:41 [W0] Look, listen and link and you go into in this order, although you will be bouncing around some of these stages throughout, providing psychological first aid.
03:19:54 [W0] When you think about the prepare stage, it's really about learning about the crisis event, what happened and what supports are available, what supports are not available and lacking that either you can help organize or that you need to learn to operate within those limitations.
03:20:10 [W0] As also, it's important to learn about what ongoing safety and security concerns exist so that you can appropriately guide the individuals with whom you're working in terms of the interventions that you provide.
03:20:24 [W0] Look is focused on observing for safety and then identifying individuals who have the most obvious, urgent, basic needs.
03:20:35 [W0] You want to look for individuals who are in acute serious distress because in terms of doing a triage, those are the individuals you want to intervene with first.
03:20:44 [W0] These are the individuals who likely need services the most and need to be connected to resources as quickly as possible.
03:20:52 [W0] Once you have looked and identified individuals who are experiencing distress, you then want to listen and make contact with individuals who may need the support.
03:21:05 [W0] You want to really learn what their needs are and you want to help calm them down in the face of the stress that they are facing.
03:21:13 [W0] And then finally, the link stage is to help people address basic needs and access services, to help people cope with problems, give concrete information about where they might receive additional services or supports, and then connect them with loved ones or other social support services and so this is a lot, but this is the high level overview.
03:21:33 [W0] We're now going to break down each and every step and give concrete ideas about what to do during each of these steps, including concrete skills of how to prepare.
03:21:43 [W0] Look, listen and link so that you can use this going forward.
03:21:48 [W0] We have a question in the chat that I think is something that we have talked about and we've talked to Danny about.
03:21:58 [W0] the person said, I'd like the speaker to comment on Edna Foa's research on risk.
03:22:04 [W0] That debriefing might backfire and, and create a exact make symptoms worse.
03:22:14 [W0] and yeah, so we can, we can talk about that and invite Danny to talk about that too. Yeah.
03:22:23 [W0] What are your thoughts about debriefing psychological first aid and that research? Yeah.
03:22:31 [W0] So there's a key distinction between psychological first aid and critical incident stress debriefing, which I don't know if that's what the person asking the question is talking about the latter.
03:22:44 [W0] And you'll see this at the very end of this presentation as a do not do is that

critical incident.
03:22:50 [W0] Stress debriefing actually has some initial positive evidence but has since been refuted.
03:22:55 [W0] So there is more and more evidence coming out that bringing individuals together can actually lead to increase distress and does not lead to a decrease in distress or have any seemingly potential benefits long term.
03:23:08 [W0] So that is sort of the literature that I'm currently aware of as it relates to critical incident stress debriefing, I know it's still done and it's done in a number of different ways, but it's one of those that I would encourage against using and using strategies like psychological first aid or other cognitive interventions instead that do not.
03:23:28 [W0] And I'll talk about this in the end, but that do not really require someone to open up and talk about things if they don't feel ready or want to.
03:23:35 [W0] Yet. Yeah.
03:23:37 [W0] Danny, did you want to comment?
03:23:39 [W0] Just wanted to add, you know, interventions could be very meaningful but not helpful.
03:23:44 [W0] This is something to distinguish and this is some of the things that the research have measured, you know, is the intervention helpful and that's a great point.
03:23:58 [W0] I really like this point, Danny, because so often as as helpers and we see this too, in response to disasters, we want to do so many things so we mean well.
03:24:07 [W0] And even though it's well-intentioned, it may not always have the outcome that we're intending
03:24:17 [W0] All right.
03:24:18 [W0] So let's dive deeper into each of these different steps, prepare can be really complicated, but again, if you are already in the situation, you may have some of this knowledge available to you.
03:24:29 [W0] So keep that in mind that even though it might seem overwhelming to think about, Wow, I have to really prepare to learn about the crisis or the available supports, the more integrated you already are in the environment and the situation, the more aware you are of the, the available supports, the easier this step will be.
03:24:47 [W0] So you want to ideally learn about what is going on to the best of your ability, knowing that also some of the information that can be provided may not be fully accurate.
03:24:57 [W0] So it's always advisable to speak to individuals on the ground who are providing some of this crisis intervention.
03:25:03 [W0] Then you want to learn about what are the supports that are available.
03:25:07 [W0] Well, so either you can create lists or bring printed materials, but very often if you work in the context of crisis work, individuals will already have some of these materials and have up to date information.
03:25:19 [W0] The challenge is that existing resources can can wax and wane, so sometimes they exist initially but may not exist at a later stage. Vice versa.
03:25:29 [W0] So resources can sometimes fluctuate and that's important to keep an eye out, especially if you have developed materials they might have to change over time as well.
03:25:38 [W0] And then key is that you want to be aware of any safety or security concerns and

you want to take appropriate precautions.
03:25:46 [W0] So if it's not safe to provide care in a certain place, it would be advisable, if at all possible, to find a place where care can be provided in a safe manner.
03:25:57 [W0] Now let's look at look, which again, our goal is to identify individuals who have the most pressing needs and to bring us back to one of the earlier slides that we discussed is that each individual response to traumatic situations uniquely, I can stand next to Katie and Danny and we can experience the exact same traumatic event, and all three of us may have vastly different experiences.
03:26:23 [W0] And that is important.
03:26:25 [W0] So when we think about it, we want to look for cognitive, emotional, behavioral, spiritual and physiological symptoms.
03:26:33 [W0] Or if we know this person from before, changes in these types of areas.
03:26:40 [W0] So for the cognitive impact, we're looking for things that we can intervene on.
03:26:47 [W0] So we can expect someone to be confused following a trauma, to not be able to concentrate, to not be able to immediately solve problems because they're still trying to process what even happened, to feel overwhelmed and even to relive the event and have nightmares when it's critical that we intervene is when they are so confused that it is incapacitating when they are no longer able to truly think through situations or when they become hopeless, suicidal, homicidal, or when we notice any hallucinations or other psychotic symptoms, we want to make sure that we connect them immediately with the appropriate medical care.
03:27:27 [W0] In terms of emotional impact, we can expect individuals to have these emotions around fear, sadness, irritability, anger, frustration, bereavement and anxiety.
03:27:37 [W0] But where we want to intervene are individuals who may show symptoms of panic attacks.
03:27:43 [W0] So, again, these are symptoms like heart pounding and difficulty breathing that are not due to a medical concern or individuals who show up as depressed or emotionally numb.
03:27:54 [W0] In terms of the behavioral impact, we might observe changes in sleep habits or eating habits and this can go in both ways.
03:28:01 [W0] Some individuals might sleep a whole lot more than they ever have or sleep a whole lot less, or eat a lot more or eat a lot less than before.
03:28:09 [W0] So these are changes. This is not an increase or decrease.
03:28:12 [W0] It might vary by individual.
03:28:14 [W0] We also can expect individuals to temporarily avoid situations, engage in compulsions or rituals that are intended in a well-meaning way to keep them safe.
03:28:25 [W0] But again, these are just rituals as well as startle responses.
03:28:29 [W0] And then when we want to intervene is when we're noticing that someone is persistently avoidant.
03:28:34 [W0] And when the compulsions become immobilizing, when they're becoming aggressive or violent, when they're removing themselves from social situations, when they're withdrawing, when they're isolating, when they're taking risks, or when they begin to self-medicate for their symptoms, using alcohol or drugs or even things like energy drinks and so forth. Individuals may also notice a spiritual impact.

