



The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

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SAMHSA DTAC Director's Corner

It has been a busy time for so many of us in the field of disaster behavioral health preparedness and response. Since our last edition of *The Dialogue*, many States have had to deal with natural disasters, such as massive flooding and tornadoes, or other disasters, such as a coal mine explosion. Most recent, and likely on all of our minds, is the Deepwater Horizon Oil Spill in the Gulf Coast. With so much on our plates, I hope *The Dialogue* provides you with useful and helpful information.

This issue includes information about cultural differences and sensitivity in disaster response (e.g., lessons learned from disaster response work with American Samoa); a Psychological First Aid training now available online; recent research about compassion fatigue and satisfaction; a communication aid to be used with people who have limited spoken language capacity; and upcoming meetings you may be interested in attending. As always, SAMHSA Disaster Technical Assistance

Center (DTAC) is here for any U.S. State, Territory, or individual in need of information or assistance related to all-hazards disaster preparedness and response. Please feel free to contact us toll free at 1-800-308-3515 for assistance.

Warmest Regards,

Amy R. Mack, Psy.D.
SAMHSA DTAC Project Director

Knowing Cultural Differences Makes All the Difference When Offering Assistance

Contributed by John Chavez¹

All disasters are NOT the same. Take, for example, the one that hit American Samoa in the quiet dawn of September 29, 2009. As families were getting ready for work and school, an 8.1-magnitude earthquake occurred, causing a destructive tsunami and major flooding. This was the first major disaster in the Pacific in 5 years, and responders found out that offering assistance outside the Continental United States can be very different from responding on the mainland.

While responders face some of the following differences during mainland response, these are more likely and perhaps more pronounced when response is required elsewhere:

Temporal Differences

The location may make you feel like you're in the middle of nowhere—and maybe you are. You may experience a drastic time difference—several hours or even a day ahead—which may make it



Several local and Federal partners worked together at distribution centers to provide essential resources to residents after the tsunami that struck American Samoa. Photo courtesy of David Gonzalez/FEMA.

difficult to keep in touch with family and friends. The weather or season could be different—lots of rain or snow; really hot or really cold; or elements that compound the disaster, like storm surges, tornadoes, and mud slides.

Differences in Provisions and Safety

Provisions, such as shots, potable water, medical services, and mental health care, may not be available, and these difficulties can be

compounded by the amount of debris and other continuing health concerns. The location may not have major stores available for shopping, so access to clothing, food, and other needed items may have been limited even before the disaster. Electricity and running water may not be in place, or these services may be disrupted by the disaster. Be prepared for lack of communications; phone, internet, radio, and television services may not be available or reliable. News and other programs, for example, may be two weeks old.

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Logistical Differences

Necessary equipment may need to be flown in or sent by cargo ships. In American Samoa, one of the two power plants was destroyed. The world's largest cargo plane, the Antonov AN-225, was used to bring in generators and alternators. Other needed items, like durable medical equipment, were brought in on commercial flights, as well as tuna and cargo ships.



Workers use a diesel tractor to unload generators from the Antonov AN-225. Photo courtesy of David Gonzalez/FEMA.

Linguistic and Other Cultural Differences

Most important are linguistic and other cultural differences, which encompass and are part of

all of the above-mentioned differences. Cultural awareness, then, is crucial to a successful response. Responders must be careful not to offend. A person should not be flighty (and this stands anywhere on this world). Know where you're going, and be sure to ground yourself with a real understanding of the people you will meet. Remember also that the islands that make up the U.S. territories are not foreign countries and should not be referred to as such. The local culture and language may be different, but both are important and should be valued.

Consider that you may run into a language barrier. You may not speak the same language as survivors. Even if you do speak the same language, cultural differences can affect the connotations of words and the interpretation of phrases and questions. These differences may even be compounded by a lack of clarity on your part. For example, survivors must fill out an application to receive assistance. One of the questions on the application is, "Are you willing to relocate?" Many applicants in American Samoa marked "No" because they thought they would have to move. This is not a mistake on their part; the question is unclear. The intended question is, "Are you willing to relocate until your house is fixed?" Perhaps lessons learned from this disaster will prompt a wording change.

