Chapter 15
Medical Family Therapy in Disaster Preparedness and Trauma-Response Teams

Tai Mendenhall, Jonathan Bundt, and Cigdem Yumbul

Attention to mental health in disaster preparedness and trauma-response teams has increased considerably over the last decade. From the formal development and expansion of stand-alone teams and those positioned within existing care structures to the integration of Psychological First Aid (PFA) as part of standard education and preparation for first responders (e.g., police officers, firefighters), behavioral health clinicians (e.g., psychology, social work), and biomedical providers (e.g., emergency medicine, family medicine), it is clear that what once was a subspecialty advanced by a small collection of practitioners has now evolved to a mainstream standing within the broader arenas of the helping professions.

Family therapists (generally) and medical family therapists (specifically) represent a comparatively new discipline to join this larger movement. They bring an orientation comfortable with the complexities of overlapping human and relationship systems and thereby add value to the nature in which fieldwork is conducted and the manners in which interdisciplinary teams function on the ground (Boss, 2006; Mendenhall & Berge, 2010). As disaster response teams evolve to most effectively engage the communities they serve, integrated groups that include a wide variety of professionals are becoming more standard. To set the stage for our discussion of this as it relates to the practice of medical family therapy (MedFT) in disaster response, we begin by sharing the story of a young graduate student, Lisa. After first working as a behavioral health responder for several incidents, she was deployed as a team leader within days of a large-scale flooding.

T. Mendenhall (✉) · C. Yumbul
Department of Family Social Science, University of Minnesota, Saint Paul, MN, USA
e-mail: mend0009@umn.edu

J. Bundt
Masa Consulting, Minnetonka, MN, USA

Clinical Vignette

[Note: This vignette is a compilation of cases that represent a disaster response effort. All patients' names and/or identifying information have been changed to maintain confidentiality.]

Lisa first got involved in disaster response work as a graduate student when one of her professors encouraged her to take part in a University-sponsored workshop regarding PFA. Over the next 2 years of her doctoral program, she was deployed to one large event (tornado) and several smaller-scale crises (e.g., student suicide at a local school, neighborhood shooting). When she was called in this morning to help at a multiagency disaster recovery center (DRC) set up in a school gymnasium in response to flooding in a rural community several miles away, Lisa was designated by the site lead, Bill Jones, as the behavioral health team's lead. This role would include efforts in providing psychological support for surviving victims and responders, alongside coordinating the efforts of four other behavioral health volunteers.

"Finally. You're here," said Mr. Jones. He sounded huffy and rushed. "Name's Bill. I'm in charge of this DRC. Your counselor colleagues are already here. I've set you all up over there."

He pointed to a corner of a large room with a table that said "mental health" on an attached poster board. "We'll send folks over if and when they need you."

Earlier in her training, this would have frustrated Lisa more than it did nowadays. She had come to understand that DRC and incident command personnel were primarily focused on saving lives and property. Mental health was (is) important to them, but not the most important.

"Bill, my experience is that providing psychosocial support is better done if it's integrated throughout the whole center. I can coordinate folks to help with the lines and registration, and we can use the space over there for more intense conversations—with survivors and/or your other staff, if they need it," Lisa said.

"Whatever," Bill said. "Just be sure we can find you. We're opening up the doors in 20 minutes."

Lisa continued to reach out. "I have a couple more thoughts about preparing our staff who will work with the impacted community members and your other staff. We will be wearing purple vests; that way folks can see us easily." Bill responded affirmatively and then ran off.

Lisa directed two of the mental health volunteers to the registration lines at the front door and instructed the others to "float" as community members quickly filled the gym looking for answers about local resources and seeking information about when and how they could return to their homes. For the next several hours, she and her colleagues worked with other team members to direct, connect with, and support dozens of highly distressed people. They also encouraged staff members to take breaks and spend time with youth so that parents could have discussions with different agency providers, checked

in with people as they registered, and assessed if/when there was more that they could do to help. In some cases, Lisa and her other mental health volunteers helped with de-escalating especially angry and/or grieving people. At other times, they helped to refer people to local resources.

Many community members had lost their homes, cars, and prized personal possessions, their businesses, and even their very livelihoods. Some had lost pets, like the inconsolable teen who one of Lisa's volunteers had been sitting with on and off now for most of the afternoon. Some had witnessed dead bodies in the water when they had been airlifted by helicopters from houses' rooftops.

"I can't do this," a volunteer—who had been staffing an information station about insurance services—said. He walked past Lisa, tearing up his nametag and wiping away tears. "If I hear one more story about a family losing everything, I'm going to lose my mind." He was visibly shaken and looked exhausted.

"I don't care about filling out your stupid forms!" someone raised their voice from the registration area. "I just need answers! Look at all these pictures! Look what happened to my home! I thought you said that you would be able to help us with money to fix these things!" The child in her arms was crying now.

"Lisa! Do something!" Bill seethed, coming up behind her.

This case is illustrative of how a medical family therapist may function on a disaster response team. Instead of sitting on the sidelines (literally) and attending only to extremely upset survivors or volunteers who need behavioral health interventions, care is purposively integrated into all facets of a response. This can look like "crowd control" vis-à-vis long lines of anxious people, helping to connect community members to other professionals and/or information sources aligning with specific needs, or offering a compassionate presence to those for whom no comforting words will "fix" the losses or trauma that they have sustained. It also includes attention to our own and other team members' functioning, driving indicated attention to ethical mandates that we maintain our own physical and emotional well-being. Lisa's immersion within the complex processes of a disaster response is illustrative of this.

In this chapter, we further describe disaster response teams and fieldwork as a care setting type. We characterize common makeup(s) of our interdisciplinary teams and outline key knowledge and skill areas for MedFTs within these teams. We describe the practice of MedFT in disaster response in accord with Hodgson, Lamson, Mendenhall, and Tyndall's (2014) five-level continuum. We present common terminology, reflection questions, recommended readings, and resources in the conclusion.

What Is Disaster Response?

The principal aims of a disaster response include the preservation of life and property and restoration of normal services to the affected population. Secondary (but as Lisa knew in the above vignette, a close second) to this mission is to support the morale and psychosocial health of the said population. Elements of disaster response are varied and personalized to the needs of a specific group or event; these include the provision of healthcare services, food and water, temporary shelter, indicated transport, reunification of family members, information regarding community resources, and connections to short- and long-term services and support.

