

Geriatric Mental Health: Disaster Preparedness and Response Curriculum

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Geriatric Mental Health
and Emergency Preparedness Curriculum

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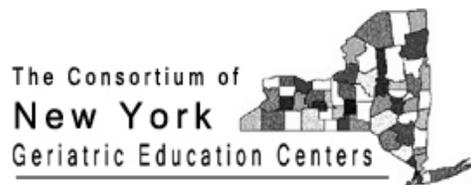
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Dedication

This project is dedicated to our colleague, Dr. Myrna Lewis, who passed away on November 15, 2005. Dr. Lewis contributed to the development of this curriculum and was a tireless advocate for the well-being of all, including older persons, who are affected by man made and natural disasters. Dr. Lewis spent many months volunteering her services after the World Trade Center disaster on September 11, 2001.

Dr. Lewis was a nationally recognized social worker, gerontologist, advocate and author, having edited several books, including *Aging and Mental Health: Positive Psychosocial Approaches* and *Late-life Depression: When and How to Intervene*. She was also a devoted wife, mother, and grandmother, friend and colleague to many. The editors deeply appreciate her substantial contributions to this curriculum on Geriatric Mental Health and Emergency Preparedness.

FORWARD

In 2003, six federally funded Geriatric Education Centers proposed a coordinated effort to develop a comprehensive curriculum on bio-terrorism and emergency preparedness (BTEPA) with the aim of disseminating this curriculum widely through the GEC network, Area Health Education Centers, Area Agencies on Aging, health professions schools, local public health agencies, and health and social service agencies serving older persons.

The need for education and training related to bioterrorism, emergency preparedness and aging has become an important issue for healthcare providers of older adults. The effects of disasters on older persons are far-ranging and may include acute injury or illness and an increase in morbidity and mortality due to exacerbation of already-existing chronic disability. Psychological effects which may occur include anxiety, isolation, insomnia, depression, grief, post-traumatic stress disorder syndrome, and suicide. Indirect effects of disasters include loss of home, access to transportation and emergency services, and services, such as home delivered meals and home care.

Those HRSA GECs funded in 2003 included California (Stanford GEC at Stanford School of Medicine; Kentucky, Ohio and Tennessee (Ohio Valley Appalachia Regional GEC at the University of Kentucky); Missouri (Gateway GEC of Missouri and Illinois at St. Louis University); New York (Consortium of New York GECs based at New York University); Texas (Texas Consortium of GEC's at Baylor College of Medicine in Houston); Ohio (Western Reserve GEC at Case Western University). Each GEC targeted those initiatives, products and outcomes that addressed the needs of their geographic areas, while adding valuable information and resources for inclusion in the national BTEPA curriculum.

The focus of the Consortium of New York Geriatric Education Centers (CNYGECs) HRSA grant is on geriatric mental health and disaster preparedness. Consortium partners are New York University College of Nursing, Columbia University, and Mount Sinai Medical Center/Bronx VA GRECC. A 13-member panel of experts representing nursing, social work, medicine, psychology and psychiatry, public health was convened in April 2004 to develop curricula materials. Faculty was drawn from New York University Division of Nursing, Columbia University Stroud Center and Center for Geriatrics and Gerontology and Mount Sinai School of Medicine/Bronx Veterans Affairs' Geriatric Research Education and Clinical Center (GRECC). After the consensus meeting, work groups developed curriculum modules which were reviewed by the core project group, with revision made as necessary. The curriculum has also been updated to reflect recent national experience with natural disasters, most notably Hurricanes Katrina and Rita in late August 2005.

It is our hope that this comprehensive curriculum will be an important resource in the years ahead in the development, implementation, dissemination and refinement of training programs in the area of disasters and geriatric mental health.

Teaching Guidelines:

Part 1- Introductory Session for Trainers

Overview

The burgeoning older population in the United States, particularly the rapid growth of those over the age of 85, calls for educational and training initiatives to prepare a health care workforce to serve this population. The 65 and older population has increased more rapidly than the rest of the population for nearly the entire 20th century. Specialized training of health care professionals and allied health care providers in mental health, and particularly mental health of older persons subjected to the effects of disasters, is necessary to meet the increasing mental health needs of this growing population.

The consequences of both international and natural disasters are far reaching with multiple ripples. For instance, a full six months after Hurricanes Katrina and Rita on US Gulf Coast, hospitals are still severely understaffed, meaning that many individuals are unable to receive medical and mental health services. Although most public health efforts have been focused on individual treatment and prevention, the social and political imperatives exist to develop educational programs and resources for health care professionals and paraprofessionals which promote healing of individuals and communities, incorporating community-based public information and training and utilizing individual-centered and community-centered educational methods.

This curriculum combines many key topics in the area of geriatric mental health with components of public health and disaster preparedness for a range of interdisciplinary health professionals. The purpose of the curriculum is to train students, faculty and health providers in mental health/illness and associated consequences of natural disasters and terrorist acts. The Introductory Training Session described here is designed to help trainers understand the need for the curriculum, to become acquainted with the format and content material, and to develop confidence in their ability to successfully implement the training plan.

Learning Objectives

At the conclusion of the Introductory Session, learners will:

Knowledge

- Articulate the rationale for this training
- Describe the importance of a structured curriculum in Geriatric Mental Health and Emergency Disaster Preparedness and Response
- Describe the overall goals and objectives of the training plan
- Assess their current knowledge of geriatric mental health and disaster preparedness and response through a pre-test

Attitudes

- Realize that older adults require special consideration—for both mental and physical health needs—during and after disasters
- Understand the importance of training health care professionals to integrate this material into their practice
- Appreciate the importance of the interdisciplinary team approach which is a key aspect of this curriculum

Skills

- Be able to implement the training plan
- Know how to use the available resource material to augment their knowledge before teaching this curriculum
- Be able to select and effectively employ interactive teaching methods appropriate for the level and type of learner they will be training.