03:29:00 [W0] We didn't talk about this before, but individuals following a traumatic experience might begin to question their faith or might question God's actions and might also discontinue faith practices that they've been engaged in for a long time or project faith onto others.
03:29:16 [W0] Those are moments when we might want to intervene if we're trained appropriately.
03:29:20 [W0] And then in terms of physiological impact, there might be a change in appetite, libido, more headaches and muscle aches. That's to be expected.
03:29:28 [W0] But we want to intervene when we notice a change in cardiac function such as chest pain, gastrointestinal function, an and dizziness and numbness.
03:29:39 [W0] And again, we want to make sure that these individuals are available, evaluated, can't say this word evaluated by a medical professional as soon as possible.
03:29:48 [W0] And as medical professionals are available.
03:29:53 [W0] When we evaluate great needs, we want to follow Maslow's hierarchy.
03:29:58 [W0] I assume that most individuals on this call, since they are mental health providers, are aware with Maslow's hierarchy.
03:30:03 [W0] But essentially Maslow built a hierarchy that focuses on physiological needs first, such as food, water, warmth.
03:30:12 [W0] These are called the basic needs that human beings have.
03:30:16 [W0] This is followed by safety needs, such as in addition to needing food, water, warmth and rest.
03:30:22 [W0] I also need to feel safe and secure.
03:30:24 [W0] The only once these two basic needs are met will I really have the ability to focus on my psychological needs, such as my need for belonging and love, or my need for esteem.
03:30:37 [W0] And then in the last stage it goes into self-actualization.
03:30:41 [W0] On why Maslow's hierarchy is important for psychological first aid is that we want to always make sure that individual's basic needs food, water, warmth, rest, security and safety are met.
03:30:53 [W0] Without this, any of the other intervention that we're trying to engage in are likely less effective or not effective.
03:31:01 [W0] So we want to start there.
03:31:03 [W0] When we look for individuals and the needs that they have, As we mentioned earlier, we want to prioritize individuals who demonstrate diminished cognitive capabilities or ability to understand their consequences.
03:31:19 [W0] So these might be individuals who are attempting to engage in risky behaviors, individuals who are depressed or who are no longer able to perform necessary functions of living and where maladaptive cognitions can get in the way in the look stage is that individuals might think this situation is hopeless or I can't do anything right in a crisis.
03:31:42 [W0] And that could cloud their judgment and so we might be able to gently probe them with questions such as what evidence they have that the situation is entirely hopeless and offer data driven assessments.
03:31:53 [W0] The key here is that we want to make sure they're ready to have these conversations and we'll talk a little bit more about what are appropriate questions, at what point in time a little bit later.

03:32:03 [W0] However, avoidance can also get in the way.
03:32:05 [W0] So individuals might be deliberately avoiding news updates or community meetings about the crisis, and that can lead to a lack of situational awareness.
03:32:14 [W0] So one thing that we can do as providers is we can ask about concerns they may have about attending community meetings or learning about the ongoing setting and gradually we work with the individual to attend at least parts of these meetings or give them fliers about or summaries of the meetings just to move them a little bit closer to getting critical information that they need to help with their recovery process.
03:32:38 [W0] Same goes for social support.
03:32:39 [W0] Individuals might refuse help or might refuse reaching out to others.
03:32:45 [W0] And this might be due to fear of stigmatization.
03:32:48 [W0] So the providers might think something bad about me if I reach out for help or mistrust.
03:32:53 [W0] These individuals don't have the best things in mind for me, and so something that we can say as providers is we can normalize that. Help seeking can be really difficult.
03:33:05 [W0] We can say things like many people find it helpful to connect with others during times of crisis, and we can then provide a vetted list of culturally appropriate resources.
03:33:17 [W0] So that takes us to the first two principles of preparing for the crisis event and then looking for individuals who need our help.
03:33:25 [W0] The most.
03:33:26 [W0] And now comes probably the most active stage, which is the listening stage of how do we actually engage with individuals that we have observed needing some support from us?
03:33:39 [W0] There are a few key things to listening in how we engage individuals.
03:33:43 [W0] And again, as mental health providers, you're likely aware of all of these.
03:33:47 [W0] But the key here will be if you used to providing therapy, providing psychological first aid is vastly different in that we're trying to get to immediate needs being met and getting there as quickly as possible.
03:33:59 [W0] Whereas in therapy, we're oftentimes used to exploring some issues in greater detail and doing so over many weeks or even months.
03:34:08 [W0] And so in order to engage individuals, especially in acute traumatic situations, we want to ask simple, respectful questions in traumatic situations, there is a lot going on.
03:34:20 [W0] So the simpler the questions can be, the better.
03:34:24 [W0] If I'm asking you what all happened and who was involved and how you got here and what you've had to eat since then.
03:34:30 [W0] And the question goes on and on and on.
03:34:32 [W0] Trauma survivors will not be able to follow much of this.
03:34:35 [W0] So the simpler and the simpler we can keep the questions, the better we we also want to maintain a calm presence as individuals are anxious, overwhelmed, depressed at whatever they may be as a result of an acute traumatic experience.
03:34:53 [W0] We want to present calm and especially for individuals who are highly anxious, you will notice that their rate of speech goes up.
03:35:02 [W0] They will talk really fast or really loud.

03:35:05 [W0] And what we want to do is not mimic that, but actually flip it around.
03:35:09 [W0] So if someone is really agitated, really loud, speaks really fast, you want to speak calmly, softly, still loud enough so that they can hear us.
03:35:17 [W0] But to help bring them down by by modeling this to the point earlier about critical incident stress debriefing, the key here is that we want to be prepared to listen, but we need to be mindful that not everybody is ready to talk These this situation is are extremely overwhelming.
03:35:37 [W0] A lot of individuals are still processing what's going on, especially if the event is still somewhat ongoing or very much ongoing.
03:35:45 [W0] So some individuals will be very open and very grateful that someone is there to listen, whereas others may not. And that's okay.
03:35:52 [W0] We want to give individuals their space, but let them know that we are here whenever they are ready.
03:35:58 [W0] We want to make sure we give information that addresses immediate needs and ideally, we want to highlight what individuals have done to get to this place where they are today, What have they done to keep themselves safe, because that helps them become more self efficacious or notice what all they are capable of doing. Wow.
03:36:18 [W0] You grabbed all of your belongings and your family and you made it here.
03:36:21 [W0] Despite it being so difficult to find the resources to get here.
03:36:24 [W0] I'm so glad you made it.
03:36:28 [W0] In terms of talking with a translator, I'm not sure if any of you will have to do this or have done this in the past.
03:36:35 [W0] But the key is to speak to the individual, not to the translator.
03:36:39 [W0] So you want to look at the survivor as you're engaging with individuals rather than the interpreter or the translator, because you're trying to establish a connection with the survivor, the same goes for doing online care in some situations it is done.
03:36:54 [W0] So look at the camera as opposed to your screen or away from your screen, if at all possible.
03:37:01 [W0] This can look a number of different ways, but here's a very simple way of engaging an individual in a crisis situation, in a crisis response center, for example, or a shelter where you might be finding yourself very simple.
03:37:15 [W0] Introduce yourself, state your name.
03:37:18 [W0] If you work for an organization, state that explain the purpose of reaching out and ask for permission to talk and inquire about their name.
03:37:26 [W0] There's something unique about connecting individuals by using their name, and then you want to identify any immediate need that this individual has.
03:37:34 [W0] It can look very simple like, Hi, my name is Philip Held.
03:37:37 [W0] I work for Rush University Medical Center, and I'm reaching out to people to see how they are doing.
03:37:43 [W0] I'm also here to help in any way I can. Would it be okay if we talk for a moment?
03:37:47 [W0] So again, I'm asking for permission to speak to this individual.
03:37:51 [W0] What would you like me to call you?
03:37:54 [W0] And then you want to thank them by their name and ask, How can I be of help?