Within this work, it is essential to integrate providers of care from diverse areas of expertise to address biopsychosocial-spiritual (BPSS) needs of survivors, their families, and communities (Engel, 1977, 1980; Mendenhall & Berge, 2010, Walsh, 2007; Wright, Watson & Bell, 1996). At such times, multiple local, national, and international agencies, personnel, policies, facilities, and jurisdictions desire to be involved in responding to trauma. However, emergency response operations need to be performed by a flexible yet well-defined structure within an organization in which people from diverse disciplines can work collaboratively. The National Incident Management System (NIMS) is a systemic and proactive management process that integrates all levels of government to work together in managing any size of disaster event (Department of Homeland Security [DHS], 2016a). The NIMS program was established in 2004 and continues to be a foundational response structure that all levels of government are required to utilize (DHS, 2016b) in times of human-caused and natural disasters.

It is important to note, too, that "disasters" can encompass foci that are both diverse and far-reaching. Responders involved in this work can face any variety of localized, small-scale incidents (that only impact a limited number of persons and families) to large-scale events (that can impact tens of thousands of—or even more—people). Events can be human-caused (e.g., school shootings, terrorist attacks, structural collapses) or natural in their geneses (e.g., pandemics, hurricanes, tsunamis, tornados, floods). They can occur across rural, suburban, and urban contexts. They can impact groups representing any ethnicity and/or socioeconomic stratum. Because teams engaged in disaster response must be equipped to handle whatever occurs within the areas that they serve, baseline training and preparation that they advance are "general" in nature; the content presented in this chapter echoes this frame. MedFTs focused on specific types of disaster response (only) are encouraged to pursue specialized training that is so oriented (for more information, see International Critical Stress Incident Stress Foundation [ICISF], 2016).

Teams in Disaster Response

Teams within disaster response are comprised of a broad range of disciplinary backgrounds and training. There is a common slogan in disaster response: "It's better to exchange business cards during training than in a real disaster." This motto pertains

to the critical importance of understanding and knowing personally the different responders that come forward to respond to a disaster. Each team's leader holds primary responsibilities to (a) maintain flow of information to the team about the rapidly changing events in the field, (b) make successful decisions in facilitating team activities, and (c) help the team plan and work efficiently toward aiding individuals, families, and communities within their scope of expertise. Team members (responders), who work under the team leader, help to carry out the team's goals and functions. The following highlight key professionals who are involved in delivering disaster response services on the ground.

Incident command. The Incident Command System (ICS) is a widely used standard management system that incorporates procedures of selecting and assigning funds, personnel, facilities, and equipment at the time of the incident (Bigley & Roberts, 2001; DHS, 2016c). ICS—which can be advanced by local, state, federal, or military organizations—is the "first-on-scene" system to organize the structure of care and support in a disaster area (Buck, Trainor & Aguirre, 2006). As a hierarchical model, ICS identifies a clear chain of command, assigns emergency management team leaders and responders, and clearly defines the responsibility and role of each team member when participating in a response (PHS Commissioned Officers Foundation, 2010). Incident command is responsible for building the following major functions: (a) command (to appoint team leaders and members), (b) information/planning (to keep all team members informed and communicating), (c) needs assessment (to identify short- and long-term needs for the affected population), (d) operations (to develop objectives to carry out plans related to care and resource provision and response), (e) logistics (to receive, store, and distribute resources like food, water, shelter, clothing, etc.), and (f) finance/administration (to track financial activities related to funding/purchasing/securing necessary resources and/or services) (Bigley & Roberts, 2001; DHS, 2016c).

Emergency management. Understanding the discipline of emergency management can best be understood through the emergency management cycle, which includes mitigation, preparedness, response, and recovery (DHS, 2016d). Initial efforts in mitigation and preparation relate to preventing disaster and crisis events from happening altogether or to minimizing the scope or intensity of events when they occur. For example, to mitigate flooding, protective barriers may be built or people's homes may be relocated away from high-risk areas. Emergency managers may also oversee the placement and functioning of notification sirens, emergency broadcast messages, and/or planned locations for DRCs if/when they are needed. Their scope in these preparedness efforts can range from an individual city to a county, a state, or even the nation as a whole—and they thereby coordinate and support other government and public safety personnel as needed. Efforts during response phases of a disaster include those designed to limit any further loss of life, personal injury, and/or damage to property. These may include the coordination of search-and-rescue teams, mass vaccinations and/or evacuations, food and water distribution, and/or emergency shelters. Efforts in the recovery phases of a disaster response (which can sometimes take months or years to complete) include early

attention to things like neighborhood cleanup, restoration of power and water facilities, and/or the construction of temporary housing or schools. Longer-term work in recovery overlaps with newfound mitigation and preparedness efforts and includes things like the relocation of personal and public buildings (and to construct these in ways that are resistant to earthquakes, flooding, or fire), restoring local economies and businesses, etc. (Baird, 2010; DHS, 2016d; Rubin, 2012).

Healthcare providers. Any disaster carries with it the potential for people to be physically injured or killed; nearby hospitals and clinics are consequently treated as secondary sites for the provision of emergency/critical care (Reily & Markenson, 2010; U.S. Fire Administration, 2016). Core providers and staff include emergency physicians, physician assistants and physician extenders, medical residents, nurses, medical assistants, pharmacists, trauma surgeons, emergency medical technicians, emergency room technicians, radiologists, radiological technicians, police and other security personnel, chaplains, social workers, behavioral health providers, emergency medicine clerks, health unit coordinators, and scribes (see chapter "Medical Family Therapy in Emergency Medicine" in this text for a detailed description of these teams and team members). Such sites can range from small community clinics to large metropolitan hospitals—and any of these can become quickly overwhelmed with the surge of patients (and/or loved ones who are looking for said patients). Many hospitals carry formal accreditations that require them to be prepared to respond to disasters dealing with these types of influxes of people—patients and loved ones alike—to their facilities (Agency for Healthcare Research and Quality, 2011; Joint Commission on the Accreditation of Healthcare Organizations, 2016). Oftentimes, however, the human elements of these influxes are not well rehearsed and can thereby punctuate gaps in training, resources, and protocols. These experiences, when assessed and evaluated, can assist in future preparedness exercises.

Public health. Public health personnel in disaster response tend to be positioned within emergency management roles (see description above). These professionals take on the responsibility of preventing, protecting against, and quickly responding to and assisting with recovery efforts from multiple types of large-scale emergencies—from infectious diseases; foodborne illnesses; chemical radiological accidents or intentional events; natural disasters like hurricanes, tornadoes, or pandemics; and even acts of human violence (Centers for Disease Control and Prevention [CDC], 2016). All public health jurisdictions are responsible for preparedness in these types of events; they are thereby an important discipline to coordinate with in relation to disaster response efforts (U.S. Department of Health and Human Services, 2016).