Introductory Session for Trainers:

Time Required: 1 hour

Procedure:

1. **Distribute materials:** Distribute name tags, handout materials, booklets, etc.
2. **Welcome:** Give a welcoming statement, brief overview of the training day, and discuss logistics (e.g., breaks, lunch, phones, bathrooms, etc.). State that group participation is encouraged and that any and all questions are welcome. If small enough session, ask each participant to introduce himself/herself.
3. **Training context:** (30 minutes) Review the need for this training as indicated by events such as the New York World Trade Center disaster and more, recently, Hurricanes Katrina and Rita.
 - a. Story of 9/11/01 older people in Lower Manhattan
(Review *References*: Lewis and O'Brien)
 - i. Federal estimate was that about 6,300 people aged 65 and older were living in that area within a few blocks of Ground Zero, and as many as 18,000 older people in the affected areas below Canal Street, which is the location of the initial red zone barricade.
 - ii. Within 24 hours following the 9/11 terrorist attacks, animal advocates were on the scene rescuing pets, yet abandoned older and disabled people waited for up to seven days for an ad hoc medical team to rescue them.
 - iii. A significant group of frailer older people faced unique situations that compromised their ability to manage, and this was especially true for those living within that so-called frozen zone or red zone that surrounded the World Trade Center area.
 1. Communication breakdown: older people had enormous difficulty just finding out what was happening, and equal difficulty in calling their friends, their family, their health care providers.
 2. Isolation: The majority of older people lived alone or with an older spouse, a significant number of these, especially the emotionally and the mentally frail, remained hidden behind the doors of their apartments and houses. They were located only after relief workers and volunteers began going door to door checking on every resident during the second week after the WTC attacks.
 3. Access to services: separation from home health aides, homemakers and home-bound services like Meals on Wheels was universal at first. Older people who rely on

- prescriptions could not get in touch with a health care provider or a pharmacy to refill their medications.
4. Health issues:
 - a) Physical—breathing difficulties due to air pollution, increased incidence of heart attacks and strokes
 - b) Mental—emotionally traumatized by fear of not knowing what was happening
 5. Evacuation issues: A number of older people were evacuated because of suspected structural damage to their apartments or homes, or dangerous breakdowns in the utilities.
- iv. The results were that a number of older persons were found in deteriorated conditions with dwindling food, water, medical supplies.
1. Some required immediate medical care, emergency medical care.
 2. The Visiting Nurse Service reported incidents of heart attacks and strokes that appeared to be directly related to 9/11.
 3. Some older people were emotionally traumatized by fear of not knowing what was happening. They had no access to information, or what would happen to them in the next days and weeks. Those who suffered from prior anxiety and depression were especially vulnerable to the exacerbation of the psychiatric symptoms.
- b. Brief Narrative on Hurricanes Katrina and Rita and the profound local, regional and national impact on our society, especially for older people.
- i. Trauma and shock associated with natural disaster itself
 - Stress of Evacuation
 - Loss of loved ones, property, neighborhoods
 - Dislocation and disorientation
 - Physical and emotional suffering
 - ii. Post-disaster reactions of anxiety, fear, anger
 - iii. Inadequate government response & follow-up
 - Higher mortality rate in population
 - Nursing home deaths in New Orleans after Hurricane Katrina
 - Lack of preparation and ability to evacuate
 - Elder neglect after hurricanes
- 4. Training Goals and Objectives:** (10 minutes) Discuss the training goals and learning objectives (see Handout #1). Explain that each section of the training

will address specific objectives.

- 5. Training Plan and Techniques:** (10 minutes) Review the week's (or day's) training schedule (see Handout #2). Discuss the training techniques that will be used (e.g., short lecture, discussion, videos, small group exercises, role-plays, experiential exercises). Discuss the rationale and values underlying techniques (e.g., people learn best by doing, disaster work affects providers personally, so sharing and support is important, balance learning new content with developing new skills).

Resources

“Introduction” PowerPoint Presentation

Handout #1: Learning Objectives

Handout #2: Training Plan

References

Center for Mental Health Services. *Training Manual for Mental Health and Human Service Workers in Major Disasters*. Washington, D.C.: U.S. Department of Health and Human Services; Publication No. 90-538, 2000.

Lewis M. The frail and the hardy seniors of 9/11: The needs and contributions of older Americans. Presented at “The Public as an Asset, Not a Problem: A summit on leadership during bioterrorism”. Center for Civilian Biodefense Strategies, Johns Hopkins University; February 4, 2003. Online. Available at: <http://www.upmc-biosecurity.org/pages/events/peoplesrole/lewis/lewis.html>. Accessed 23 Feb 2004.

O’Brien N. Emergency Preparedness for Older People. International Longevity Center Issue Briefs. January-February 2003.

Handout #1

Teaching Guidelines: Part I Learning Objectives

At the conclusion of the Introductory Session, learners will:

Knowledge

- Articulate the rationale for this training
- Describe the importance of a structured curriculum in Geriatric Mental Health and Emergency Disaster Preparedness and Response
- Describe the overall goals and objectives of the training plan
- Assess their current knowledge of geriatric mental health and disaster preparedness and response through a pre-test

Attitudes

- Realize that older adults require special consideration—for both mental and physical health needs—during and after disasters
- Understand the importance of training health care professionals to integrate this material into their practice
- Appreciate the importance of the interdisciplinary team approach which is a key aspect of this curriculum

Skills

- Be able to implement the training plan
- Know how to use the available resource material to augment their knowledge before teaching this curriculum
- Be able to select and effectively employ interactive teaching methods appropriate for the level and type of learner they will be training.

Teaching Guidelines: Part 2
Learning Objectives

1. Description of Training Options
2. Learning Objectives of Geriatric Mental Health and Disaster Preparedness Curriculum
3. Incorporating the Principles of Adult Learning into Teaching
4. Interactive Teaching Methods
 - a. Case Analysis
 - b. Journal Articles
 - c. Videotapes
 - d. Videotaping with Immediate Feedback
 - e. Table Top Exercises
 - f. Interactive Rituals

Table 1: Geriatric Mental Health & Disaster Preparedness
2-Hour Overview Module

Table 2: Geriatric Mental Health & Disaster Preparedness
1 Day Elective

Table 3: Geriatric Mental Health and Disaster
Preparedness
5 Day Elective

Bibliography

Section I

Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- *Define and compare “disaster” vs. “emergency”*
- Describe types of disasters and the responses required for each
- Explain the disaster response system and the role of the health care provider in that system
- Identify typical reactions commonly observed during and after disasters
- Describe special considerations for older adults in disasters