Experience is sometimes an enemy. We may move ahead on cruise control because we know what we

are doing, but we may be used to communicating with the same people all the time. We need to be aware of how we communicate with local peers, those affected, other agencies—anyone. In a disaster, it is important to not misinterpret things or sound like an alarmist. And remember that news travels fast in small communities and islands.

Cultural differences also include practices and beliefs, such as specific times for prayer sessions, curfews, and rules on Sundays, like no drinking or selling of alcoholic beverages. For example, in American Samoa, funerals are large, family events. A funeral may last for hours or days. Money and gifts are given to the family and those in attendance. And then, the deceased is buried on family property, not in a cemetery.

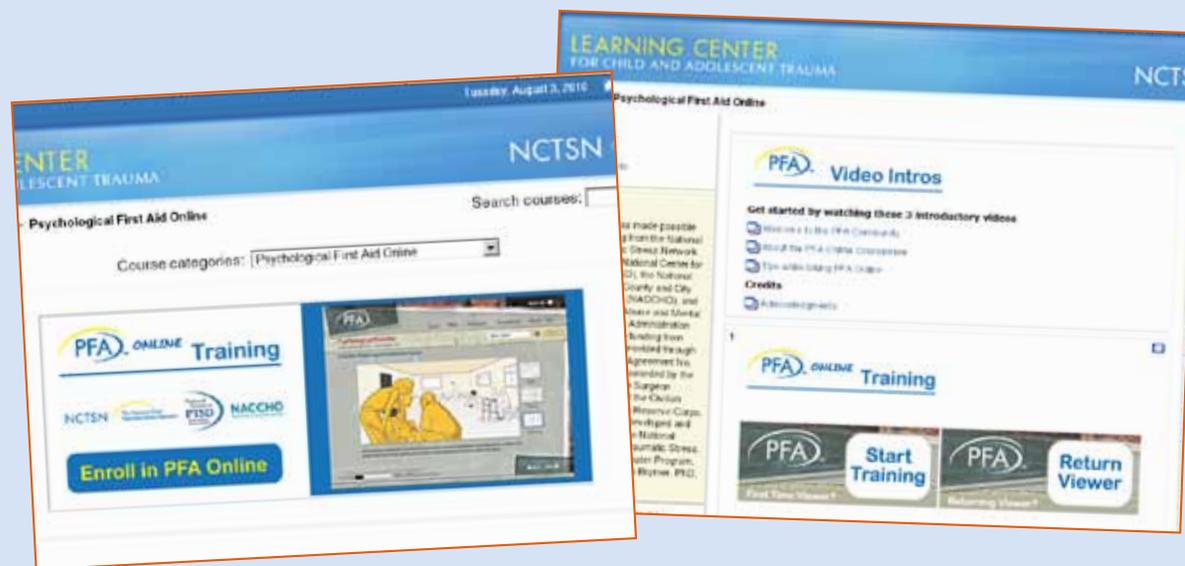
There are many special considerations, challenges, and unique factors when working away from the mainland, or even in a different part of the mainland. One and all have to manage expectations and work together. All available resources should be evaluated, and attention should be paid to assisting those in vulnerable populations. Working together will assist in recovery and ensure that those affected are not conquered by the disaster. Most importantly, we must remember that cultural differences matter and that all cultures are to be valued.

Special Feature

Develop Your Psychological First Aid Skills at the PFA Online Learning Center

Contributed by Melissa J. Brymer, Ph.D., Psy.D.,¹
and Gilbert Reyes, Ph.D.²

Immediately following Hurricane Katrina, the National Child Traumatic Stress Network (NCTSN) and the National Center for Posttraumatic Stress Disorder (NCPTSD) released the Psychological First Aid (PFA) Field Operations Guide, which was developed with funding from SAMHSA. This field operations guide was the result of a multi-year, collaborative effort among the two national organizations. The goal was to define and organize what is known about PFA and to create a systematic intervention protocol supported by empirical evidence and linked to best practices. PFA is an acute, post-disaster intervention designed to reduce survivors' initial distress and foster short- and long-term adaptive functioning and coping. It includes eight core actions: Contact and Engagement, Safety and Comfort, Stabilization, Information Gathering, Practical Assistance, Connection with Social Supports, Information



on Coping, and Linkage with Collaborative Services. The PFA Field Operations Guide has been adapted for religious professionals, members of the Medical Reserve Corps, school personnel, and staff of nursing homes and homeless youth and family shelters. It has been translated into numerous languages, including Spanish, Italian, Mandarin, Simplified Chinese, and Japanese.