Volunteer agencies. A common and encouraging element of many communities' response to disastrous events centers on the strong and commonplace human desire to help each other. Churches, schools, local aid organizations, and even individual people will often arrive at disaster sites, recovery centers, healthcare facilities, and other locations to offer assistance. However, not all volunteers are created alike. While most are well intentioned, many impromptu volunteers can actually be disruptive to the efforts of a formal response. In disaster preparedness work, Incident

Command and DRC Systems are set up to work with agencies that have extensive experience with disaster response training—like those formally recognized by nationwide networks such as Voluntary Organizations Active in Disaster (VOAD, 2016). Groups mobilized by the American Red Cross, The Salvation Army, and the International Critical Incident Stress Foundation are some of the most consistently active of these organizations. Other organizations—many of which are faith-based—focus on providing cleanup of debris, dissemination of food and clothing, and a wide range of human service support systems (e.g., case management).

Community representatives. Local community members and representatives are often utilized to provide basic information and physical/behavioral healthcare services within a disaster response (Federal Emergency Management Administration, 2011; Lichterman, 2000). These team members are generally trained through aforementioned VOAD agencies beforehand; others who receive just-in-time (JIT) training are integrated into targeted facets of a formal response as necessary. Some may serve as cultural translators (e.g., when working with refugee or other minority populations). Community representatives can include schoolteachers, village resources (e.g., the village headman), spiritual leaders, elders, governmental and nongovernmental organizations (NGOs), volunteers and survivor camp workers, and media workers (TV, radio, newspaper).

Chaplains. Chaplains are important to differentiate from clergy (Association of Professional Chaplains, 2016; Joyner, 2016). A member of a clergy maintains a specific faith-based ideology and practice (e.g., Catholic, Lutheran). His or her orientation is to work within that faith-based system. Secondary to the vulnerability that people tend to have in the midst of a disaster event and recovery, it is considered unethical for members of a clergy to impress their faith-based system onto individuals who have not identified themselves as followers of that specific religion. Conversely, a chaplain brings a nondenominational (read: spiritual) perspective; his/her goal is to meet individuals where they are. Chaplains do not bring forward any particular religion's perspective unless the individual(s) they are supporting ask for this. Chaplains who have experience and training with public safety or hospital care are preferred during disaster events (National Disaster Interfaiths Network, 2007; North American Mission Board, 2016). Their skill sets offer a wide range of personal and spiritual resources for individuals and families who are coping with traumatic events, ambiguities about the future, and losses of property and/or of loved ones through death.

Fundamentals of Disaster Response

MedFTs working in disaster response must be familiar with, and skilled in, a myriad of contents. Principal foci include the following.

Psychological First Aid

PFA is an evidence-informed approach that builds upon core concepts of human resilience (National Child Traumatic Stress Network, 2006; Ruzek et al., 2007). At its core is the recognition of signs and symptoms of stress, alongside providing a safe environment, facilitating a sense of calm, and empowering recipients toward healthy action. Many disaster response organizations have developed their own versions of PFA training, e.g., the Federal Emergency Management Agency (FEMA), National Child Traumatic Stress Network (NCTS), and International Critical Incident Stress Foundation (ICISF). These trainings range in time and intensity, from single introductory courses (e.g., half-day, online) to in-depth and extensive course collections and foci (FEMA, 2013; ICISF, 2016; NCTS, 2006).

Common elements in PFA include, but are not limited to, the following: (a) engaging distressed persons through composed safe self-introductions (e.g., assuring confidentiality) and attention to immediate needs (e.g., offering food or water); (b) providing safety and comfort (e.g., offering blankets for warmth, offering information about events/responses/resources); (c) stabilizing survivors who are emotionally overwhelmed (e.g., offering a compassionate presence and good listening skills, relaxation, and calming sequence); (d) gathering information regarding needs and concerns about separations from loved ones, worries about property, potential suicidality, etc.; (e) offering practical assistance (e.g., accessing childcare resources); (f) promoting social connections and other support systems (e.g., friends, faith communities); (g) psychoeducation about common stress reactions and coping sequences; and (h) linking people to collaborative services for follow-up and/or longer-term needs. PFA can be used when working with individuals, couples, and families (Fox et al., 2012; Pynoos & Nader, 1988; Vernberg et al., 2008). It can also inform the design of support centers, e.g., attending to the physical layout of DRC facilities and resource/information desks so that those needing services are effectively identified and promptly cared for (University of Minnesota Academic Health Center, 2017).

Team Coordination

As discussed earlier, a formal disaster response is embedded within a structured management system. Behavioral health providers within this system focus their principal energies on and across two teams. The first team is the team of behavioral responders, themselves. These teams tend to be comprised of multiple disciplines and are organized in a 2×2 "buddy system" fashion. These sub-teams of two professionals each are best advanced with purposeful attention to the diverse nature of their members, e.g., pairing a MedFT with a psychologist and pairing a social worker with a chaplain. Doing this equips each team with a rich interdisciplinary mixture of wisdom and expertise (Mendenhall, 2006). Pairing the teams in groups of two (regardless of which disciplinary backgrounds are represented therein) is also purposeful because it enables team members to check in with each other,

process difficult stories, and encourage breaks and other self-care sequences (Mendenhall, 2006; Mendenhall & Berge, 2010).

The second team that MedFTs and other behavioral health providers function within is the larger, overarching team that is responding to the incident. Members within this frame include other care providers of all types (behavioral health and physical health), law enforcement, police officers, firefighters, public health officials, community leaders, and government officials. It is important to conduct one's self with persistent attention to the manner in which these multiple team members (and the respective constituents they represent) function. Doing this effectively is facilitated by a priori efforts to learn about and get to know each other (e.g., meeting with and/or shadowing members of local law enforcement, participating in local training and simulation exercises that include multiple response agencies), becoming conversant in common terms and phrases/acronyms employed by ICS and others (see Figure 15.1 and Glossary), and being flexible and responsive to lead agencies' efforts in managing personnel and related resources (Kaji, Langford, & Lewis, 2008; Larkin, 2010).

Figure 15.1 Common Abbreviations in Disaster Response

ACS	Alternate Care Site
ARC	American Red Cross
CBRNE	Chemical Biological Radiological Nuclear Explosive
CDC	Centers for Disaster Control and Prevention
CFLOP	Command Finance Logistics Operations and Planning
CIKR	Critical Infrastructure and Key Resources
COOP	Continuity of Operations
DA	Disaster Assistance
DBH	Disaster Behavioral Health
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DRC	Disaster Recovery Center
EEG	Exercise Evaluation Guide
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
HHS	Department of Health and Human Services
HICS	Hospital Incident Command System
HSEEP	Homeland Security Exercise and Evaluation Program
IC	Incident Commander
LTCR	Long-term Community Recovery
MRC	Medical Reserve Corps
NDMS	National Disaster Medical System
NICS	National Incident Management System
NTSB	National Transportation Safety Board
PFA	Psychological First Aid
PIO	Public Information Officer
PPE	Personal Protective Equipment
RDD	Radiological Dispersion Device
SOP	Standard Operating Procedure
SME	Subject Matter Expert
VOAD	Voluntary Organizations Active in Disasters
WMD	Weapons of Mass Destruction

Timing of Mental Health Services

Most individuals who are exposed to a disaster event will present with some degree of BPSS stress (e.g., insomnia, racing thoughts, interpersonal conflict, poor work performance, spiritual crisis). These responses are both common and expected, and it is thereby important to normalize them in the contexts of providing early support. Research has shown that the majority of those impacted by a disaster will experience a reduction and/or dissipation of symptoms over the next few weeks and that more than two thirds of surviving victims do not manifest long-term psychological disorders (e.g., PTSD) that would indicate formal mental health treatment (American Red Cross, 2016; Butler, Panzer, & Goldfrank, 2003).