Attitudes

- Express sensitivity to the special psychological and emotional needs and reactions of older people in an emergency
- Recognize obstacles to older people seeking and receiving mental health services in disasters

Skills

- Include discipline-appropriate immediate response for type of disaster
- Include coordinated service responses in initial assessment
- Incorporate coordinated service responses into plan of action
- Describe chain of command within agency in an emergency response
- Identify and describe the agency emergency response plan
- Apply creative problem solving to emergency situations
- List 4 emergency preparedness core competencies for public health workers

Section II
Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Acquire a greater understanding of what disaster work may entail, with a focus on frail older adults
- **Determine how prepared their own organization is and what remains to be done to put a program of disaster preparedness in place**
- Understand the timing and focus of interventions

Attitudes

- Examine personal attitudes and readiness to act in periods of possible confusion and even personal danger in order to help their older clientele
- Realize that recovery from disaster is ongoing, with treatment focused on “the possible” rather than an abstract ideal
- See problems as challenges rather than obstacles

Skills

- Acquire general skills appropriate to both the immediate and the ongoing effects of disasters
- Search for community disaster information and resources
- Develop specific skills around the importance of communication, rapid and appropriate response, assessment, and treatment interventions

Section III
Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Define terms used by practitioners in mental health and aging
- Distinguish between normal psychological changes of aging and mental illness
- Identify the continuum of long-term care for the elderly and the national, state and local network of aging
- Describe the cultural factors impacting on the well-being of older adults.
- Articulate spiritual dimensions of well-being in later life
- Delineate social factors contributing to well-being in late life
- Describe economic conditions impacting on older adults' well-being

Attitudes

- Describe individual and societal attitudes toward aging, older adults and mental health
- Differentiate between myths, stereotypes and realities of aging & mental health
- List three attitudes that the provider should be aware of in order to deliver culturally competent care

Skills

- Describe age specific risks to mental health of older adults
- Administer three geriatric mental health screening tools
- Demonstrate the incorporation of 3 cultural factors into an initial assessment
- Demonstrate the inclusion of 2 spiritual dimensions in an initial assessment
- Demonstrate the inclusion of 3 psychosocial factors in an initial assessment
- Demonstrate the inclusion of 2 economic or financial considerations into an initial assessment

Section IV

Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Identify the various types of normal vs. pathological reactions to disasters
- **Describe anticipated reaction to immediate threats, situational and long term effects.**
- Discuss normal grief responses as they apply to physical, cognitive, behavior, and social behavior
- Differentiate between symptoms of acute stress and post traumatic stress disorders and understand the variable course, presentation and functional impairment associated with each
- Appreciate the relationship between underlying psychopathology and the impact of disasters on relapse and exacerbation of symptoms.

Attitudes

- Recognize that mental disorders in the elderly are treatable and intervention may be life-saving
- Understand the concept of cumulative lifetime trauma in the context of disasters in such groups as combat veterans and Holocaust survivors
- Realize that unique affective, behavioral, cognitive and perceptual disturbances that present during disasters

Skills

- Recognize the clinical features of delirium, depression, dementia and anxiety disorders
- Diagnose the major mental disorders presenting in the elderly during and after a disaster
- **Incorporate understanding of normal vs. pathological reactions to disasters into assessment of older adults**

Section V

Learning Objectives

At the conclusion of this session, the learner will be able to:

Knowledge

- Discuss the fundamental theoretical principles of elder mistreatment in different physical and social environments
- Describe the potential impact of disasters on physical and social geriatric environments leading to the vulnerability of older adult
- Identify and discuss risk factors of possible occurrence of elder mistreatment, abuse and neglect during and after disasters

Attitudes

- Realize that older adults require special consideration as they are more vulnerable to physical and psychological mistreatment
- Recognize the older adults' needs as they varies depending on their emotional, cognitive, physical, interpersonal and spiritual states
- Understand the role of the health care worker in identifying elder mistreatment during a disaster
- List three attitudes that the healthcare first responder or worker has to identify in order to assess for elder mistreatment during an act of terror or disaster

Skills

- Perform assessments of relative risk of elder mistreatment and neglect or abuse employing a logical, systematic approach
- Apply knowledge about disaster related elder mistreatment (DREM) to develop prevention, intervention, amelioration and follow up strategies as

Section VI: Part 1
Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Discuss the concepts of successful aging, resilience, crisis, and human needs as they relate to older adults during a disaster.
- Describe the rationale for geriatric mental health screening and assessment.
- Discuss two interdisciplinary non-pharmacological approaches to mental health assessment.
- List one screening tool for cognitive impairment and one screening tool for depression in older adults.
- Delineate the immediate goals of stabilization of older emergency patients.
- Describe two common pre-existing medical problem in older adults.
- Describe why hospitalization can be a critical live event for the elderly.

Attitudes

- Understand the implications of successful aging, resilience, crisis, and human needs as they relate to older adults during a crisis.
- Appreciate the complex issues related to mental health conditions in the elderly and the need to screen for these conditions.
- Demonstrate awareness of the particularly vulnerable state of older people compared to younger people in an emergency situation.

Skills

- Apply knowledge of successful aging, resilience, crisis theory, and human needs in developing interventions which support older adults during a disaster.
- Conduct a screening for cognitive impairment and depression.

Section VI: Part 2

Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Understand the general principles of prescribing psychopharmacologic agents in the elderly, using low doses and observing for side effects
- Differentiate between the various classes of medication used for psychosis, depression and anxiety disorders
- Understand that psychotropic medications are potent agents and should only be prescribed when clinically indicated

Attitudes

- Psychotropic medications are potent and should be used cautiously in the elderly with mental disorders
- Alternative treatments should be considered including behavioral techniques, individual and group therapies
- Serious mental disorders including major depression, psychosis and disabling anxiety can be effectively treated with psychotropic medication

Skills

- Formulate a treatment plan which may include using a psychotropic medication if clinically indicated
- Determine the safest agent to use given the symptoms of the disorder and the medication side effect profile
- Monitor the patient carefully for potentially dangerous side effects including excessive sedation, confusion, and gait disturbance
- Determine when patients should be referred to a specialist for further evaluation and treatment of a major mental disorder