Since the development of the field guide, hundreds of organizations and thousands of

providers have participated in standardized, field-tested, face-to-face workshops led by skilled and experienced PFA trainers. Despite the development of a PFA train-the-trainer program, the demand for PFA education has steadily increased, while various logistical and cost factors have limited access to highly qualified trainers. To address the widespread unmet demand for PFA education, the NCTSN developed an online educational program called PFA Online, which provides a high-quality interactive learning experience at no financial

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The PFA Online Course emphasizes eight core actions to help responders deliver the care appropriate to the stage of disaster.

cost to the consumer. Dr. Jo Sornborger served as the Project Director for this project, and Dr. Melissa Brymer served as the Project Co-Director. The project included a team of diverse experts that reviewed the content at each phase of development, along with an external review team. Funding was provided by SAMHSA, NCPTSD, the National Association of County and City Health Officials, and the U. S. Surgeon General's Office of the Civilian Volunteer Medical Reserve Corps.

PFA Online is a 6-hour interactive course that puts the participant in the role of a provider at a post-disaster scene. The course includes examples of working with survivors of all ages and highlights the need to adapt PFA for different cultures, settings, and emergency situations. PFA Online has five learning modules:

Module 1 introduces learners to the course and the navigation features, including a glossary of terms, a list of additional resources, and a text version of the narration.

Module 2 provides a basic introduction to PFA, including the five early intervention principles of PFA, the eight core actions, and general guidelines for providers delivering PFA.

Module 3 provides an in-depth description of each of the eight core actions of PFA and is set in a shelter after a tornado caused destruction and loss of life to a community.

Module 4 focuses on provider care and highlights some of the challenges of conducting acute disaster work; factors that providers need to consider before, during, and after deployment; and the role organizations need to play in supporting staff and volunteers.

Module 5 summarizes the key points made throughout the course.

Two professional narrators guide learners through the course modules, which feature innovative activities, video demonstrations, and mentor tips from a mix of trauma survivors and nationally recognized experts in this field. For example, learners are asked to consider what they would say to a man whose wife died and who is struggling with how to talk with his children. Learners must select one of two choices; neither answer is wrong, but one is better. Once a learner selects an option, he or she receives feedback. Learners then continue with this conversation tree exercise for several more slides. Two

mentors, one a provider and the other a bereaved mother, highlight key principles to keep in mind when working with grieving individuals and families. Using innovative e-learning activities, the course incorporates various knowledge checks throughout the learning experience. For example, to facilitate learners' abilities to gather information, they are introduced to the Survivor's Needs Form, and they listen to a conversation between a provider and a survivor. Learners then fill out the form based on what they heard. The conversation is in segments so that learners can get feedback throughout. In the provider care module, learners must develop a list of issues they would consider before deploying for a train accident. The learner types his or her list on a clipboard and then compares it to a comprehensive list.

PFA Online is designed to meet the learning needs of individuals with varying experience—from those who are new to disaster response and want to learn the basic framework, goals, and techniques of PFA, to more seasoned practitioners seeking to maintain and enhance their expertise. Individuals who complete the course and the post-test receive a certificate of completion and may also opt to receive six hours of continuing education credit. Learners must understand, however, that this online course is no substitution for the practice and field exper-

ience that are needed to become proficient in providing PFA. The learning certificate does not constitute certification of proficiency.