During the early stages of a disaster response, then, PFA interventions are most indicated. On some (usually rare) occasions, providers may need to advance care that prioritizes personal safety above all else (e.g., when a person is suicidal). For individuals who have pre-existing mental health challenges (e.g., major depression, anxiety) or significant life stressors leading up to an event (e.g., unemployment, marital distress), MedFTs are well equipped to assess for such concerns and provide care in a manner that simultaneously honors immediate needs for stability and longer-term needs for psychological healing, adaptation, and growth. Once the initial phases of response have concluded (i.e., as an immediate disaster response moves into a recovery phase), the most common interventions that survivors benefit from include group and/or responder support (formal or informal). Aforementioned long-term interventions—e.g., those that either target stressor build-ups now overwhelmed by trauma or those that promote adaptation to lasting effects of trauma per se—are described in more detail below. These efforts are most indicated for individuals who are still presenting with problematic symptomology 1–2 months after a disaster event (Foa, Stein, & McFarlane, 2006; North & Pfefferbaum, 2013).

Working with the Media

In the current age of social media, the desire to communicate information in a timely and accurate manner can be complicated. Initial information during disasters may, indeed, be timely—but oftentimes it is not very accurate. Developing the capability and capacity to respond through social media is important for any organization. Part of this preparedness activity includes establishing relationships with reputable media outlets (Mangeri, 2015). Oftentimes this responsibility rests in the hands of an organization's public information officer (PIO). The PIO is responsible for the interaction between the general public and the media. He or she reports to the incident commander to assure that the information that is being communicated to the general public is accurate (Hughes & Palen, 2012). A MedFT's role in all of this—unless serving in the formal capacity of a PIO—is to purposefully not engage with the media and to encourage and support colleagues and community members to do

the same. And while the MedFT may be asked to help craft messages that a PIO delivers (e.g., for content that speaks to human resilience), he or she—not the university, care site, or professional organization that the MedFT is primarily affiliated with—should be formally identified.

Compassionate Presence

One of the greatest needs that individuals have during times of crisis is knowing that there are people who are trying to assist them—even if and when there are not clear ways to solve the struggles that they face. Many trainees and young professionals worry about what to say when working with those who are hurting, but oftentimes the best way to respond is to not say anything (at least not verbally). A core element of PFA is providing this compassionate presence; providers work to meet people where they are (not where they believe they "should" be). Aligning with the adages that God gave us two ears and a mouth for a reason and that the word "listen" and "silent" contain the exact same letters, there are times in disaster response that the most helpful thing to offer a surviving victim is one's undivided attention. Listening—indeed, being wholly present (without waiting to jump in and say something "helpful" or "supportive")—is sometimes difficult for providers who are trained to ask questions, assess for diagnoses, and/or advance interventions to "help" (Engel, Zarconi, Pethtel, & Missimi, 2008; Gehart & McCollum, 2007; Puchalski, 2001). But just as "common factors" in baseline clinical work go further than any one particular clinical approach, so too does compassionately walking alongside (not leading) someone who is figuring out his/her own path (Lambert & Barley, 2001; Morse, Bottorff, Anderson, O'Brien, & Solberg, 2006).

Active Listening Skills

In conjunction with compassionate presence, the effective conduct of behavioral health support in disaster response includes skill sets in active listening. While the execution of specific skills in active listening varies in accord with the personal attributes, cultures, and contexts in which the work is carried out, common nonverbal sequences include eye contact, pleasant or smiling facial expressions, concerned or empathic facial expressions, and posturing one's body to lean forward. Common verbal sequences include asking questions for further information or clarification, recalling details (e.g., bringing them back up in conversation) within the context of loved ones and/or others with whom survivors have safe and ongoing relationships, and paraphrasing or summarizing what speakers have said so as to demonstrate comprehension (Fassaert, van Dulmen, Schellevis, & Bensing, 2007; Levitt, 2002; Roberston, 2005).

Suicide Ideation Assessment

While relatively uncommon, suicidality is nevertheless a real danger encountered by MedFTs engaged in disaster response. Any team deployed in this work must maintain a general skill set in doing suicide screenings and have at least one team member qualified to make these types of formal assessments (for a list of recommended assessment tools, see Additional Resources section at the conclusion of this chapter). An effective assessment targets verbal ques that are direct (e.g., "I want to kill myself.") and indirect (e.g., "My life isn't worth living anymore."). It includes attention to a person's psychological functioning (e.g., feeling overwhelmed or hopeless) and behaviors (e.g., giving away prized possessions, marked withdrawal from family or friends). Providers ask questions directly about whether a person is thinking about hurting or killing himself/herself and if he or she has a plan and/or means to carry out this intent. If and when the provider determines that a person is at risk, then he or she must work to ensure the person's safety. Indicated methods for doing this vary in accord with each situation and include interventions that range from less intense (e.g., no-harm contract) to more intense (e.g., hospitalization) (Berman, Jobes, & Silverman, 2006; Simon & Hales, 2012). Having referral resources within the team or at a healthcare facility to conduct assessments and follow through with, especially, more intense responses is essential within a disaster response.

Sensitivity to Diversity

Communities display diverse responses in the face of trauma and death. Assessment of risks, vulnerabilities, resources, and capacities of a trauma-impacted population is substantial in developing and implementing effective PFA models for these populations (Buckle, Marsh, & Smale, 2003). Studies have long demonstrated the need to focus on transnational and ethno-cultural issues while responding to mental health of mass trauma-affected populations (Green, 1996). Disasters can have severe consequences, especially on communities of ethnic minorities and developing countries, such as populations affected by Hurricane Katrina or the East-Asian tsunami of 2004 (Masella & Christopher, 2004). In the face of disasters, trauma response and recovery should incorporate cultural and ecological factors associated with resilience and resources of individuals, families, and communities. This standpoint has challenged individualized, Western, medical approaches to trauma recovery, which often lack consideration for contextual elements (Summerfield, 2004). And indeed, some people from different cultural backgrounds may react poorly to Western intervention models (Shah, 2007). Incorporating indigenous healing methods and values into Western evidence-based models, for example, may facilitate a more rapid and drastic change in individuals and families exposed to trauma (Brave Heart, Chase, Elkins, & Altschul, 2011; Mock, 2004; Mollica, 1988). This does not mean that Western models should not be used in non-Western populations; with

appropriate cultural adaptations and by paying careful attention to local cultures' authentic ways of reacting to and coping with trauma, these models can be effectively adapted for communities affected by disasters (Hoshmand, 2007).