03:37:57 [W0] Or more concretely, if you already have identified some specific needs, do you need anything like water or snack in terms of how to engage with individuals as we're distinguishing between open and closed ended questions, closed ended questions refer to questions that are usually answerable with one word.
03:38:18 [W0] Oftentimes yes or no or specific number.
03:38:21 [W0] And these are used to obtain specific factual information quickly.
03:38:26 [W0] We want to use this during the look phase when we're looking for individuals who have specific needs, we want to quickly identify whether individuals have needs.
03:38:36 [W0] And in that context, asking a yes or a no question is really critical.
03:38:41 [W0] Do you have immediate medical needs? Yes. No.
03:38:44 [W0] Are you able to reach your family? Yes. No.
03:38:47 [W0] And we want to use closed ended questions again in the link phase when we want to confirm that they are able to access services and supports.
03:38:55 [W0] Do you think you can make an appointment with this provider?
03:38:58 [W0] Yes. No. Closed end. The question stand.
03:39:02 [W0] In contrast with open ended questions and these are to encourage dialog or explore feelings and gather nuanced information.
03:39:09 [W0] These don't have a yes or no answer because they require the individual to elaborate a little bit further.
03:39:14 [W0] So can you tell me a little bit more about what you're experiencing right now?
03:39:18 [W0] How are you feeling about the support you're receiving these types of questions require an individual to elaborate and by elaborating you're establishing a connection with these individuals.
03:39:30 [W0] This is why open ended questions are so key during the listen phase when we want to connect with survivors as we're trying to reestablish the sense of trust, you're sharing something and I'm listening this interaction in and of itself is a form of building trust with individuals.
03:39:50 [W0] We also want to use this in the link phase when we're discussing potential coping strategies just to see whether they can visualize themselves applying these types of skills that we're teaching them in future situations.
03:40:04 [W0] The key, though, is balancing the two.
03:40:06 [W0] If I only ask close ended questions, yes, no, it will quickly feel like an interrogation.
03:40:12 [W0] And that's not at all what we want.
03:40:14 [W0] So once I've established immediate needs that an individual has, I want to transition to open ended questions again to facilitate that relationship.
03:40:23 [W0] And once again, we want to be aware of the situation and we want to make sure that if individuals have immediate needs and we need to identify them, we want to start with open ended questions.
03:40:33 [W0] And even for we want to start with closed ended questions.
03:40:36 [W0] I apologize and even for individuals where we're using open ended questions, we want to be mindful that if someone does not want to talk, that's okay.
03:40:44 [W0] We need to allow them their space in acute traumatic situations so that we're

encountering.
03:40:51 [W0] I think most of you are familiar with reflective listening, but a few tips here.
03:40:55 [W0] It's to validate individual's experiences, to demonstrate understanding and encourage further exploration of feelings and this can look a number of ways.
03:41:03 [W0] But a sample dialog would be that a survivor says, I can't stop thinking about what happened. It's always in my head.
03:41:11 [W0] And essentially taking the content of that message and rephrasing it back to the individual and slightly different words such as you're finding it hard to escape.
03:41:20 [W0] Those thoughts might be enough to engage individuals and show them that you are listening because you're able to reproduce the content of the message they provided to you.
03:41:34 [W0] We can also use non non sentences. So brief utterances such as I see.
03:41:41 [W0] Yes, ma'am. Or encouragers like great.
03:41:45 [W0] Or nice work can also help keep the conversation going so it doesn't always have to be a full reflective statement.
03:41:51 [W0] It can be these small encouragers that make a big difference.
03:41:56 [W0] Key is also our non verbals.
03:41:59 [W0] So what our face looks like, whether we make eye contact, the gestures, our body orientation and a key here is that for all of these, their unique cultural nuances that if you're operating in a context where you're familiar with the culture, you'll be very well aware of what is and is not acceptable.
03:42:17 [W0] This oftentimes applies to touch as well as making eye contact with individuals or not making eye contact.
03:42:24 [W0] Generally, it's good to maintain an open posture and to have a neutral or positive facial expression.
03:42:31 [W0] Now, keep in mind that individuals are undergoing an acute trauma, So if you're overly excited and if you're overly positive, that might also backfire because it creates then questions about your ability to understand what they have been through.
03:42:43 [W0] So you want to try to match it with a neutral or positive facial expression.
03:42:48 [W0] What they're presenting with.
03:42:52 [W0] So we have a couple questions that might be good right now.
03:42:55 [W0] One is, in what sense can psychological first aid be applied to the event that is ongoing or what is the time frame for after the trauma and which psychological first aid is maybe no longer first aid?
03:43:14 [W0] Yeah, that's that's a great question, especially for in situations that might also still be a little, a little or a lot ongoing.
03:43:22 [W0] so essentially what we're looking for is intervention within the first month.
03:43:27 [W0] That's usually when we see symptoms express themselves quite a bit.
03:43:31 [W0] So psychological first aid, we oftentimes think about intervening within the first month following an event.
03:43:38 [W0] Now if it's ongoing, individuals may not have been impacted by the event right away.
03:43:43 [W0] So it's not a month hard, a hard and fast set in stone, but it's about roughly a month around when the individual may have been exposed to this.

03:43:54 [W0] That said, a lot of the techniques that we're talking about, like checking in with someone about their needs, can always be used because even if someone is has experienced chronic symptoms, they might benefit from you doing an assessment and identifying the appropriate resources at that chronic stage in the disease process.
03:44:13 [W0] the next question, the last question I have is open ended questions.
03:44:18 [W0] So in close proximity to the event, couldn't that cause more damage?
03:44:23 [W0] Like because it gives the person a an emotional reaction rather than a cognitive action? yeah, yeah.
03:44:36 [W0] Great point. It can. It can.
03:44:39 [W0] And this is sort of where the nuance is important.
03:44:42 [W0] It can be cathartic for individuals to elaborate and to feel understood and to be able to talk about some of these situations.
03:44:48 [W0] However, if I'm using open ended questions and I'm noticing that the person engages with me and overly engages and becomes extremely emotional and it seems to be getting in the way, then at that point in time, I want to take a step back and either switch to closed ended questions or walk them through some of the coping skills that we'll be talking here in a in a few slides that help bring down some of the immediate distress that they're experiencing.
03:45:13 [W0] ING One of the things in some of the questions that I've answered, just in the Q&A via text is that there's not a one size fits all.
03:45:29 [W0] And one thing that's really incredible for you all as mental health clinicians is that you have experts keys in assessment.
03:45:43 [W0] And knowing the people that you're talking with and your clinical judgment is incredibly important.
03:45:51 [W0] So as Philip continues to talk and the other trainings that we have, you always are going to have to use that with your clinical judgment and attune to the person in front of you
03:46:12 [W0] and see if I can add, I think that learning from the experience in Ukraine, you know, a lot of people went through a trauma and needed an intervention an and things continue to be, you know, ongoing and things happen. But they were able to get therapy.
03:46:33 [W0] And we talked with people about, you know, relative safety or, you know, as safe as things could be and worked within this context.
03:46:42 [W0] I mean, now we have a war we don't know how it's going to unfold.
03:46:47 [W0] But I think the interventions are relevant and can be used even in this situation.
03:47:00 [W0] Yeah, I love this point, Danny, because a lot of the interventions that you all will be learning as part of this lecture series have been applied in ongoing war and other crisis situations.
03:47:12 [W0] The reason here for the first 30 days is that for a lot of the trauma responses we see that symptoms tend to subside within that first month following exposure.
03:47:23 [W0] So we want to wait and make sure that individuals are given the time to naturally recover from some of these experiences and then launch into some of the additional treatments, the actual treatments, not these brief psychological interventions that I'm talking about today down the road.
03:47:42 [W0] So key when intervening on acute psychological distress is to provide as much