Since PFA Online launched two months ago, over 1,000 participants from around the nation and the world have enrolled in the course. Of the 700 participants who have filled out the participant survey, 77% are female, 53% report having a bachelor's degree or less education, and 50% reported never responding to a disaster previously. When asked their primary reason for taking the course, 29% cited being part of a volunteer organization, 40% answered that it was for their employer, and 42% were interested for their own benefit. The participants reported a variety of professions, including mental health professional, health professional, first responder, government employee, educator, student, and volunteer. Surprisingly, 59% of users reported that they, themselves, are disaster survivors. About half of these individuals have completed the course, with over 98% of participants stating that they would recommend the course to others. The overall feedback has been positive and indicates that participants have found the material engaging, practical, and useful for their work. There were no differences between behavioral health and other professionals concerning how helpful or satisfied they were with the course.

PFA Online also offers a Learning Community, where participants can share their experiences with using PFA in the field, receive guidance during times of disaster response, and obtain additional resources and training. For example, the Learning Community offered a Webinar this past month entitled "Assisting Children and Families Affected by the Oil Spill." Webinars greatly enhance the delivery of PFA by adding a social dimension, allowing interactive consultation and problem solving, and creating a more dynamic learning environment. The Learning Community should prove particularly helpful in soliciting input and feedback to ensure that PFA is provided in a culturally sensitive manner that is accessible, acceptable, and helpful across communities and precipitating events.

Experience PFA Online for Yourself

- Step 1:** Create an account at <http://learn.nctsn.org>.
- Step 2:** Check your email and confirm your account by clicking on the link.
- Step 3:** Return to <http://learn.nctsn.org> and enroll in Psychological First Aid Online.

Our Cultural Experience Working in American Samoa

Contributed by Patricia J. Watson, Ph.D.,¹ Melissa J. Brymer, Ph.D., Psy.D.,² and Robin H. Gurwitch, Ph.D.³

On September 29, 2009, an 8.1-magnitude earthquake caused a deadly tsunami that struck parts of American Samoa. To address the behavioral health needs of those most affected, American Samoa developed and implemented a Crisis Counseling Assistance and Training Program (CCP) called A'Apa Atu. To assist in addressing the training needs for the program, CCP staff asked the National Center for Child Traumatic Stress (NCCTS) to provide training in the *Skills for Psychological Recovery* (SPR) and *Healing after Trauma Skills* (HATS) interventions. SPR and HATS are designed to help survivors learn and use the following skills: problem solving, positive activity scheduling, reaction management, helpful thinking, and rebuilding of healthy social connections. SPR uses a modular approach to help children, adults, and families

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FEMA Federal Coordinating Officer Kenneth R. Tingman offers words of comfort to tsunami survivor Rose of Sharon, who lost a loved one and her harbor-side home to the disaster on September 29, 2009. Photo courtesy of Richard O'Reilly/FEMA.

on an individual level, while HATS is designed for use in classrooms or other group settings with children. The HATS exercises reinforce and complement the SPR modules.

This was the first time these interventions were used in American Samoa, so we needed to ensure that the interventions were culturally appropriate. Our NCCTS team reviewed and adapted each of the intervention strategies. Initially, we consulted with the CCP directors

and mental health providers who had worked previously in American Samoa. We also received insights from members of the Peko family, who had recently returned to the U.S. from a post-disaster visit to American Samoa (Domata Peko is from American Samoa and plays football for the Cincinnati Bengals). From the discussions, we learned first that people in this community generally do not label emotions or use psychological concepts to describe their distress.

continued

Thus, training had to review the use of such terms in detail. Group discussions were held to better understand how adults and children express distress or concerns.

Second, Samoans are extremely respectful and will often express agreement with those they identify as elders or experts, even if they do not agree with what is being said. To overcome this barrier, the trainers often asked the counselors to repeat back what was said in the training to make sure they had a good grasp of what was being taught. We frequently asked, “How does this fit into your culture?” “What words would you use with survivors to introduce these concepts?” “How does your culture view this?” We also found that the counselors felt more confident in expressing disagreement with how to deliver a specific intervention strategy if they could do so using their wonderful senses of humor. Finally, trainers conducted regular phone consultations with the trainees throughout the program so that the trainers could continue to help counselors identify ways to better provide interventions in different villages and with different populations on the island. For example, to implement the positive activities scheduling skill, we had to adjust expectations and include on the list of activities those that were doable and practical for communities closer to town or those that were more practical for remote communities with fewer options, depending upon the community.