Disaster Response Across the MedFT Healthcare Continuum

Medical family therapy is an important field in the integration of behavioral health, disaster preparedness, and trauma-response team efforts. Specific training, practice, research, and policy competencies represent important facets of this work as professionals engage in this often chaotic and unpredictable work. Tables 15.1 and 15.2 highlight specific skills that characterize MedFTs' involvement in trauma-response contexts across Hodgson et al.'s (2014) MedFT Healthcare Continuum. As we move along the continuum, we carry greater expectations regarding roles, knowledge, and overall contributions to care.

At the beginning of the continuum, MedFTs at *Levels 1* and *2* should possess general understanding(s) of BPSS approaches to working with highly distressed persons (individuals, couples, families). They are familiar with normative stress reactions to acute situations versus longer-term sequences (e.g., posttraumatic stress disorder) and are familiar with PFA as a basic intervention. They do not likely engage with trauma teams regularly, but maintain a basic understanding of their structure when volunteering in this kind of effort. While clinical knowledge and skills in balancing active listening and compassionate presence are arguably manifest within any competent clinician, maintaining this balance is more difficult for practitioners situated within the fast-paced and potentially high-intensity contexts of a disaster response. MedFTs are adept in maintaining such balance when they need to (e.g., during times that they are deployed). As they perform in-the-field assessments for suicidality and homicidality, they are knowledgeable about and highly capable of coordinating the services of other providers and institutional resources if and when indicated. Lisa and her supervisees (in our vignette above), for example, would need to be vigilant about doing such assessments for survivors of the flood. Adults who had lost their homes and livelihoods—or the teen who had lost his beloved pet—could very well experience such emotional and/or behavioral instability during acute phases of a disaster recovery.

A clinician equipped with knowledge and skills outlined in *Level 3* is able to collaborate with and/or function within a trauma-response team without considerable orientation and/or just-in-time preparation. He or she is thereby readily able to integrate family therapy interventions with PFA principles in the conduct of care. For example, Lisa could work to promote baseline safety (a PFA goal) through facilitating discussions and collaboratively problem-solving with a couple who had recently lost their home to secure temporary housing. MedFTs at this level are also familiar with multiple constituents (e.g., incident command, volunteer organizations, community leaders) and their respective roles, missions, and work foci; equipped with this fluency and a comfort for working with groups of people (versus

Table 15.1 MedFTs in Disaster Preparedness and Trauma-response Teams: Basic Knowledge and Skills

MedFT Healthcare Continuum Level	Level 1	Level 2	Level 3
Knowledge	Basic knowledge about BPSS approaches to working with highly distressed individuals, couples, and families; sensitive to how acute stress responses, mood, and behaviors are mutually influential. Familiar with Psychological First Aid as a baseline trauma intervention. Limited understanding of trauma-team structure(s).	Can differentiate between types of trauma reactions (e.g., normative stress responses to acute situations, PTSD). Familiar with benefits of couple and family engagement in acute fieldwork processes and follow-up recovery (accomplished on survivors' own and/or with clinical support). Basic knowledge about trauma-team structures (e.g., incident command, buddy systems).	Working knowledge of specific team members (e.g., incident commander, public information officer, first responder, chaplain) and terms in trauma response (e.g., family reunification center, PFA, JIT, ICS, NIMS). Basic knowledge of team coordination (e.g., behavioral response teams, law enforcement, community leaders) and timing of mental health services within a response (psychoeducation, PFA, long-term interventions). Familiar with the family therapy interventions as applied to trauma contexts and informed by BPSS and systems training.
Skills	Can discuss (and psychoeducate) basic relationships between biological, psychological, and behavioral foci vis-à-vis acute stress. Can effectively balance active listening and compassionate presence with highly distressed individuals, couples, and families. Minimal collaborative skills with other providers; generally works in an individual practitioner model, but occasionally volunteers in trauma-response teams.	Able to apply systemic PFA interventions in practice; assess survivors for potential suicidality/ homicidality. Adequate collaborative skills; works with trauma-team personnel with some regularity; can coordinate referrals and follow-up with indicated specialists if longer-term care is indicated.	Coordinate and integrate respective team members' expertise and counsel into immediate response sequences and follow-up planning. Able to conduct family therapy interventions in a manner that effectively integrates key elements of PFA; advances these efforts in a manner sensitive to short- versus long-term treatment goals and sequences. Can effectively work with the media (if designated to do so) or encourage and support PIO colleagues who do.

one on one), they are able to coordinate and integrate behavioral health providers into the moving parts of a coordinated response without undue disruption. Within a leadership role (as with Lisa in our vignette), this MedFT competently organizes and directs (and redirects) behavioral health providers' efforts in synchrony with the changing needs and evolution of larger response efforts.

A MedFT functioning at *Level 4* maintains high skill and knowledge in the range of human reactions to stress (acute and long-term) and can readily bridge his/her efforts in fieldwork to follow-up care provided for individuals, couples, and families for whom this is necessary. Being capable with core content and terms essential to trauma therapies enables him/her to effectively translate and track respective team members' efforts over the course of a referral (when this is possible)—and it is at this level that such efforts are most likely to occur within the

Table 15.2 MedFTs in Disaster Preparedness and Trauma-response Teams: Advanced Knowledge and Skills

MedFT Healthcare Continuum Level	Level 4	Level 5
Knowledge	Adept understanding of acute trauma reactions (e.g., normative responses, triggered responses vis-à-vis high-risk psychosocial histories) and related clinical behaviors and presentations.	Understand treatment and care sequences for unique and/or challenging topics in trauma response (e.g., suicidality, intimate partner violence, alcohol and/or drug abuse); can consult effectively with diverse healthcare professionals.
	Conversant in a range of trauma-focused treatments and terminologies.	Conversant with evidence-based treatments regarding most follow-up trauma-related therapies; has background to provide psychoeducation to patients about a variety of symptoms, medications, and stress management leading up to indicated referrals.
	Conversant in nearly all terms, measures, and facets of disaster preparedness and behavioral health response.	
	Basic knowledge of emergency management phases and the manners in which behavioral health is (or can be) effectively integrated into them.	High content knowledge in clinical topics, research practice, policy, and administrative areas of disaster response; proficient in developing a curriculum on PFA, behavioral health roles, and other supportive sequences to provide other professionals involved in all phases of emergency management response cycle(s).
		Experienced and well informed regarding common symptoms of (and ways to mitigate) compassion fatigue.