education on both the current situation and experience of symptoms as we can in acute psychological distress.
03:47:56 [W0] Individuals oftentimes times don't have the capacity to take in a whole lot of information.
03:48:01 [W0] So we want to make sure that the information we provide is concrete and as as detailed as the individual can receive at that point in time.
03:48:09 [W0] To Katie's earlier point, that there's no one size fits all approach.
03:48:14 [W0] The other thing we want to do is to validate and normalize.
03:48:17 [W0] A lot of times individuals who go through acute traumatic situations, lions don't really understand whether their symptoms are normal.
03:48:24 [W0] Is this something I should be experiencing or does this make me weak or is it wrong for me to have these these types of symptoms so reassuring that the symptoms that they're experiencing are normal in the face of traumatic situations can go a very long way because it provides them with a sense that maybe their body and their mind is doing exactly what it's intended to do in these types of situations.
03:48:48 [W0] If we know, we also want to provide some guidance in terms of what to expect in the next hours, days or weeks to come.
03:48:55 [W0] And ideally, we want to help with any problem solving that we can and correct misinformation that they may have.
03:49:04 [W0] And we'll talk about each of these steps in more detail here soon.
03:49:07 [W0] But be mindful that we want to be honest and avoid false reassurance.
03:49:12 [W0] So we don't want to say and make statements like, don't worry, everything will go back to just exactly how it was, because we don't know this in many of these types of situations.
03:49:20 [W0] And sometimes these empty promises or these false reassurances can backfire because again, thinking about the cognitive schemas they get in the way of the sense of trust that we're trying to establish with individuals, oops.
03:49:35 [W0] And so in terms of providing education on the current situation, individuals might say things like, I feel like I can't catch my breath, my heart is racing.
03:49:44 [W0] So having these classical symptoms of what seems to be a panic attack and simply reflecting that what you're experiencing are common symptoms of acute stress.
03:49:54 [W0] They're your body's way of responding to the traumatic event.
03:49:57 [W0] So making sure that they understand that what I'm feeling in this situation is normal.
03:50:02 [W0] We can always try to do something about it and offer some additional skills here in a second.
03:50:07 [W0] But starting with ensuring individuals that what they're experiencing is to be expected is helpful in these acute stress situations.
03:50:17 [W0] Individuals may also say, I feel so lost all the time.
03:50:20 [W0] Is it normal to feel this way, really questioning whether there's something wrong with them and you can say things like, yes, it's completely normal to have strong emotional or physical reactions following a traumatic event.
03:50:32 [W0] Again, providing that reassurance and instilling hope.
03:50:37 [W0] In terms of instilling hope, though, questions will oftentimes come up of will I ever

feel okay again?
03:50:44 [W0] And this is kind of tricky because, again, we don't want to make false promises.
03:50:49 [W0] So we want to still instill hope.
03:50:51 [W0] But we are walking a very fine line here.
03:50:54 [W0] And we can say things like, you know, many people find that with time and support, they start to feel better. You're not alone and help is available.
03:51:02 [W0] So we're reassuring them.
03:51:04 [W0] We're instilling hope, but we're not making false promises about the ability that this person will ever feel okay again, because that's a subjective experience that only that individual can really determine whether they will or will not ever feel okay again.
03:51:19 [W0] We also want to provide guidance. Everything is so confusing, right?
03:51:23 [W0] Individuals might feel lost and they might have made it to a shelter where you're helping them out.
03:51:27 [W0] But even everything in the shelter is is so new and so you can reassure them by saying things like in the coming hours and days, you might experience a range of emotions.
03:51:38 [W0] It's important to monitor how you're feeling and seek help if needed. You can add things like, I'm here.
03:51:44 [W0] If you need me, I'll be sitting right over there or I'll be checking in with you every now and then, letting them know exactly what to expect so that they can also feel prepared.
03:51:53 [W0] Which if you think back to the cognitive schemas, goes right into the sense of safety as well as the sense of power and control.
03:52:02 [W0] Oftentimes following trauma individuals will think about what they might want to do different.
03:52:07 [W0] And while that exploration process can be helpful, some some decisions to act might seem rather drastic such as I just want to quit everything. I want to quit my job.
03:52:17 [W0] I want to leave everything.
03:52:19 [W0] And it's sort of our role to delay those impulsive actions.
03:52:22 [W0] It's not for us to say whether they should or should not be doing, but these these things.
03:52:27 [W0] But we want to make sure that they have sufficient time and they're in an emotional and mental state to make reasonable decisions.
03:52:34 [W0] So saying things like it's understandable to have strong reactions, but making major life decisions right now might be in your best interest.
03:52:41 [W0] Let's take things one step at a time and then we want to teach stress management techniques.
03:52:50 [W0] So this gets at the question that Katie read from the chat What happens if we're engaging in open ended questions and suddenly the individual is experiencing stronger negative emotional reactions or might say, I think I'm having a panic attack.
03:53:06 [W0] You can simply say things like, would you like to take deep?
03:53:09 [W0] Would you like to try a deep breathing exercise with me?
03:53:13 [W0] It can help calm your nervous system.
03:53:15 [W0] And there are many other management techniques that we can engage in.
03:53:20 [W0] So maybe a more comprehensive response could be if we don't know each other,