We also had to address how to conduct the SPR interventions in family settings, as families are extremely important in this culture. In most villages, extended family members all live on the same plot of land, so it was important to help the counselors (1) teach skills with larger groups and (2) find opportunities to work one-on-one with individuals when needed. We also made sure that the children’s activities included images that Samoan children would be familiar with and materials that were easy to procure. For example, illustrations in the HATS intervention (e.g.,

pearls, first responder hats, and native animals and flowers) were created specifically for use with American Samoan children, and materials for projects were generously donated by *The Domata Peko Foundation: Giving Kids a Brighter Future*.

A critical step in meeting the ethnocultural needs of the program was allowing the counselors to take each of the trainers out in the field, in essence allowing the counselors to be teachers. During these field trips, the counselors introduced trainers to situations in which they wanted more assistance and traditions they wanted trainers to



American Red Cross/AmeriCorps volunteer Nichole Hill reads to Eline in Tula, American Samoa. Photo courtesy of Talia Frenkel/American Red Cross.

continued

better understand. For example, two trainers were taken to the home of a mother whose child died in the tsunami. This experience allowed for a fuller discussion of how grief is expressed in American Samoan culture and how managing reactions could help the family adjust to loss and cope with the trauma reminders that it was still experiencing. Another trainer was introduced to a high chief to show the importance of getting permission to carry out the program from leaders of the many villages. These visits also highlighted the tremendous importance of weaving faith and religion into response work. These ideals were further underscored each morning, as the day began with hymns sung in beautiful harmony and followed by a heartfelt prayer.

We joined the A'Apa Atu program as consultants, but in the end, we gained a family. We felt that the counselors had already given us a gift by demonstrating the true value of faith, family, and community. However, in keeping with their tradition of providing gifts to visitors, we attended a farewell at which we received tangible gifts. After the group sang a traditional hymn, some of the women danced and others played music; we were asked to stand in the front of the room. One by one, each counselor presented us with a gift that he or she had personally selected to thank us for our help. This was a very moving and humbling experience, one we will treasure forever.

RESEARCH FROM THE FIELD

Compassion Fatigue and Satisfaction: An Overview of the Research and Practice Literature

Charles R. Figley, Ph.D.,¹ Joseph A. Boscarino, Ph.D., M.P.H.,² and Richard E. Adams, Ph.D.³

Introduction

Traumatic stress originates from both primary and secondary sources (Figley, 1995). Our growing understanding of one leads to an understanding of the other. Helping others is an important source of satisfaction, but what if the effort to understand and help patients becomes a burden itself? The purpose of this article is to provide a brief overview of what we know about secondary trauma—frequently called compassion fatigue or vicarious trauma.

Compassion Fatigue and Vicarious Trauma

Our work suggests that vicarious trauma and job burnout are separate concepts and that each of these syndromes is related to working with traumatized clients (Adams, Figley & Boscarino,

2008). Our recent conceptualization of vicarious trauma was developed from analytical models incorporating the broader conceptualization of compassion fatigue in the clinical literature (Figley, 1995).

With the inclusion of posttraumatic stress disorder in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (American Psychiatric Association, 1980), stress response symptoms related to psychological trauma were defined as a psychiatric disorder. Afterwards, the concept of “compassion fatigue” emerged when clinicians noted the occupational impact of mental health work with traumatized clients. In essence, some professionals appeared to experience the effects of their clients’ traumas “vicariously” (Figley, 1995). It was observed that vicarious trauma seemed to be a risk among those working with traumatized individuals if the mental health professional was exposed to significant numbers of these persons and had an empathic patient orientation (Figley, 1995, 2002a,

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2002b). Thus, when therapists report symptoms related to re-experiencing a client's traumatic event, wishing to avoid both the client and reminders of the client's trauma, and persistent arousal due to knowledge of the client's traumatic experiences, they may be suffering from vicarious trauma, a component of the broader concept of "compassion fatigue" (Figley, 1995, 2002b; Schauben & Frazier, 1995; Jenkins & Baird, 2002).