Section VII
Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Identify the signs and symptoms of secondary traumatization
- Describe the risk factors for secondary traumatization
- Discuss self-care areas for health care providers

Attitudes

- Acknowledge the reality of stress in the health care environment
- Understand how this stress can influence one's health and well-being, and compromise the ability to help others

Skills

- Assess their personal and professional sources/symptoms of stress
- Develop strategies/solutions to prevent burnout and secondary traumatization

Section VIII
Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Identify the various types of alternative/complementary therapies
- Discuss CAM modalities most useful in traumatic/disaster situations
- Describe key benefits of using CAM with older adults
- Discuss the relevance of spirituality within the context of a disaster experienced by older adults
- Understand the role of rituals in disasters
- Identify key benefits of developing rituals for disaster recovery
- Enumerate the benefits of rituals in disaster recovery
- Describe types of rituals
- Relate the importance and function of symbols and the senses to ritual

Attitudes

- Be supportive of older adults and their needs during a disaster
- Enable older adults and their healthcare providers to find meaning in the trauma and long term consequences of disaster
- Accept the role of ritual in helping an individual understand or make meaning out of disaster
- Understand that rituals can enable older adults and healthcare providers to find meaning during and after disaster
- Perceive the ongoing contemporary need and of ritual and its place in individual and community history

Skills

- Incorporate select CAM modalities into practice for older adults in disaster recovery
- Conduct a spiritual assessment of older adults who have experienced a disaster.
- Employ effective spiritual and CAM interventions to promote the well-being of older adults during a disaster
- Incorporate healing rituals to build community and provide comfort and trust
- Identify the components of ritual
- Describe items that might be included in a ritual “toolkit”
- Develop commemorative rituals to mark disasters
- Develop relief rituals for older adults, first responders and health care providers
- Incorporate healing rituals to build community and provide comfort and trust

Handout #2

Geriatric Mental Health: Disaster Preparedness and Response Outline

Day 1

Introduction to Disaster Preparedness and Mental Health and Aging			
TOPIC	TIME	PRESENTER	A/V NEEDS
Introduction and Goals of Certificate Program	9:00am - 9:30am	Andrea Sherman	
Disaster Preparedness Overview	9:30am - 10:00am	John Toner	
Break	10:00am - 10:15am		
Mental Health and Aging Overview	10:15am - 12:00pm	Zvi Gellis	
LUNCH	12:00pm - 1:00pm		
Exercise: Voices of Wisdom Video	1:00pm - 2:00pm		
Table Top Exercise	2:00pm – 3:00pm	Rebecca Terranova	
Break	3:00pm – 3:15pm		
Group Project	3:15pm – 4:30pm	Judy Howe	

Geriatric Mental Health: Disaster Preparedness and Response Outline

Day 2

Special Populations and Considerations			
TOPIC	TIME	PRESENTER	A/V NEEDS
Welcome	9:00am – 9:15am		
Veteran’s Populations	9:15am – 10:45am	Joann Izzo	
Break	10:45am – 11:00am		
Community Response to 911	11:00am – 12:00pm	Nora O’Brien	
LUNCH	12:00pm – 1:00pm		
Elder Neglect and Abuse Issues	1:00pm – 2:00pm	Terry Fulmer	
Group Project	2:00pm – 4:00pm		

Geriatric Mental Health: Disaster Preparedness and Response Outline

Day 3

Team Processes			
TOPIC	TIME	PRESENTER	A/V NEEDS
Overview of Teamwork	9:00am – 12:00pm	Judy Howe, Eileen Callahan	
LUNCH	12:00pm – 1:00pm		
Rituals	1:00pm – 2:15pm	Andrea Sherman	
Break	2:15pm – 2:30pm		
Group Project	2:30pm – 4:30pm	Judy Howe	

Geriatric Mental Health: Disaster Preparedness and Response Outline

Day 4

Clinical Response and Perspectives			
TOPIC	TIME	PRESENTER	A/V NEEDS
Disaster Mental Health		Doug Sanders	
Group Work			
LUNCH	12:00pm – 1:00pm		
Medical Co-morbidity and Mental Health Outcomes		Mark Nathanson	
Recognizing Mental Health Risk: Case Examples from the Emergency Room		Mark Nathanson	
Videotape Presentation: Surviving 9/11: A Conversation With Flo		John Toner (Moderator) and Mark Nathanson	

Geriatric Mental Health: Disaster Preparedness and Response Outline

Day 5

Self-Care			
TOPIC	TIME	PRESENTER	A/V NEEDS
Integrative Modalities Overview	9:00am – 12:00pm	Carla Mariano	
LUNCH	12:00pm – 1:00pm		
Presentation of Group Projects	1:00pm – 4:00pm	Terry Fulmer – 1-2 Judy Howe Nora O'Brien	
Wrap-up and Presentation of Certificates	4:00pm – 4:15pm	Judy Howe Brenda Rodriguez	

Teaching Guidelines:

Part 2 - How to Use this Curriculum

Overview

The need for education and training related to bioterrorism, emergency preparedness and aging has become an important issue for healthcare providers of older adults in light of recent events. The effects of disasters on older persons are far-ranging and may include acute injury or illness, an increase in morbidity due to exacerbation of already-existing chronic disability, or death. Psychological effects which may occur include anxiety, isolation, insomnia, depression, grief, and post-traumatic stress disorder syndrome. Indirect effects of disasters include loss of home, access to transportation and emergency services, and services, such as home delivered meals and home care.

This curriculum was developed by a 13-member panel of experts which was convened by the Consortium of New York Geriatric Education Centers (CNYGECs) HRS. In April 2004, faculty was drawn from New York University College of Nursing, Columbia University Stroud Center and Center for Geriatrics and Gerontology and Mount Sinai School of Medicine/Bronx Veterans Affairs' GRECC (Geriatric Research Education and Clinical Center)*.

*This panel helped contributors identify the learning objectives and domains of the curriculum. The members were Gabriella Angel, Tobe Banc, Eileen Callahan, Terry Fulmer, Judith L. Howe, Bianca Lopez Maymi, Patricia J. Moscou, Mark R. Nathanson, Anne Ottomanelli, Constance Sheehan, Andrea Sherman, Deborah Sherman, Albert Siu, John Toner, Andrea Villanti.