Hey, so-and-so, it's me, Philip.
03:53:27 [W0] Can you please look at me?
03:53:28 [W0] We want to make sure they maintain eye contact with us. Thank them for that.
03:53:33 [W0] And one, make sure they are aware where they even are and then we want to explain that after frightening experiences, we can sometimes find ourselves feeling overwhelmed with emotions or unable to stop thinking about what happened.
03:53:46 [W0] Would you be willing to practice a technique called grounding with me?
03:53:49 [W0] It can help us feel less overwhelmed, and if they say yes, we can reinforce it and say, Great, now try to sit back and uncross your arms and legs, breathe in and out slowly. Great.
03:54:01 [W0] Now look around and tell me what you see.
03:54:04 [W0] Tell me what you hear and so forth.
03:54:07 [W0] We just want to make sure that as they're looking for things and as they're listening for things that you are in a place where they're not looking at graphic images or graphic scenes or hearing terrible sounds.
03:54:22 [W0] So just be mindful of engaging in these types of techniques, make sure that it's appropriate for the individuals.
03:54:29 [W0] We also want to jump in.
03:54:32 [W0] There was a comment in the Q&A about the media and that unfortunately, the media isn't always a accurate sort of source of truth.
03:54:46 [W0] And we are our experience that also in the US.
03:54:51 [W0] And so one thing to consider is thinking about within your communities, where are places where people can get more accurate truth if if the media is not a good source, there's another comment about the normalization of symptoms, and that is, is it that these symptoms are a natural reaction to to trauma?
03:55:21 [W0] So we expect that people who experience trauma are going to have symptoms like difficulty sleeping, hypervigilance, feeling on guard nightmares.
03:55:36 [W0] But we would expect that for some people after trauma exposure to subsides, most people that those symptoms would naturally decline and it wouldn't need an intervention.
03:55:50 [W0] They wouldn't be diagnosed with something like PTSD.
03:55:54 [W0] So I hope that that helps to answer.
03:55:59 [W0] It's not that having nightmares or difficulty sleeping right now are in and of itself problematic, but they do cause a lot of distress.
03:56:11 [W0] So helping people understand what to expect next and how what they might do to take care of themselves is really important
03:56:33 [W0] All right.
03:56:34 [W0] I'll let you take over again. All right.
03:56:37 [W0] Great.
03:56:39 [W0] we do want to correct misinformation for individuals so survivors might think or have heard that, you know, if I'm feeling this way, it means that I'm weak.
03:56:48 [W0] And so we want to be pretty quick about saying that that's a misconception often just because we want to set up individuals on the right track of healing.
03:56:56 [W0] The key here is that we want to make sure that we're aware enough of cultural norms and where these information, these pieces of information come from.

03:57:04 [W0] Just because everybody will have learned these in different places.
03:57:10 [W0] We talked about being honest and avoiding false reassurance, not making guarantees, not making promises.
03:57:16 [W0] Unless you truly know that you can maintain those.
03:57:19 [W0] But that is really hard in acute crisis situations.
03:57:22 [W0] So try to stay away from that and avoid false reassurances.
03:57:29 [W0] So a few things to avoid doing.
03:57:31 [W0] I think we've talked about most of these, but a few key things to highlight is that that we as mental health providers oftentimes think of symptoms as such.
03:57:43 [W0] But for lay individuals who are experiencing a traumatic event or a crisis, they may not resonate with the with the term symptom.
03:57:51 [W0] So find a term that they're using to describe their symptoms and use that term going forward.
03:57:58 [W0] Also, in terms of debriefing, we discussed this asking for explicit details can really backfire and should only be guided by the individual themselves and then in terms of things to not say is I know exactly how you feel.
03:58:16 [W0] Because again, even if two individuals have undergone the exact same traumatic event, they may have vastly different experiences of that event and reactions following it right in the interest of time, I'm moving forward.
03:58:31 [W0] I think much of this is relatively self-explanatory, but you might want to get additional information on a variety of different areas and these slides will all be available.
03:58:41 [W0] So the specific prompts that you might be able to use or think about are listed, but you do want to learn a little bit more whether they have lost anyone, whether they have concerns about ongoing threat or being disconnected from individuals they loved thoughts about causing harm to themselves or even others, as well as the availability of social support.
03:59:03 [W0] Because these are key elements to address with the resources that you might have available, even if you might not be able to be the one finding loved ones from whom they're disconnected, oftentimes working in crisis situations, the organization or the shelter that you're supporting will be connected to networks where they collect names or have the resources to at least be informed when individuals are identified.
03:59:29 [W0] We want to be really focused on the strengths and abilities that the survivors bring to the table.
03:59:35 [W0] We want to focus on exactly what that is and see if we can highlight it.
03:59:40 [W0] So if they've been very creative in making their way to the shelter, despite a lot of adversity, we want to highlight that and we want to see, you know, given that you're so able to identify resources for yourself despite adversity, I wonder if we can build on this a little bit further.
03:59:56 [W0] The more you can build on what they're bringing to the table, the better in terms of adaptive coping strategies.
04:00:03 [W0] I think most of you are familiar with these, but it can be as easy as going for a walk behavioral activation, getting people active can work wonders for individuals because, one, it elevates their mood in many cases.
04:00:16 [W0] You can reinforce that by highlighting that.

04:00:19 [W0] Did your mood increase as a result of taking a brief walk? Again?
04:00:22 [W0] Only if it's safe, but also it can help challenge some of the assumptions around safety?
04:00:27 [W0] Well, I was able to walk around and I was okay.
04:00:31 [W0] You can also help individuals engage in other activities such as progressive muscle relaxation, breathing, retraining or diaphragmatic breathing.
04:00:40 [W0] You want to connect them with other individuals.
04:00:42 [W0] This might not necessarily be loved ones or individuals they knew prior, although that can be helpful, but it can be other individuals in the shelter or the situation where you're currently at.
04:00:52 [W0] Ideally, however, you want to connect individuals with others who are already in a stable place so that again, that social support, that connectedness can help improve symptoms rather than increase distress that individuals might be experiencing.
04:01:07 [W0] We also want to get individuals back to structures or routines that they had prior to the acute crisis.
04:01:14 [W0] As soon as possible.
04:01:16 [W0] And again, there might be situational or contextual barriers that we want to take into account.
04:01:21 [W0] But getting individuals back into routines can facilitate recovery relatively quickly because it allows them to to go back to quote unquote, normal, even though it's not. Sorry.
04:01:34 [W0] The last piece.
04:01:36 [W0] and we'll we'll talk about this in one slide in more detail but tackling problems head on and breaking them into small pieces is really important in the face of a disaster or crisis, individuals may have lost a number of things, including loved ones, houses, possessions, pets, you name it.
04:01:54 [W0] And so the thought of how am I going to put all of this back together can be extremely overwhelming because you see so many areas where things are lacking.
04:02:02 [W0] So our goal as a helper is to take one problem at a time and find concrete steps as small as possible that the individuals can take in order to address these issues.
04:02:15 [W0] The smaller the problems are, the more likely individuals are able to address them, the more likely they are able to feel that they are capable of addressing these issues and building that sense of efficacy and momentum in the right direction.
04:02:33 [W0] I have a few examples of self efficacy and behavioral activation, but given time I will skip these.
04:02:41 [W0] You will learn a lot about Socratic dialog from Dr. Patricia Resick next week or in the few weeks following, I believe and I want to move now into the link phase, which is the last phase.
04:02:55 [W0] We want to make sure that after we've identified the issues, we've stabilized individuals, we've taught them appropriate coping skills, that we refer them to a higher level of care if needed.
04:03:06 [W0] At that point in time.
04:03:07 [W0] So if we feel like this goes beyond my role as a helper in this situation, they need medical care, they need faith based care.