Compassion fatigue has been clinically defined as the formal caregiver's reduced capacity or interest in being empathic or "bearing the suffering of clients" and is the consequent behavior and emotional state resulting from knowing about a traumatizing event experienced or suffered by another person (Figley, 1995). Our work suggests that compassion fatigue is a hazard associated with many clinical settings and is composed of at least two components—vicarious trauma and job burnout (Adams, Figley & Boscarino, 2008; Boscarino, Figley & Adams, 2004; Adams, Boscarino & Figley, 2006).

In the behavioral sciences, the general psychological mechanisms for the patient-to-therapist transmission of this condition could be understood in terms of the same processes related to cognitive-behavioral conditioning in humans (Beck, 1995; Bandura, 1986; Mahoney, 1974). Others have suggested more complex mechanisms to explain this phenomenon, such

as counter-transference (Sabin-Farrell & Turpin, 2003), but we prefer a cognitive-behavioral framework because of its parsimony and direct therapeutic implications (Thorpe & Olson, 1997).

The current evidence also suggests that vicarious trauma and job burnout tend to overlap (Figley, 1995; Nelson-Gardell & Harris, 2003; Jenkins & Baird, 2002; Figley, 2002a, 2002b; Stamm, 2002). However, vicarious or secondary trauma is not the same as job burnout and each seems to have a unique effect on well-being (Jenkins & Baird, 2002; Sabin-Farrell & Turpin, 2003; Salston & Figley, 2003). Job burnout is often defined as a response to prolonged exposure to demanding interpersonal situations and is characterized by "emotional exhaustion, depersonalization, and reduced personal accomplishment" (Maslach, Schaufeli & Leiter, 2002).

High emotional involvement without adequate social support or feelings of personal work accomplishments (i.e., job satisfaction) may leave the healthcare professional vulnerable to job burnout, which was shown to be the case in our recent study (Adams, Figley & Boscarino, 2008). Elsewhere, we talk about the Stress-Process Model (Adams, Figley & Boscarino, 2008; Adams, Boscarino, and Figley, 2008) which suggests that challenging environmental stressors typically require individuals to respond both physiologically through alterations in the neuro-

endocrine and hormonal systems (Boscarino, 1997) and psychologically, usually through alterations in cognitive functioning (Adams, Boscarino & Figley, 2008).

Concluding Thoughts

Clearly, compassion fatigue resonates among professionals who work with trauma survivors and others who are suffering. Psychiatrists are drawn to work with those who have mental health problems because they value providing care to others, often above their own needs. The characteristics that bring people into the caring professions are, ironically, the very factors that make them vulnerable to vicarious trauma and job burnout. It is our responsibility to ensure that these adverse outcomes are minimized among those who have chosen such a career.

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RECOMMENDED RESOURCE

Emergency Communication 4 ALL: A Picture Communication Aid

Communication during disasters is critical for conducting life-saving response activities, increasing safety, and decreasing stress and anxiety. Increased stress from disasters can often make existing challenges to communication more difficult to overcome. Emergency responders and crisis counselors encounter a variety of people during a disaster and are likely

to encounter people with whom communication is difficult. These include the following people:

- > Those whose spoken language responders and counselors may not understand but who can still understand what is said to them
- > Those who have some difficulty understanding spoken communication

Emergency Communication 4 ALL Picture Communication Aid

FREE SPACE (for your custom message)

I can't speak but I can hear and understand you.

My technology needs to be charged.

My vital information is on the back on this page.

Please contact my family.

Ask me questions if you need to, but please wait patiently for my replies.

I will point to where I hurt.

0 1 2 3 4

5 6 7 8 9

A B C D E

F G H I J

K L M N O

P Q R S T

U V W X Y

Z ? . !! SPACE

MY NAME IS I, me, my Bleed Infect Allergy Disability Help Bathroom

WHO You, yours Broken Need/Want Blanket Disaster Home Walker

WHERE She, her, hers Burn Rescue Clothes Emergency Hospital Wheelchair

WHAT He, his, him Choke Spell Cold Family Sick Wind

WHEN They, them, their Communicate Talk Damage Fire Pets Worried

WHY We, ours Evacuate Understand Danger Flood Shelter Worse/Worst

HOW YES Hurt/Injure Wait Communication Device Heat/Hot Seizure NO

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Copyright © 2009 (www.disabilities.temple.edu/aacvocabulary/e4all.shtml) Developed by Diane N. Bryen & Rachel Ravitch through a grant from the National Institute on Disability and Rehabilitation Research #H133E033018.