(continued)

Table 15.2 (continued)

MedFT Healthcare Continuum Level	Level 4	Level 5
Skills	Able to deliver seminars and workshops about the BPSS complexities of disaster preparedness and trauma-response work to a variety of professional types (e.g., mental health, biomedical).	Proficient in nearly all aspects of trauma-response efforts; able to synthesize and conduct research; engages in collaborative efforts to organize and advance team preparedness.
	Can apply several BPSS interventions in trauma response (e.g., greeter and reunification roles, assisting medical examiners with death notifications) and follow-up care.	Routinely engages in team-based approaches to trauma-response work, with consistent communication through patient introductions, curbside-consultations, and team debriefing meetings and visits.
	Consistently collaborates with key team members (e.g., incident commander, public health, volunteer agencies, primary care provider, chaplain); coordinates behavioral providers within larger team of multiple providers engaged in a response.	Proficiently integrates research-informed practices (across multiple system levels) with trainees, alongside vigilant attention to compassion fatigue assessment (and, when necessary, intervention and support).
		Proficiently coordinates, directs, and leads disaster response teams within larger ICS deployments.
		Engaged in advocacy efforts to integrate behavioral health foci into mitigation, preparation, and response phases of emergency management.

arenas of trauma response. If or as a MedFT's work overlaps with the provision of such longer-term care (albeit not with persons originally encountered during field-work), he or she would evidence working familiarity and competence with multiple treatment modalities—e.g., cognitive behavioral therapy (CBT) and eye movement desensitization and reprocessing—performed in family-based contexts. For example, a clinician's work with individuals and families over the weeks and months following a traumatic event (e.g., the flood that Lisa and her team initially responded to) could be toward repairing attachment injuries that were acutely brought forth or exacerbated. Alongside this, MedFTs at this level will work purposefully to build relationships with other members of an integrated behavioral healthcare team (e.g., primary care provider, social worker) so that they are ready and able to either serve in immediate response efforts (like Lisa) or as a resource for those who need assistance later on.

MedFTs who function at *Level 5* generally have practiced at all levels of care and work in various roles within a trauma-response team (e.g., behavioral health team

member, team lead, team coordinator). As a baseline clinician, proficiency in acute interventions and BPSS approaches includes competence and knowledge regarding other providers' contributions (e.g., healthcare, food assistance). This is evidenced in active and effective participation in—and leading of—team-based collaboration, which by default extends beyond the acute incident's time frame. As an educator and mentor, the MedFT is proficient in the didactic and supervisory instruction of these skill sets and knowledge—evidenced across live classroom and fieldwork sequences and professional development workshops and/or in the construction of instructional materials (e.g., refereed journal articles, texts, conference workshops). Further, professionals at this level tend to be involved in research (e.g., testing and/or comparing interdisciplinary team-based methodologies, evaluating care efficiency across different team-based models), policymaking (e.g., advocacy for the integration of behavioral health foci into all phases of emergency management), and other administrative duties (e.g., overseeing behavioral health internships that include training for and experience in disaster preparedness and trauma-response team work).

Level 5 clinical efforts following the vignette provided in this chapter could engage MedFT trainees in how to coordinate the presence of behavioral health providers throughout the geography of a response (e.g., from check-in lines to behind-the-scenes break rooms for staff), alongside how to deliver PFA to a range of surviving victims (e.g., from the angry person wanting insurance information to the despondent teenager whose pet died). As a supervisor, the MedFT is likely to also see and attend to symptoms of compassion fatigue or burnout for any team member or trainee under his or her watch and to—when needed—support said team member or trainee in steps toward self-care, recovery, and healing. As a researcher, a MedFT could seek in-depth understandings about survivors' and responders' experiences in the acute phases of a response (e.g., a qualitative case study targeting what community members found most helpful in stabilizing their psychosocial disruptions, a quantitative study tracking first responders' depressive and anxiety symptoms over the course of the deployment vis-à-vis their engagement—or not—in supportive sequences of team debriefing and related self-care). As an educator, the MedFT could use survivors' or responders' stories (either with their permission or in a manner appropriately disguised and potentially even with their coauthorship) as case examples in training manuals and/or professional presentations. As an advocate, he or she could present patients' and families' stories in preventative and/or reparative efforts as examples to persuade and/or guide indicated policy and administrative sequences that facilitate the purposeful integration of behavioral health foci in larger emergency management efforts.

Research-Informed Practices

In this section, we briefly review what is known about preventing posttraumatic symptoms and treating early symptoms of posttraumatic stress and other potential sequelae of traumatic events. We highlight ecologically oriented approaches (or the

lack thereof) within the immediate and acute phases of post-incident care. Attention to PTSD-related measures in our review reflects the major focus of literature in the area of trauma, and this is not meant to give the impression that PTSD is necessarily the primary or sole focus of PFA.

Litz (2008) defines "immediate" interventions as those occurring within 48 hours of the potentially traumatic event(s) and "acute" as taking place a few weeks later. Following the acute phase, treatment of chronic symptomology is the focus of most formal interventions. For the purposes of this account, then, we focus this review on immediate and acute time frames.

Immediate Interventions

At the present time, there is no empirical support for any behavioral health intervention that is advanced during the first few hours after a traumatic event (e.g., as a way to prevent PTSD) and only some support for cognitive behavioral interventions in the hours and days that follow (Agorastos, Marmar, & Otte, 2011; Fox et al., 2012; Watson, 2015). It is also important to note that research regarding immediate interventions has largely focused on psychological debriefing and multicomponent interventions, such as critical incident stress management (CISM) (Everly, Flannery, & Eyler, 2002; Everly, Flannery, & Mitchell, 2000; Peltier & Peltier, 2016). Most of these efforts have been conducted with individuals (not couples or families) across 1:1 or group therapy formats. And while MedFT in disaster response should build on the current knowledge that is available, we must endeavor to advance methods and understandings that are sensitive to the BPSS complexities of the patients and families we treat. The following is a summary of what we know so far.

Psychological Debriefing

A great deal of research attention to lessening negative effects post disaster—often measured by preventing PTSD—has been given to a group of interventions known as psychological debriefing (PD). The mostly widely known form of PD is critical incident stress debriefing (CISD) (Campfield & Hills, 2001; Fantini-Hauwel, Dovi, & Antoine, 2015). PD is generally understood as a single individual or group (not couple/family) session occurring soon after a traumatic event in which the event is collectively recounted and debriefed. This is an area surrounded by considerable controversy (Rabstejnek, 2014; Robinson, 2007; Wagner, 2005) and thus warrants attention here.