04:03:14 [W0] And I'm not, trained in that area.
04:03:17 [W0] You want to make sure you link them up with the appropriate resources.
04:03:22 [W0] The other thing in order to establish trust is that you as the helper want to follow up with individuals and you want to follow up one because it shows that you are a trustworthy helper and you mean well, but also to make sure that you have a chance to check in on the possibility of whether individuals have actually had their appointments with the resources that you have set up for individuals and to identify what other additional needs they might have.
04:03:53 [W0] So you essentially at that point in time ask, were you able to attend your medical appointment at Do you mind sharing with me what came out of this?
04:04:00 [W0] Are there other needs that you have?
04:04:01 [W0] So you essentially reengage them in the identification of resource needs or other needs cycle and start over again.
04:04:10 [W0] Keep in mind that people may not need long term care.
04:04:13 [W0] And I think we've been talking about this as part of this presentation for some individuals, just getting basic resources will get them back on track.
04:04:21 [W0] So even though a mental health providers and we oftentimes see individuals for longer term care that may not be needed even for some drastic disasters, others do need long term care, both in terms of financial, medical, mental health, But you want to make sure to not assume that everybody needs long term care. You want to be their liaison.
04:04:43 [W0] You want to advocate for them.
04:04:44 [W0] If you have the ability to schedule appointments for them, if they're not able to, you want to do so.
04:04:50 [W0] And you want to leave the therapy for a time when someone has continued symptoms. So we talked about this.
04:04:55 [W0] If the symptoms last over a longer period of time, that's when you want to engage in some more of the therapeutic services.
04:05:05 [W0] Individuals might have beliefs that get in the way of wanting to be linked up to situations such as I should be able to just handle this myself.
04:05:12 [W0] I've been handling handling situations all my life, like, why can't I handle this one?
04:05:18 [W0] And so things you can say is that it sounds like you feel like you have to go through this alone, which can be scary, but supports are available.
04:05:25 [W0] So you want to be the resource that not necessarily challenges their beliefs at this point in time, especially if they're very set in them. But you want to let them know that help is available.
04:05:35 [W0] And I'm here as you need me.
04:05:44 [W0] All right.
04:05:44 [W0] So in terms of ethical considerations when providing psychological first aid, this is very important, especially as we're switching roles from being a therapist to being a helper in a crisis situation.
04:05:56 [W0] We don't want to exploit our relationship as a helper.
04:06:00 [W0] So oftentimes we're viewed as someone who has resources, who comes with a lot of knowledge, and we don't want to exploit this.
04:06:07 [W0] We definitely don't want to ask the person for any money or favor for helping

them.
04:06:11 [W0] So I'm happy to set you up with a medical appointment, but I need X, Y, and Z in return.
04:06:16 [W0] That's a big no no.
04:06:18 [W0] We talked about not making false promises or giving false information.
04:06:22 [W0] We also don't want to exaggerate our skills. yeah, sure, I can.
04:06:25 [W0] I can take a look at your wound right now, but I actually don't have medical training.
04:06:29 [W0] That's not something we want to do.
04:06:31 [W0] And then we also don't want to push ourselves onto individuals again.
04:06:35 [W0] They have the right to decide whether they do want to share or don't want to share.
04:06:39 [W0] And we want to make sure that we don't judge the person for their actions or feelings.
04:06:44 [W0] Some individuals may respond to a traumatic event different than we might expect, and that is okay because every individual reacts in their own individual way.
04:06:54 [W0] So we don't want to judge them for this, and we also don't want to share their story with other individuals who shouldn't know about their story.
04:07:01 [W0] So be sure to maintain confidentiality.
04:07:03 [W0] Aside from situations where medical needs or other needs need to be shared in order for them to be resolved and you have explicit permission from the individual.
04:07:13 [W0] So critical incident, stress debriefing.
04:07:15 [W0] Sorry, before put the don't do this, sign up. Quick quick overview of what this is.
04:07:20 [W0] There are recent studies that show that there are no long term benefits to critical incident stress debriefing.
04:07:27 [W0] It's usually a single session, group based intervention that happens a day to three days following the situation.
04:07:33 [W0] Individuals are oftentimes encouraged to discuss their traumatic experiences in great detail and unfortunately, it's oftentimes mandatory.
04:07:42 [W0] So it ignores the natural recovery process and prevents individuals from having the agency to make that decision.
04:07:48 [W0] Whether they do or do not want to engage in this.
04:07:51 [W0] And it's also more of a one size fits all approach.
04:07:54 [W0] So maybe something that you're lacking from psychological first aid is like, where is the specific recipe you just taught me how to cook, but now I still got to put this together myself.
04:08:03 [W0] This is a very clear cut recipe, but also that allows for much less flexibility, which makes it not very helpful to all individuals and it can intensify negative emotional reactions.
04:08:16 [W0] So this would be one of the interventions now to consider and then finally, before we wrap up, working with individuals, especially in acute trauma settings, can be really taxing on us as providers.
04:08:33 [W0] One of the things we notice or can notice is a sense of burnout or compassion fatigue or vicarious or secondary trauma.

04:08:41 [W0] And these are two different categories that are important to at least be aware of, because sometimes they can sneak up on us and it's really impactful for our work.
04:08:51 [W0] So burnout is often driven by work environments such as the workload that we're taking on.
04:08:56 [W0] We may be helping too many people or are constantly on duty in a perceived or actual lack of control and insufficient reward.
04:09:05 [W0] So doing all this work, providing psychological first aid in the shelter, may feel futile because I don't really see individuals getting all that much better. They might still be struggling.
04:09:16 [W0] And so that type of work might creep up on me in a negative way.
04:09:21 [W0] Burnout is usually gradual, and it's really hard to recognize because the changes that it has on us or the impact that it has on us are is oftentimes not very noticeable initially until we're mid burnout.
04:09:35 [W0] And unlike vicarious or secondary trauma, it affects primarily your job performance and satisfaction.
04:09:41 [W0] But it doesn't necessarily change the view you have of the world or your sense of safety or anything along those lines.
04:09:49 [W0] So it's more about I'm dreading going to work this is so painful.
04:09:53 [W0] If I'm driving to work, maybe I'll sit in my car and listen to another one or 2 or 5 songs before I actually go in and noticing those types of symptoms in those we might notice that we're procrastinating.
04:10:06 [W0] We feel more tired chronically, we become more cynical if we're burned out.
04:10:12 [W0] And we, like I mentioned, might listen to more songs on the radio for going into work.
04:10:17 [W0] So we we tend to be late find excuses for doing certain tasks that might be challenging for us to be happy and also in terms of the career, we oftentimes question whether we've we've actually made the right career choice.
04:10:33 [W0] Burnout is very different than vicarious or secondary trauma, which this one has.
04:10:40 [W0] Actually the term trauma in the description because it is so this is the psychological or emotional impact felt by helpers when indirectly exposed to the traumatic events through clients.
04:10:53 [W0] Depending on the situation in which you're functioning, you yourself may have been impacted by the same trauma that individuals who present to your shelter or to the place where you're providing psychological first aid faced.
04:11:05 [W0] This, however, is different than secondary trauma.
04:11:09 [W0] Secondary trauma happens when we are interacting with individuals who've been through trauma and we hear their stories, and hearing this over and over can change our worldview and our sense of safety, trust, power and control, and the overall sense of efficacy of what we're able to do.
04:11:27 [W0] So the exact same things that we talked about earlier in terms of the impact of trauma applied to us.
04:11:33 [W0] But through listening to stories of others and it can build over time, but it's more sudden usually than what we're seeing with burnout.