The Emergency Communication 4 All: Picture Communication Aid helps those with communication challenges communicate more effectively with disaster response workers and crisis counselors.

continued

- > Those who do not understand or speak English well
- > Those with hearing difficulties

The communication aid Emergency Communication 4 All can be used with these survivors to increase each survivor's understanding of what responders and crisis counselors are trying to communicate and to ease responders' and counselors' task of communicating their messages. This tool can be carried by both service providers and persons with disabilities. The communication aid includes a personal information sheet with which survivors can keep track of emergency information,

including contacts, medications, allergies, and equipment and support needed for independence.

The communication aid was developed by Diane N. Bryen and Rachel Ravitch through a grant from the National Institute on Disability and Rehabilitation Research. The aid is currently available at the Web site of the Institute on Disabilities at Temple University: <http://www.temple.edu/instituteondisabilities/>

Emergency Communication 4 ALL: A Picture Communication Aid is available in PDF format at <http://disabilities.temple.edu/aacvocabulary/e4all/EprepPictureAid.pdf>. It is also available in Spanish and Haitian-Creole, downloadable at <http://www.temple.edu/instituteondisabilities/aacvocabulary/e4all.shtml>.

CALL FOR INFORMATION

The Dialogue is an arena for professionals in the disaster behavioral health field to share information, resources, trends, solutions to problems, and accomplishments. Readers are invited to contribute profiles of successful programs, book reviews, highlights of State and regional trainings, and other news items. If you are interested in submitting information, please contact SAMHSA DTAC at DTAC@samhsa.hhs.gov.

PERSONAL INFORMATION		6. PRESCRIPTION MEDICATIONS	13. EQUIPMENT/SUPPORT NEEDED FOR INDEPENDENCE
1. NAME _____	DOB _____	Name & Dosage _____	Personal Assistance Services Name _____ Phone _____ Allotted Hours _____ Mobility/Transferring _____ _____ Communication _____ _____ Hygiene/Toileting /Vision _____ _____ Telephone Use _____ _____ Finances/Writing _____ _____ Cooking _____ _____ Eating and Diet _____ _____ Transportation _____ _____ Service Animals _____ _____
Address _____	Cell Phone _____	Name & Dosage _____	
Home Phone _____	Email _____	Name & Dosage _____	
2. EMERGENCY CONTACT	Name _____	Name & Dosage _____	
Address _____	Address _____	7. OVER THE COUNTER DRUGS	
Cell Phone _____	Home Phone _____	1) _____	
Home Phone _____	Relation _____	2) _____	
Relation _____	3. 2ND EMERGENCY CONTACT	8. PHARMACY NAME _____	
Name _____	Name _____	Contact Person _____	
Address _____	Address _____	Phone _____	
Cell Phone _____	Cell Phone _____	9. ALLERGIES [complete list] _____	
Home Phone _____	Home Phone _____	10. RELEVANT MEDICAL HISTORY [brief] _____	
Relation _____	Relation _____	_____	
4. DOCTOR	Name _____	11. SUPPORT AGENCY [if applicable] _____	
Name _____	Address _____	_____	
Address _____	Phone _____	12. MEDICAL EQUIPMENT/TECHNOLOGY SUPPLIER	
5. HEALTH INSURANCE	<input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____	_____	
Policy Number _____	Date Issued _____	_____	

Emergency Communication 4 ALL



The back side of the Emergency Communication 4 All: Picture Communication Aid provides a form for people to list their personal information and other critical information, such as prescription medications.

Upcoming Meetings

2010 American Association for the Treatment of Opioid Dependence Conference

October 23–27, 2010; Chicago, IL

The theme of this conference is “Building Partnerships: Advancing Treatment & Recovery.” It will focus on promoting the opportunities afforded by partnering and collaborating with other entities to address the special needs of the medication-assisted treatment system.