Teaching Guidelines

5. Description of Training Options
6. Learning Objectives of Geriatric Mental Health and Disaster Preparedness Curriculum
7. Incorporating the Principles of Adult Learning into Teaching
8. Interactive Teaching Methods
 - a. Case Analysis
 - b. Journal Articles
 - c. Videotapes
 - d. Videotaping with Immediate Feedback
 - e. Table Top Exercises
 - f. Interactive Rituals

Table 1: Geriatric Mental Health & Disaster Preparedness
2-Hour Overview Module

Table 2: Geriatric Mental Health & Disaster Preparedness
1 Day Elective

Table 3: Geriatric Mental Health and Disaster
Preparedness
5 Day Elective

Bibliography

Teaching Guidelines

1. Description of Training Options

This curriculum has been designed to be applied in three different lengths: two-hours, one day, and five days. The schedule of topics and formats for each are found in Tables 1 –3. The two-hour Overview Module is designed to be either free-standing or part of a one-day Geriatric Education Center training workshop. The one-day training is designed to be offered as one of the three elective days required as part of the five day (40 hour) Consortium of New York Geriatric Education Centers (CNYGEC) Certificate. Finally, the in-depth and comprehensive five-day course will be offered as a separate 40-hour CNYGEC Certificate on Geriatric Mental Health and Disaster Preparedness for those trainees desiring exposure to the entire curriculum.

2. Learning Objectives of Geriatric Mental Health and Disaster Preparedness Curriculum

The Curriculum Panel for this project agreed on the following curriculum learning objectives:

- Describe types of man-made and natural disasters.
- Define and provide examples of such terms as “crisis”, “emergency”, “disaster”, “preparedness”, and “readiness”.
- Delineate special considerations of the elderly with regard to housing, transportation, psychology, and health.
- Describe common mental health problems and the diagnosis and assessment of mental problems in the elderly.
- Describe geriatric mental health issues during an event, including individual responses, normal versus abnormal responses, elder abuse in times of crisis, and differential diagnosis of mental disorders.
- Describe geriatric mental health issues post event, including coping strategies, assessment, interventions, pharmacological therapies and the use of complementary medicine.
- Explain the role of complementary and alternative modalities of care, pet therapy, spirituality and rituals in treating the elderly.
- Describe the importance of self-care for the healthcare provider with respect to trauma and burnout.

3. Incorporating the Principles of Adult Learning Into Teaching

Given the fact that the trainees will be adults with varied backgrounds and experiences, it is important to keep in mind the principles of adult learning. Adult learners are a diverse group, with numerous life and work backgrounds and often carry multiple responsibilities. Therefore, learning styles vary greatly, and some may be less flexible as learners. For some, there may have been negative past learning experiences that are a barrier to adult learning. But, for most, adult learners are voluntary learners as well as problem-centered learners. When teaching adult learners, it is important for the instructor to interact with them as colleagues and be

aware of factors such as sensory deficits and the need for a comfortable physical environment.

For all teaching tracks (2 hour, 1 day, 5 days), the most effective teaching strategy is the seminar format. Seminars are optimal with adult learners for the following reasons:

- They enable discussions during which learners take responsibility for the structure and content of an educational encounter.
- Seminars are useful for the dissemination and critical evaluation of theoretical and empirical literature.
- Seminars assist in critical thinking, independence, and problem solving.
- They promote skills in group leadership and understanding group dynamics.
- They are consistent with andragogy which stresses use of experiences and self-motivation in adult learning.
- The seminar format provides an opportunity to bridge the theory-practice gap.
- Seminar discussion increase awareness of professional roles and responsibilities.
- Finally, seminars allow the challenging of established practices in light of literature and the experience of peers. (Wilkinson & Wilkinson, 1996)

When planning for a seminar series, the following points should be considered.

- The optimal group size is 10 to 20 learners.
- There need to be ground rules regarding confidentiality, valuing others' opinions and critical analysis of issues not personalities.
- One-half of the seminar time should be devoted didactic presentation and the other half to interactive discussion or exercises.
- Students must be prepared to participate in seminars; this can be facilitated by assigned readings, articles, or cases prior to each session.

4. Interactive Teaching Methods

There are many interactive learning techniques that can be incorporated into seminars and into the 1-day and 5-day curriculum track. The following are described in this module:

- Case analysis
- Journal articles
- Videotapes
- Videotaping with immediate feedback
- Table top exercises
- Interactive rituals

A. How to Use Case Analysis

Cases make learning more “real” and are excellent tools for enhancing critical thinking and problem-based learning. They allow learners to address and analyze the often-complicated medical, ethical, financial, and social considerations of a

Comment [JH1]: Page: 1
Let's just doublecheck that all of the methods are in fact being used in the different curriculum doses.

specific case. It is also helpful in aiding the students to see the “larger picture”, as well as the practical applications of the topics that they have been studying. In discussing each case, students can discuss what they would do in order to prevent any adverse outcomes and how they would develop a treatment plan to deal with the patient’s needs. Having an interdisciplinary group discuss a case is especially effective because of the team’s unique dynamic. For example, all aspects of the patient’s health and well-being are likely to be addressed. Furthermore, team members will be made more aware of the issues important to the members of other disciplines.

Cases may be developed by the faculty member or by the learners themselves. One technique is to have students rotate presenting “cases from the field” at weekly seminars. Students may work in smaller groups first and present their recommendations to the rest of the class. Each group can then compare and discuss their respective recommendations with those of the other groups.

B. How to Use Journal Articles

Although “Journal Club” was initially designed to help practitioners stay abreast of scientific developments, it is more recently used in a classroom setting. Journal Club is a teaching format in which students work either alone or in small groups to appraise a recently published research paper and then present their findings to their peers. Its main goals are to facilitate the development of the student’s crucial and analytic skills, and to encourage students to critically analyze scientific texts, papers and reports. Other goals also may include teaching students research, design, medical statistics, clinical decision theory, and clinical epidemiology.

Although the primary purpose of discussion of a journal article is to encourage critical analysis and discussion of the issues, it is an especially useful tool with learners from different disciplines such as in the BioT training. Students develop a greater appreciation and understanding of the points of view, issues important to, and opinions of the members of various disciplines.