04:11:42 [W0] And it really impacts both our personal but also our professional all lives things to look out for is feeling more depressed.
04:11:51 [W0] I wanted to say, yeah, that, you know, many of the therapists we talk to and supervise, they have the experience from the stories they hear because the stories are really, you know, I can say I'm in the field of PTSD for over 20 years.
04:12:12 [W0] These are not traumas that we see or hear about normally.
04:12:17 [W0] And, you know, maybe if you can say, you know, few things about how do you think, you know or what are your thoughts about self care in this time for therapists?
04:12:29 [W0] Because, you know, a lot of the therapists, you know, when bringing things to supervision, they they have very strong emotions. They cry.
04:12:37 [W0] I think, of course there should be space for that.
04:12:39 [W0] But if you have any thoughts on that, we'll be happy to.
04:12:45 [W0] Yeah, really good timing, Danny.
04:12:48 [W0] It's so important in this space providing trauma work, both in terms of trauma therapy, but also psychological first aid to be sure to take care of yourself.
04:12:57 [W0] And exactly what you just mentioned is actually what are the most recommend interventions.
04:13:01 [W0] So talking with your peers who are able to understand what you're going through because maybe your family, your spouses, your friends have no idea because their lives are so vastly different.
04:13:12 [W0] So having someone in in your realm who gets what you're doing and consulting with them can be helpful.
04:13:19 [W0] Same with supervisors and then in terms of what self-care looks like, again, this is not a one size fits all approach.
04:13:26 [W0] Some individuals really enjoy mindfulness, others enjoy applying some of these cognitive skills we're talking about others like to go out and not try to think about it and really focus on their social connections.
04:13:39 [W0] And then in some cases, if you're noticing that it's truly impacting your work, there might be some considerations about either reducing your workload or your caseload for clinical care or maybe switching the types of cases that you're seeing so that you don't always have to hear trauma.
04:13:55 [W0] But I think to your point, Danny, in terms of like what self-care looks like, everybody unfortunately has to find this themselves.
04:14:01 [W0] But what I really like about what you have set up here is that you're creating a network of a lot of providers who are so passionate and caring about a certain situation that automatically through this initiative you're creating that network.
04:14:15 [W0] And I'm hoping that you can facilitate some of these conversations among providers and be this place where not everything falls on one individual, but there's this this shared, this unity in the mission.
04:14:27 [W0] So I think that will be really important
04:14:34 [W0] And so I wanted to provide a few additional resources.
04:14:38 [W0] So I'll point you to them Again, the slides will be made available.
04:14:41 [W0] And then in addition to that, you have other resources that are made available on

psychological first aid.
04:14:48 [W0] There are lots of manuals out there and lots of additional information.
04:14:51 [W0] Just wanted to point out that there is actually an application for iOS and Android for those of you who really like technology, it helps walk you through the steps and provides a place for you to to capture some of the information.
04:15:05 [W0] And with that, I really just wanted to thank you.
04:15:07 [W0] I know this webinar was was mostly me talking at you all.
04:15:10 [W0] I'm hoping that some of the information was useful or applicable and just.
04:15:15 [W0] Yeah, thank you for, for putting this together.
04:15:17 [W0] This is a really meaningful initiative.
04:15:19 [W0] Thank you, Danny and all. Thank you. Philip.
04:15:24 [W0] We we have a number of questions that thought we could kind of bring together and and really open it up to, you know, Philip and Danny to and myself to share thoughts says regarding younger and older children, how can we be relatively honest but reassuring?
04:15:51 [W0] Yeah, that's excellent. And recognizing I did not talk about different age groups.
04:15:55 [W0] So maybe let me start there really quick.
04:15:57 [W0] You want to make sure that the language you use applies to the age group.
04:16:01 [W0] So oftentimes we might be used to talking to adults, but you need to talk to children or older adults with some cognitive impairments in a slightly different way, using easier terms, simpler messaging and so forth.
04:16:14 [W0] And in terms of the how to approach children, that is actually not my specialty.
04:16:18 [W0] I work primarily with adults, so I welcome any feedback from Danny or Katie, anything that you have.
04:16:23 [W0] But again, just making sure that that you're honest, but in a way that they can comprehend the message and the impact that maybe Mommy or daddy are not not coming home for dinner tonight or whatever it might be.
04:16:42 [W0] Yeah, On November 15th, we have a colleague, Julie Kaplow, who will be talking about how to support Youth Exposed to Trauma and Traumatic loss.
04:16:54 [W0] I'll say a few things in that, you know, there are a lot of unknowns.
04:17:00 [W0] and I think that one of the things that we as parents, when think about myself as a parent sometimes do in a well-intentioned way, is say things like there's nothing to worry about or it's going to be fine.
04:17:17 [W0] and I think that while it might be well-intentioned, you know, I think that that sometimes that that contradicts what, what they're currently experiencing and so I think we want to be be honest like it is scary that I feel scared these are the things I'm doing to make sure that we we are safe.
04:17:43 [W0] We don't have total control. Right.
04:17:47 [W0] What are the things that we can do to help you to feel safer in this moment?
04:17:54 [W0] so I think just being really you know, attuning to your child and as a parent, I can say that I have one kiddo who would respond like, okay, and I have another kiddo that would respond with 7 million more questions.
04:18:12 [W0] And that the more that I answer his try to answer his questions, the more the anxiety grows.

04:18:19 [W0] And so part of what we do, we I do as a parent is thinking about helping him to practice that breathing, that grounding, thinking about self-regulate, action.
04:18:33 [W0] And so anything that we can do to model that for the young people around us and and know that the same answer may be work for one kiddo, but another kiddo may need something else.
04:18:51 [W0] And I think if we think about a lot of our responses related to, to regulation, being dysregulated, there was a question in the chat about like dissociate sedation, right?
04:19:05 [W0] That's the highest level of dysregulation in what we think about is grounding.
04:19:11 [W0] And so using our voice to bring someone back to the here and now, using their name, saying today is Wednesday, November 1st. Right?
04:19:25 [W0] It's the evening we're in our house.
04:19:28 [W0] Feel the the chair below you the feet.
04:19:32 [W0] Your feet are feet touching the chair.
04:19:36 [W0] Right or you can feel your toes on the floor just all these things to activate all of those sensations, to bring someone back.
04:19:45 [W0] And if we think about grounding ING at kind of a micro level, some of the breathing, the relaxation, all of this is helping someone move from an heightened state of emotion to somewhere a little bit lower.
04:20:04 [W0] and practicing, you know, as a family like the reality is we have to practice these things just like we have to, you know, practice things like working out.
04:20:17 [W0] And I wish, I know that I would benefit from a mindfulness practice, but it's hard.
04:20:26 [W0] So the more that we can get into these routines and we can model it for those around us will help to reduce.
04:20:37 [W0] Okay, Someone said, What about people who want to talk about what happened?
04:20:42 [W0] So I think that kind of comes back also to regulation.
04:20:45 [W0] So some people are regulated and they want to cognitively process that story and that is very different than somebody else that is fully dysregulate in which we're we're kind of helping ground in the moment. Other thoughts.
04:21:05 [W0] So it's in my opinion, then that's okay.
04:21:09 [W0] We can we can help them talk through their story and monitor that.
04:21:14 [W0] You know, the only thing I would add. go ahead, Danny.
04:21:18 [W0] I can say I think that some people really process through talking about it and some people talking, you know, process it in a more internal way and they don't want extra information in.
04:21:31 [W0] And I think the thing is and it's not necessarily easy, but you, you know, if you are a person that likes to talk, you have to just you know, see that you're talking with people that you know, are able to talk about it and tolerated and that you're not creating, you know, in another family member suffering or pain that is related to talking about it.
04:21:58 [W0] But I think it's a it's a delicate it's a delicate task, but definitely with a therapist, I think talking about it is is part of processing.
04:22:13 [W0] And, you know, we can actually we will see it in the lectures to come.
04:22:19 [W0] But with the Patty and Sonja Norman about, you know, we can ask questions about the experience to help actually restructure and reduce guilt and shame and pain.