<http://www.aatod.org/2010chicago.html>

International Association of Emergency Managers (IAEM) 58th Annual Conference & EMEX 2010

October 29–November 4, 2010; San Antonio, TX

The purpose of the conference is to provide a forum to discuss current trends in emergency management and public health, information about the latest tools in homeland security, and the latest advancements in IAEM committee work.

<http://www.iaem.com/events/annual/intro.htm>

International Society for Traumatic Stress Studies (ISTSS) 26th Annual Meeting

November 4–6, 2010; Montréal, Québec, Canada

The meeting’s theme is “Translation, Collaboration and Mutual Learning.” The meeting is an opportunity to get updated on recent traumatic stress research and learn about new clinical insight and innovations.

<http://www.istss.org//AM/Template.cfm?Section=Home1>

American Public Health Association (APHA) 138th Annual Meeting & Exposition

November 6–10, 2010; Denver, CO

This exposition will cover best practices in public health, products, and services, and it will provide a forum for attendees to share public health experiences with their peers in emergency and disaster issues.

<http://www.apha.org/meetings/>

Compassion Fatigue/Vicarious Trauma Training

November 9–10, 2010; Albuquerque, NM

The training will focus on compassion fatigue, vicarious trauma, and posttraumatic stress disorder.

<https://www.seiservices.com/OVCTTAC2010/11CompassionFatigue.asp>

23rd Annual Emergency Preparedness Conference

November 23–25, 2010; Vancouver, British Columbia, Canada

This conference provides an opportunity for emergency health services, social services, search and rescue workers, and emergency planning workers to present their accomplishments and collaborate on future ideas on emergency preparedness initiatives.

<http://www.jibc.ca/epconference/index.htm>

Webinars and Trainings

Integrating All-Hazards Preparedness with Public Health

This Webinar by the National Association of County & City Health Officials features four demonstration sites that integrate all-hazards preparedness into traditional public health activities. It has been archived at <http://webcasts.naccho.org/session-archived.php?id=684>

Planning for Pandemic Influenza: Issues and Best Practices

This Webinar by the National Association of County & City Health Officials features discussions on local challenges relating to vaccine distribution, isolation and quarantine, risk communication, hospital and personnel surge capacity, and community engagement. It has been archived at <http://webcasts.naccho.org/session-archived.php?id=505>

State of All Hazards Preparedness for Children: Partnerships & Models for Merging Emergency Department & Disaster Preparedness Efforts Nationwide

This Webcast by the Maternal and Child Health Bureau features resources and tools for pediatric disaster planning, lessons learned from the H1N1

pandemic, and perspectives from national stakeholders and partners in planning. This Webinar has been archived at <http://www.mchcom.com/liveWebcastDetail.asp?leid=414>

The National Child Traumatic Stress Network (NCTSN) Psychological First Aid (PFA) Online Course

This online training center is geared toward professionals and families seeking to learn more about child traumatic stress. Many resources specifically focus on disaster-related trauma and grief.



The NCTSN Learning Center also features the PFA 6-hour interactive course that puts the participant in the role of a provider in a post-disaster scene. This professionally narrated course is for individuals who are new to disaster response and want to learn the core goals of PFA, as well as for seasoned practitioners who want a review. It features innovative activities, video demonstrations, and mentor tips from trauma experts and survivors. PFA Online also offers a Learning Community in which participants can share experiences using PFA in the field, receive guidance during times of disaster, and obtain additional resources and training. <http://learn.nctsn.org/>

ABOUT SAMHSA DTAC *Established by SAMHSA, DTAC supports SAMHSA's efforts to prepare States, Territories, and local communities to deliver an effective mental health and substance abuse (behavioral health) response to disaster. SAMHSA DTAC provides disaster behavioral health preparedness and response consultation; develops resource collections addressing disaster behavioral health planning, special populations, and emergent topics; and supports collaborations between Federal entities, States, local communities, and nongovernmental organizations. To learn more about SAMHSA DTAC, please call 1-800-308-3515, e-mail DTAC@samhsa.hhs.gov, or visit the DTAC Web site: <http://mentalhealth.samhsa.gov/dtac/>*