A number of randomized control trials (RCTs) have yielded mixed results regarding the effectiveness of PD (e.g., Adler et al., 2008; Rose, Brewin, Andrews, & Kirk, 1999; Sijbrandij, Olff, Reitsma, Carlier, & Gersons, 2006). Some studies have found no significant effects of PD over no-treatment control groups (e.g., Bisson, McFarlane, Rose, Ruzek, & Watson, 2009). Others have advanced support for the approach (e.g., Adler, Bliese, McGurk, Hoge, & Castro, 2009; Campfield & Hills, 2001), while others still have found that PD as a stand-alone intervention may actu-

ally increase posttraumatic symptomology (Bisson, Jenkins, Alexander, & Bannister, 1997; Deahl et al., 2000; Mayou, Ehlers, & Hobbs, 2000; Sijbrandij et al., 2006).

To make sense of these conflicting findings, researchers have argued that many studies evaluating PD have used the intervention incorrectly. Hawker, Durkin, & Hawker (2011), for example, maintain that PD is intended for groups of people who have ongoing relationships with each other (e.g., family, friends, co-workers) and that studies that have found harmful effects with individuals (especially those that treated strangers together) should thereby not be generalized. Robinson (2008) adds to this discussion in claiming that CISD is not meant to be a stand-alone or individual intervention, anyway. Instead, it should be integrated as a component to other, more complex, approaches.

Multicomponent and Multisession Interventions

One common multicomponent intervention is critical incident stress management (CISM), which utilizes PD as one of its facets. In a similar manner to PD literature described above, researchers have found mixed and contradictory findings (e.g., Everly et al., 2002; Roberts, Kitchiner, Kenardy, & Bisson, 2010; Wei et al., 2010). For example, Everly et al. (2002) conducted a statistical review of CISM and concluded that it is effective at reducing psychological distress (Cohen's $d = 3.11$, $p < 0.0001$). It is important to note, however, that the studies they reviewed included a variety of outcome measures and were not all immediate interventions or identified as being RCTs.

In a Cochrane Review of multisession interventions (which did not include CISM) for preventing PTSD, Roberts et al. (2010) concluded that—at the time of the review—there was (is) "little evidence to support the use of psychological interventions for routine use following traumatic events and that some multiple session interventions, like single session interventions, may have an adverse effect on some individuals" (p. 12). They further recommend that researchers continue to evaluate areas that show promise with caution because of the evidence that some interventions appear to be harmful at times. The studies included in this review represented a range of interventions (e.g., adapted PD, group counseling, integrated CBT and family counseling, and individual counseling).

No studies of such multicomponent/multisession interventions to date have purposefully evaluated BPSS outcomes; future research should investigate the effects of relational interventions (advanced in the immediate aftermath of disasters) on such health factors so as to better inform MedFT practice and related clinical methods.

Acute Interventions

MedFT can readily integrate with efforts to address negative effects of traumatic events during acute phases of treatment. The interventions with the most support during these phases are forms of cognitive behavioral therapy (CBT). Other interventions, such as eye movement desensitization and reprocessing (EMDR) and

school-based interventions, are also being used—but empirical support for these is less developed.

Cognitive Behavioral Therapy

CBT is used in various forms for treating acute stress disorder (ASD) and for preventing chronic PTSD. These studies have generally been carried out with people who have ASD or PTSD symptoms weeks or months after a traumatic event and have generally yielded positive results. In a thorough review of the literature in this area, Litz and Bryant (2009) conclude that early CBT "should be employed routinely as an early intervention for survivors of relatively discrete accidents who endorse significant, enduring posttraumatic difficulties" (p. 128). Because of the resources involved with administering most forms of CBT, it is recommended that CBT only be used once time has elapsed so that those who continue to experience posttraumatic symptomology can be identified and receive treatment. While the use of CBT to prevent chronic PTSD following non-interpersonal accidents has strong support (Bryant, Harvey, Dang, Sackville, & Basten, 1998; Ehlers et al., 2003; Litz and Bryant, 2009), the support for CBT for PTSD resulting from interpersonal traumatic events is less definitive—with both positive results (e.g., Bryant, Moulds, & Nixon, 2006) and neutral results (e.g., Foa, Zoellner, & Feeny, 2006).

Eye Movement Desensitization and Reprocessing

EMDR is an integrative therapy method that employs a number of standard protocols that reflect several unique treatment approaches. It targets past memories of trauma, present disturbances and struggles, and future/planned actions and behaviors. The goal of this therapy is equip patients with the emotions, insights/understandings, and perspectives/life approaches that they need to lead to healthy and satisfying lives (for more information, see EMDR International Association, 2017). A number of protocols for the early application of EMDR have emerged (e.g., Shapiro, 2009; Shapiro & Laub, 2008). Early support for EMDR in the relief of posttraumatic symptoms during acute phases of care (and in the prevention of future symptoms) is promising—whether the intervention occurs weeks after the event (Jarero, Artigas, & Luber, 2011; Silver, Rogers, Knipe, & Colelli, 2005) or months after the event (Grainger, Levin, Allen-Byrd, Doctor, & Lee, 1997). More comprehensive research is needed in this area, however, especially as it relates to couple and family therapy interventions and physical health outcomes.

Family and/or Ecologically Oriented Interventions

Most researched interventions during the acute stages of trauma work have focused on individual therapies. While some focus on the community is seen in the literature, little attention has been paid to the effects of trauma on the family. The importance of understanding the relationship between trauma and the family has been

addressed (Gewirtz, Forgatch, & Wieling, 2008); however, this has not yet significantly translated into clinical models for or application to disaster relief. Early calls to address this gap in knowledge are only beginning to be answered. For example, Salloum and Overstreet (2012) found trauma narration with children combined with coping skills training to be more effective than unimodal approaches. Boyd-Franklin and Bry (2012) have shown how family therapy interventions can extend and overlap into school and community foci. As with other approaches, more comprehensive research is needed regarding couple and family therapy interventions—especially— and their respective impact(s) on BPSS outcomes.

Interventions for Chronic Symptoms

There is strong empirical support for many interventions that address trauma-related symptoms and disorders for chronic symptoms; the majority—as already described—are individual treatments for PTSD (Cohen, Mannarino, & Deblinger, 2016; Haagen, Smid, Knipscheer, & Kleber, 2015; Najavits & Hein, 2013; Niles et al., 2012). MedFT strategies can draw on the knowledge gained from these interventions, alongside recognizing that we must maintain vigilance in identifying those potentially in need of long-term treatment, make appropriate referrals when/ as necessary, and/or honor patients' BPSS systemic complexities in care. In this section we briefly review systems-oriented interventions for addressing chronic trauma-related symptoms and grief and loss. These treatments are recognized across couple/family therapy, psychoeducation, and school-based interventions.