04:22:37 [W0] Yeah there was one in the chat about, and these are, this is something that Danny and I have talked about.
04:22:46 [W0] There have been some awful atrocities that we've heard that, including, you know, young kids, babies who have died, people who have been raped.
04:23:02 [W0] And, you know, sometimes that leads us to think, how does one move on after something like that?
04:23:11 [W0] You know, and it is really, really awful.
04:23:14 [W0] And I wish that we had a magical wand to to prevent that from happening in people's life.
04:23:23 [W0] but we know that if someone develops PTSD that we have good treatments.
04:23:33 [W0] And through Danny's leadership, along with Jonathan Huppert and others, that there will be more training and specific interventions like cognitive processing therapy.
04:23:47 [W0] Some of you may be trained in are trained in Emdr or prolonged exposure.
04:23:52 [W0] We know that these therapies are very, very effective.
04:23:55 [W0] And unfortunately, I have had and and Danny and and Philip probably also have had the privilege of treating individuals who've had atrocity as and they have had recovery.
04:24:13 [W0] And that's hard for us to believe.
04:24:17 [W0] And there have been times where myself as a therapist have questioned whether recovery is possible.
04:24:25 [W0] But we we do know and we have seen that.
04:24:29 [W0] And so we're we're here to support you, your clients and everyone affected.
04:24:36 [W0] there's a question in the chat about, and we have attendees from the US.
04:24:46 [W0] We've got attendees that are from Argentina who are supporting those not in Israel that are being that are affected.
04:24:57 [W0] They are all they're saying is there a role of psychological first aid in college students or anyone outside of Israel that is being impacted?
04:25:10 [W0] They also are experiencing unprecedented amounts of anti-Semitism.
04:25:16 [W0] so thoughts about psychological first aid or supporting those further away
04:25:26 [W0] Yeah.
04:25:27 [W0] Thinking about contra indications of psychological first aid, maybe that's sort of like where my mind goes.
04:25:32 [W0] There really are very few.
04:25:34 [W0] It's used in a variety of different content. That's right.
04:25:37 [W0] We talked about the different traumatic events upfront.
04:25:40 [W0] the specific one you mentioned wasn't listed, but there should be no reason why psychological first aid in its principles could not help those individuals as well.
04:25:50 [W0] And at least be a point to do this initial assessment to determine what other care might they need.
04:25:56 [W0] And if we refer to appropriate resources after that. So I don't see a reason why this wouldn't work.
04:26:03 [W0] And I scrolled up in the chat.
04:26:04 [W0] It looks like there's the questions also about doing so via telehealth.
04:26:09 [W0] And there should be no reason why that that would not work.

04:26:13 [W0] And it is being, it is being done.
04:26:15 [W0] So yeah it also references watching a constant graphic video social media, you know, and one thing that I would recommend is, you know, to talk with the person about potentially limiting that that may or may not be that helpful to them and that there may be other ways in which they can gather information that might be more helpful.
04:26:45 [W0] we have another question.
04:26:48 [W0] how do we help our clients whose basic needs of safety cannot be met?
04:26:54 [W0] I have clients without safe rooms.
04:26:56 [W0] We have rockets a few times a day here.
04:26:59 [W0] They are experiencing intense anxiety, but if we can't help meet their basic needs for safety, I feel like that's problematic
04:27:16 [W0] And do you have any thoughts I can share with you.
04:27:27 [W0] You know I can say, you know, many of the I mean, many people, right now definitely are more stressed and feel distress following this attack.
04:27:42 [W0] We had many rounds of fighting with Hamas.
04:27:45 [W0] But this is definitely something different that we experienced before.
04:27:51 [W0] A in many in many ways, the events of October 7th, but still the events that are continuing, It's a very long time for Israel to have such alarms and missiles every day, a few times a day.
04:28:07 [W0] And I, I personally think I'm not a person that uses a lot of regulating and mindfulness techniques, but these are the times that I think that these tools are relevant and can be used to, you know, help regulate and, and and I think that we can talk with people about, you know, relative safety and not total safety, you know, or which doesn't exist.
04:28:42 [W0] It's a it's a a kind of a fantasy or idea that we have that there's total, but definitely there's higher risk.
04:28:54 [W0] Now.
04:28:55 [W0] And still we can talk about relative safety.
04:28:59 [W0] So that's how I would work with people who are dealing with it.
04:29:07 [W0] Yeah
04:29:13 [W0] I think one of the things is meeting our clients where they're at and helping them to
04:29:33 [W0] move through the days as that and engage in meaningful life.
04:29:43 [W0] And so for some of us in that circumstances, the anxiety might be paralyzing and we don't leave our houses for other people.
04:29:56 [W0] Well, they may have different thoughts s about what that means and they may be taking reasonable risks in order to engage in daily life.
04:30:12 [W0] I wish the basics of safety was universal.
04:30:17 [W0] everywhere.
04:30:19 [W0] and, and and somehow some people are still navigating life even when it's unsafe.
04:30:32 [W0] And so I think we want to meet people where they're at and think about helping them to engage in the things that are important to them and make the decisions about reasonable risk.

04:30:49 [W0] one of the comments in the, in the Q&A is related to the translation services and we are using an AI translation where we have a glossary of terms and we know that it wasn't perfect, but if that person wants to provide their contact information, we'd love to follow up.
04:31:16 [W0] We want to thank everybody for taking their time this evening to be with us and thank Philip for his wonderful presentation and and and Danny for helping coordinate the many, many, many people who wanted to be here.
04:31:35 [W0] We will share this via email, but we we apologize.
04:31:40 [W0] We have had some technical difficulties.
04:31:44 [W0] So some of your colleagues may not have been able to attend.
04:31:49 [W0] but we have recorded this and we're going to work on the translation and the technical difficulties for next week.
04:31:59 [W0] Next week, Dr. Resick will be presenting focusing on Socratic dialog for initial trauma reactions.
04:32:09 [W0] And thank you all for, for what you're doing and we will continue to to reach out and provide updates via email with the zoom links, the where the recordings can be found, the pdf of the handouts and also the psychological first aid resources
04:32:36 [W0] Okay, thank you all.
04:32:38 [W0] Have a great Katie.
04:32:40 [W0] I want to thank you again for your willingness to share the knowledge and offering this help.
04:32:48 [W0] It's very meaningful to us.
04:32:51 [W0] We we we want to do that.
04:32:53 [W0] What we we didn't know is how, how complicated technology would end up being and how many people were in need.
04:33:06 [W0] So we'll we'll be better next time. But thank you all. All right.
04:33:12 [W0] We can we can treat it as a newborn.
04:33:16 [W0] It takes time to develop. It takes time. I'm sure. I'm sure.
04:33:22 [W0] I'm sure we will improve.
04:33:24 [W0] And, you know, there are like 12 year olds live streaming things and us mental health professionals are not always the most technology savvy, but we'll get there.
04:33:35 [W0] Thanks, Philip. All right. Take care, everyone.
04:33:38 [W0] Night