C. How to Use Videotapes

Videotapes are an effective method to stimulate discussion and reflection in the classroom. Often the tapes depict client-provider encounters and enable learners to hone communication and assessment skills, understand cultural differences, and medical ethics. Tapes can be purchased or made by faculty members themselves. Also, sections of popular films can be used to trigger discussion in a particular area. See Table 1 for tips on using videotapes for teaching.

When using videotapes for teaching the following checklist will be helpful (adapted from Westberg, J. & Jason, H. *Teaching Creatively with Video: Fostering Reflection, Communication, and other Clinical Skills*, New York: Springer Publishing, 1994)

- Set the stage and present a challenge before showing each trigger.

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Teaching Guidelines: Part 2- How to Use This Curriculum

- After showing each trigger, repeat the challenge.
- Avoid telegraphing the “correct” responses.
- Consider asking learners to write down their responses?
- After asking a question, pause and wait for a response.
- If working with a large group, consider repeating each learners’ response.
- React to learners’ responses in nonjudgmental ways.
- Use neutral follow-up questions.
- Consider writing down the learners’ responses on a flip chart or board.
- Rotate questions among all learners.
- Discuss the responses.
- Show support for learners whose views deviate from the norm.
- Provide sufficient wait time after questions posed by learners.
- Turn learners’ questions addressed to the facilitator back to the group, at least initially.
- Replay all or parts of each trigger as appropriate.
- Have learners’ role play extensions of – or optional reactions to – the event(s) depicted in each trigger.

D. How to Use Videotaping with Immediate Feedback

Video recording interdisciplinary team meetings, whether real or stimulated, with immediate video feedback, is a “real time”, creative teaching techniques. This method not only requires equipment such as a video camera and TV/VCR set-up, but a level of trust among peer learners. These sessions need to be carefully facilitated by faculty, with clear objectives, ground rules, and a discussion of the value of self-assessment and peer feedback. In a trusting environment, this technique will enhance the learner’s skills and self-confidence as a professional.

E. How to Use Table Top Exercises*

A tabletop exercise is a low cost activity which is used as a teaching tool in this curriculum in the 5-day training track. In a tabletop exercise, learners participate in various simulated emergency situations. It is designed to train individuals with their roles and responsibilities within the organizational emergency response plan and the overall emergency management system. Participants, upon being presented with situations or messages discuss the actions they would normally take based upon the presented information.

The tabletop exercise is informal and should be conducted in a non-threatening environment. Players have an on-going discussion on actions and/or decisions.

The following are guidelines that make tabletop exercises more effective:

1. The exercise should be held in a room with a conference table, or with the seating arranged in a manner in which the participants are able to see all other participants.

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2. Having coffee/soda available for the participants helps promote a relaxed atmosphere.
3. Provide a large detailed map of the exercise area so that all participants can visualize the area involved.
4. A recorder (not an exercise “player”) should write down exercise responses and note the major issues/problems.
5. Plan on at least one hour, preferably three for the exercise. If the exercise fails to become productive within the first hour, it’s best to discontinue and discuss the possible reasons why this has occurred.

After the exercise-all participants should be asked to complete an evaluation of the exercise, and make suggestions and comments with regard to emergency operations plan revisions. Provide time to process the exercises and “re-orient” the participants.

*Wisconsin Emergency Management. (n.d.) Wisconsin Emergency Management Tabletop Exercise Scenarios (Volume 1). Retrieved May 10, 2005, from <http://emergencymanagement.wi.gov/>

F. How to Use Interactive Rituals

Rituals provide a framework, a container, and way to symbolically “mark” events. Rituals have specific stated intentions and separate ritual time and space from the everyday. Choose appropriate symbols for the ritualized event, and stimulate the senses through sensory props. It is important to acknowledge and honor cultural and religious practices and beliefs of participants. Distinguish between secular and religious rituals. Have a conversation on ritual with participants, have them visualize the components of a ritual. Use this as a starting point for discussing and planning rituals. Use stories as a basis for creating rituals.

The trainer may find it useful to build a ritual toolkit as it provides a ready made way to respond to and develop rituals in a variety of settings and situations. The toolkit might include:

1. Senses and symbols: include a shawl or colored cloth, bowl of water, candle or flashlight, shells, flowers & vase, and sweet candies. Add to the kit other items such as: camera, colored paper & pens, yarn, colored stones and feathers.
2. Music: collect healing music, cultural music, music from different areas, chimes, bells, and other instruments and musical genres.
3. Use the elements of ritual: beginning, middle, end, and stated intention, opening, activity, and closing. Be creative. Don’t forget the power of the circle as a formation for doing ritual.

In Summary: Adult learners are independent, self-directing, and have accumulated a great deal of experience which can be used as a resource for learning.

Points to remember:

- Establish a conducive learning environment
- Encourage learners to identify resources and develop strategies

Geriatric Mental Health: Disaster Preparedness and Response Curriculum

Teaching Guidelines: Part 2- How to Use This Curriculum

- Involve learners in framing their own needs, formulating their own learning, and evaluating their own progress

Table 1

**Geriatric Mental Health & Disaster Preparedness
2-Hour Overview Module**

This 2 hour module is intended to give learners an introduction to key issues related to geriatric mental health and disasters. It can stand alone as a 1 hour session or be part of a longer training session on geriatric mental health issues or disaster preparedness and response in general.

1. Definition of Terms for Disaster Preparedness (Refer to Section II)
[Crisis, Emergency, Disaster, Preparedness, Readiness]
Teaching Aides
Resilience
2. Differential Diagnosis of Mental Disorders (Refer to Section IV, D)
 - a. Clinical unifying themes
 - b. Rationale behind differential diagnostic process
 - c. Acute stress disorder
 - d. Post traumatic stress disorder
 - e. Delirium or acute confusional states
 - f. Dementia
 - g. Depression
 - h. Somatoform disorders
 - i. Schizophrenia and psychotic disorders
 - j. Other anxiety disorders
3. Assessment / Screening Tools (Refer to Section V, B)
4. Interventions (Refer to Section V, C)
Self-care (Section VII)
Rituals (Section V, A)
Spirituality (Section IV, A, 1)
5. Special Populations: Veterans / Culture / Holocaust Survivors

Table 2

Geriatric Mental Health & Disaster Preparedness 1 Day Training Module

The following one day module is designed to provide an overview of disaster preparedness, outcomes, diagnosis and screening and effective team-based interventions. It can be offered in a single free-standing day or be part of a longer training.