Couple/Family Therapy Approaches

A few small studies have introduced the use of conjoint treatments for couples to address PTSD, such as cognitive behavioral conjoint therapy (Monson et al., 2011) and structured approach therapy (Sautter, Armelie, Glynn, & Wielt, 2011). Other interventions have directly targeted the family or partner of someone affected by trauma, such as support and family education (Sherman, 2003). Trauma interventions with the most strong theoretical bases that focus on both couples and families, such as emotion-focused therapy (EFT; Johnson, 2012; Johnson, 2002), are demonstrating especially promising results (Agnus, 2012; Ehlers et al., 2014). Specifically, EFT is an approach to therapy that purposefully integrates the science on adult attachment and bonding to couple's functioning in their relationships. Clinicians work with patients and partners to (a) expand and reorganize key emotional responses to attachment- and other trauma-related foci, (b) promote changes in partners' respective interaction patterns, and (c) build secure relational bonds. Figley and Figley (2009) articulate further support for such systemic thinking in the treatment of trauma, too; they maintain that collaborative meaning-making processes in couples and families are a primary component of healing from trauma upon which all other growth evolves.

Psychoeducation Approaches

While psychoeducation can arguably be a part of any intervention type, some evidence exists for its utility as a stand-alone approach with couples, families, and groups in addressing trauma. A lifestyle management course described by Devilly (2002), for example, showed improvement in measures of anxiety, stress, depression, and PTSD. The *Linking Human Systems* approach has been used with a wide range of populations, including those affected by trauma, and highlights the importance of family and community connections (Landau, Mittal, & Wieling, 2008) in healing from traumatic events. For a thorough review, Makin-Byrd et al. (2011) have described these and other couple and family interventions and guidelines in depth.

School-Based Interventions

While many may not be familiar with the notion that family therapists and MedFTs are well equipped to function within school environments, emerging evidence supports this (Alexander, Waldron, Robbins, & Neeb, 2013; Kennedy, 2008; Laundy, 2015). Treatment of PTSD for youth in these environments is becoming increasingly recognized and supported. In a review of school-based interventions and protocols, for example, Kataoka et al. (2012) highlighted *Multimodality Trauma Treatment* (Amaya-Jackson et al., 2003), the University of California's *Trauma Grief Component Treatment Program* (Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001), and *Cognitive-Behavioral Intervention for Trauma in Schools* (Stein et al., 2003) as effective evidence-based approaches. Rolfsnes and Idsoe (2011) conducted a meta-analysis of school-based interventions for PTSD; they concluded that those employing CBT strategies had the most support (with others demonstrating promising results as well).

Conclusion

Disaster preparedness and trauma-response teams represent an increasingly visible and important presence across local, state, federal, and international agencies. MedFTs—equipped with behavioral and relational skills in working with individuals, couples, and families (alongside BPSS understandings of trauma per se)—are well equipped to engage in this work. Emerging evidence supports their systems-informed contributions, and—as behavioral health foci are progressively more valued in response and recovery efforts—MedFTs' participation across multiple and overlapping foci in disaster preparedness and response will continue to grow.

Reflection Questions

1. As a MedFT who is already busy with clinical, teaching, and/or research commitments, how can you effectively plan so that you are ready and able to deploy on a disaster response team?
2. Efforts in self-care and compassion fatigue prevention are especially important for providers engaged in disaster relief efforts. What are some strategies and methods that would be especially important and/or helpful for you to do so as to best maintain your own BPSS health?
3. How would you most appropriately respond to a request to do an interview with a local news station after returning from a deployment? How about a request from your boss, department head, major professor, or colleague to do a presentation in your academic department or clinical site?

Glossary of Important Terms in Disaster Response

After action report (AAR) A retrospective analysis regarding a simulated or actual disaster response sequence. Key content generally includes a summary and overview of the response, major strengths and successes of the effort, key weaknesses and lessons learned, and recommendations for improvement.

Family Assistance Center (FAC) A site set up to provide resources and support for families affected by a disaster. Principal goals include facilitating effective communication about evolving events, exchanging information with appropriate personnel to assist in identifying missing or deceased loved ones, providing death notifications (and discussions with medical examiners regarding the release of human remains), providing private spaces for families to grieve, protection from media and/or curiosity seekers, and offering medical, psychological, and/or logistical support.

Just-in-time training (JIT) A collection of online or app-based resources designed to train (or refresh knowledge of) responders rapidly. These resources are generally employed immediately after a disaster has occurred, during which time responders are preparing for—or awaiting directions relevant to—deployment.

Nongovernmental organization (NGO) A nonprofit organization involved in a disaster response that is independent from state, federal, or international governance. NGOs are usually funded by donations and run by volunteers.

Point of contact (POC) Identified supervisor to whom a person involved in a disaster response reports with relevant updates, field reports, troubleshooting, and questions. The POC directs personnel under his or her watch regarding indicated tasks, duties, and responsibilities.

Tabletop exercise (TTX) During trainings and/or simulations, TTXs involve key and indicated personnel discussing how to best respond to hypothetical scenarios. These sequences facilitate understanding regarding the viability and adequacy of plans and procedures vis-à-vis extant resources. They also serve to establish and promote collaborative relationships and agreements between agency leads that can be utilized during an actual incident.

Additional Resources

Literature

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Measures/Instruments

Columbia-Suicide Severity Rating Scale (C-SSRS). http://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf

Life Events Checklist (LEC). http://www.integration.samhsa.gov/clinical-practice/life-event-checklist-lec.pdf

Professional Quality of Life Measure (Version 5). http://www.proqol.org/uploads/ProQOL5_English.pdf

Suicide Assessment Five-step Evaluation and Triage (SAFE-T). http://www.integration.samhsa.gov/images/res/SAFE_T.pdf

Trauma-informed Care in Behavioral Health Service. http://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.pdf

UCLA Child/Adolescent PTSD Reaction Index for DSM-5. https://www.ptsd.va.gov/professional/assessment/child/ucla_child_reaction_dsm-5.asp

Organizations/Associations

American Red Cross. http://www.redcross.org/
Department of Homeland Security. https://www.dhs.gov/
Federal Emergency Management Administration. www.fema.gov
Green Cross Academy of Traumatology. http://greencross.org/
International Committee of the Red Cross. https://www.icrc.org/
International Critical Incident Stress Foundation. https://www.icisf.org/
National Child Traumatic Stress Network. http://www.nctsn.org/
National Incident Management System. http://www.fema.gov/national-incident-management-system

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