1. Introduction (1hour)
Goals of the Day
Pre-Test
2. Brief Overview of Disaster Preparedness (1 hour)
Utilize Section I
3. Brief Overview of Individual & Public Outcomes (1 hour)
Utilize Section IV
4. Brief Differential Diagnosis / Screening Tools (1 hour)
Utilize Section V
- LUNCH
5. Interventions (1 hour)
Use of Complementary / Alternative / Integrative Modalities [CAM]
[Culture – Teams] (1 hour)
Utilize Section V, E
6. Team Process for Clinical Perspectives and Processes in the Care of Older Adults During Disasters (1 hour)
Utilize Section VI

Wrap – Up
Summary / Post Test / Evaluation

Table 3
Geriatric Mental Health & Disaster Preparedness

5 Day Elective

The longest adaptation of this curriculum is a five-day certificate program in Geriatric (Mental Health) Emergency Preparedness. It is a comprehensive training experience which is geared to staff and faculty from senior centers, home care programs, nursing home, offices for the aging, hospitals and colleges and universities. In this train-the-trainer session, participants will be exposed to seminar knowledge and skills, as well as effective interactive teaching techniques for engaging learners.

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Teaching Guidelines: Part 2- How to Use This Curriculum

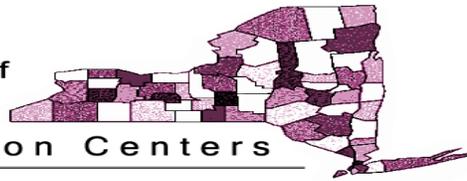
Table 3

Day 1:	Day 2:	Day 3:	Day 4:	
Introduction to Goals of the Day/Training Plan	Geriatric Mental Health & Disaster Preparedness Individual and Public Outcomes	Clinical Response Section V,A [CAM]	Interdisciplinary Teamwork/ Processes [Teams]	Integrative Modalit Self-Care / Spirituality [CAM]
Overview Disaster Preparedness (PP)	Clinical Section IV, A [CAM]	Section V,B [Culture]	Table Top Exercises [Teams]	Section V, E
Overview of Aging & Mental Health (PP)[Culture]	Section IV,B Normal vs. Pathological (PP) TREM Section IV, C	Section V,C		Network & System
Exercises Video / Training Manual	Section IV, D (OH) Special Populations: Vets/Holocaust Survivors/Victims of Child Abuse/PTSD	Section V,D (OH)		Presentation of Gro Table Top Exercise Games, Simulation [Teams]
Group Project: Suggest topics to present at end of 5 day session.[Teams]	Group Reflection, Processing and Exercises [Teams]	Group Reflection, Processing and Exercises [Teams]	Group Reflection, Processing and Exercises [Teams]	Summary / Resourc Post Test Evaluation of 5-day
Summary Evaluation of the Day and Speakers	Summary Wrap-up for the day	Summary Wrap-up for the day	Summary Wrap-up for the day	

Geriatric Mental Health & Disaster Preparedness

5 Day Elective

(PP)= Powerpoint Slides available. (OH)=Overheads available. (Need to be converted to PP.) (CAM)=Complementary and Alternative Medicine



GERIATRIC EMERGENCY PREPAREDNESS (GEP) Certificate Program

WHAT:

- ❖ CNYGEC is offering a new 5-day certificate program in Geriatric Emergency Preparedness. This new certificate program responds to the increased need of healthcare providers for enhanced knowledge and skills in emergency and disaster preparedness.

WHO SHOULD ATTEND:

Staff and faculty from:

- ❖ Senior centers
- ❖ Home care programs
- ❖ Local and state offices for the aging
- ❖ Nursing homes
- ❖ Hospitals

TOPICS INCLUDE:

- ❖ Emergency preparedness and response
- ❖ Assessment and intervention skills
- ❖ Specific populations and considerations
- ❖ Elder neglect and abuse
- ❖ Spirituality
- ❖ Rituals
- ❖ Interdisciplinary group project

COST: \$175.00 (cash, check or money order)

5 DAY CERTIFICATE PROGRAM:

- ❖ 3 Specialized Emergency Preparedness Core Days:
 April 25, 2006, May 2, 2006, May 9, 2006
- ❖ 2 Electives:
 May 16, 2006 and May 23, 2006

Elective: May 16, 2006

“Mental Health and Quality of Life in Emergencies and Disasters”

Methods for assessing, identifying and referring for treatment of mental health problems associated with emergencies and disasters in older persons. Training will incorporate case studies and videotapes of interviews with older 9/11 survivors.

Elective: May 23, 2006

“Self-care for the Health Care Provider”

The identification and assessment of burnout, coping mechanisms, and treatment options will be discussed. The importance of self-care for both caregivers and older adults will be addressed with an overview of methods for promoting self-care, including integrative and alternative therapies.

Funded by the Federal Health Resources and Services Administration and the New York City Department for the Aging.

Registration

Name: _____ Last 4 digits of SS#: _____

Position: _____ Institution: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Fax: _____

Tel # (day): _____ Tel # (eve): _____

To register, please fax this form to 212-995-4561, or call Brenda Rodriguez at 212-998-5618. You may also visit our website at www.nygec.org.
 Space is limited.

Section I: Overview of Disaster Preparedness and Response

Introduction: The goal of this curriculum is to help health professionals deal with a range of catastrophic emergencies including terrorist acts as well as explosions, fires, natural disasters (such as hurricanes and floods). In large-scale mass casualty events our healthcare workers must be knowledgeable about the need for efficient coordination among local, state and federal emergency response efforts; how to protect themselves and others from further harm; how to communicate effectively with other emergency personnel and the media; and how to address the unique psychological impacts and related social chaos that may ensue.

This first section of the curriculum is divided into 2 parts: (1) an overview of the basic principles of disaster preparedness and response; and (2) guidelines for more specific disaster responses by healthcare professionals.

Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- **Define and compare “disaster” vs. “emergency”**
- Describe types of disasters and the responses required for each
- Explain the disaster response system and the role of the health care provider in that system
- Identify typical reactions commonly observed during and after disasters
- Describe special considerations for older adults in disasters

Attitudes

- Express sensitivity to the special psychological and emotional needs and reactions of older people in an emergency
- Recognize obstacles to older people seeking and receiving mental health services in disasters

Skills

- Include discipline-appropriate immediate response for type of disaster
- Include coordinated service responses in initial assessment
- Incorporate coordinated service responses into plan of action
- Describe chain of command within agency in an emergency response
- Identify and describe the agency emergency response plan
- Apply creative problem solving to emergency situations
- List 4 emergency preparedness core competencies for public health workers

Curricular Content

Part 1: Overview of Disaster Preparedness and Response

A. Disaster vs. Emergency. Disasters are different from emergencies

because they involve entire communities and frequently strain social support systems.

Communication and transportation are typically disrupted; there is extensive loss of electrical power, water, and utilities. Emergencies and disasters both require a rapid reallocation of resources. An emergency can be handled by allocating existing agency resources while a disaster requires use of additional resources from other outside agencies.

B. Definition of Terms (See also Appendix A: "Useful terms from the Office for Domestic Preparedness")

1. Crisis—an unstable situation of extreme danger or difficulty

2. Emergency— An emergency is a sudden occurrence demanding immediate action that may be due to epidemics, technological catastrophes, or strife from natural or man-made causes.

3. Disaster—an unforeseen and often sudden event that causes great damage, destruction, human suffering and serious disruption in the services that are essential for the normal operation of a society.

a) FEMA defines disaster as: “An occurrence of severity and magnitude that normally results in deaths, injuries, and property damage and that cannot be managed through the routine procedures and resources of government.
and...requires immediate, coordinated, and effective response by multiple

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Section I – Overview of Disaster Preparedness and Response

government and private sector organizations to meet human needs and speed recovery.” (DHHS Publication No. ESDRB SMA 99-3323 p. 6)

b) The Red Cross defines a disaster as an event that involves 10 or more deaths, affects 100 or more people, or leads to an appeal to them for assistance.

There are approximately 500 incidents annually, worldwide (Norris, F. Disasters in Urban Context).

4. Preparedness—the attempt to limit the impact of a disaster by structuring the response and affecting a quick and orderly reaction to the disaster.

5. Readiness—the state of having been made ready or prepared for use or action.

C. Types of Disasters

There are numerous types of disasters, each with specific set of characteristics and a variety

of recommended immediate responses. Types include:

1. Natural (Fires, floods, earthquakes, hurricanes, tornados)
2. Technological (Blackouts, terrorism)
3. Health (Epidemics)
4. Social (Riots)

D. Characteristics of Disasters

Describe and discuss characteristics of disasters and their potential psychological impact. (See References: Section 2 of Training Manual for Mental Health and Human Service Workers in Major Disasters for more information).

- Natural vs. man-made
- Degree of personal impact
- Size and scope
- Visible impact/low point
- Probability of recurrence

1. According to the U.S. Department of Health and Human Services disasters are usually characterized by:

- a. Widespread destruction of property
- b. Many injuries, often with loss of life
- c. Direct consequences to many persons and their families

2. Disasters challenge local infrastructure and community response.

“For the survivors, disaster may engender an array of stressor, including threat to one’s life and physical integrity, exposure to the dead and dying, bereavement, profound loss, social and community disruption, and ongoing hardship.” (Norris)

3. Disasters are not equal in the manner in which they affect communities,

with many variables predicting the gravity of impairment.

- In the United States, disasters of mass violence are thought to be most stressful, followed by technological disasters, and last those that are natural in origin. (Norris et. al The Range, Magnitude, and Duration of Effects...PTSD fact sheet)
- In the case of natural disasters the causes are forces of nature, and blame is placed on no one.
- In the cases of mass violence and technological disasters, the causes are human with the blame often being placed on persons, government, or business. (U.S. Department of Health and Human Services)

E. Disaster Responses:

1. General Response Strategy: 'Person Priorities'

(Davis, L et al, Individual Preparedness and Response to Chemical, Radiological, Nuclear, and Biological Terrorist Attacks – A Quick Guide)

- a) Act first to ensure your own survival.
- b) Take steps to decontaminate yourself.
- c) Help others if it is safe to do so.
- d) Make contact with family/friends.

2. Specific Types of Disasters and Recommended Immediate Responses:

- a) Natural Disasters
 - Hurricane/ Tornado
 - Heat wave/Snowstorm
 - Wildfires
 - Flood/High Water
 - Explosions

Recommended Immediate Responses:

- a. Assess and ensure physical safety within guidelines of emergency responders
- b. Assess the necessity of medical treatment and ensure appropriate care.
- c. Early psychological intervention includes the provision of psychological help to victims/survivors within the first month after a critical incident, traumatic event, emergency, or disaster aimed at reducing the severity or duration of event-related distress. Early interventions should be delivered as needed in a manner acceptable to survivors and in keeping with best available practice. (NIMH - Mental Health and Mass Violence)
 - i. Psychological first aid

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Section I – Overview of Disaster Preparedness and Response

- ii. Needs assessment
 - iii. Consultation
 - iv. Fostering resilience
 - v. Triage
- b) Man-made/Intentional Disasters:
- Technological Emergency such as power or phone outages or water main breaks.
 - Biological, chemical, radiological, and nuclear terrorism

Recommended Immediate Responses

- a. Chemical – Find clean air very quickly. Once protected from chemical agent decontaminate by removing clothes and showering. When conditions are safe to move about freely, seek medical treatment.
- b. Radiological – Avoid inhaling dust that could be radioactive. Decontaminate by removing clothing and showering. Relocate outside the contaminated zone, only if instructed to do so by public officials.
- c. Nuclear – Avoid radioactive fallout: evacuate the fallout zone quickly or, if not possible, see best available shelter.
- d. Biological – Get medical aid and minimize further exposure to agents.
 - i. If symptomatic, immediately go to medical provider specified by public health officials for medical treatment.
 - ii. If informed by public health officials of being potentially exposed, follow their guidance.
 - iii. For all others, monitor for symptoms and, for contagious diseases, minimize contact with others
 - iv. Leave anthrax-affected area once on antibiotics if advised to do so by public health officials.

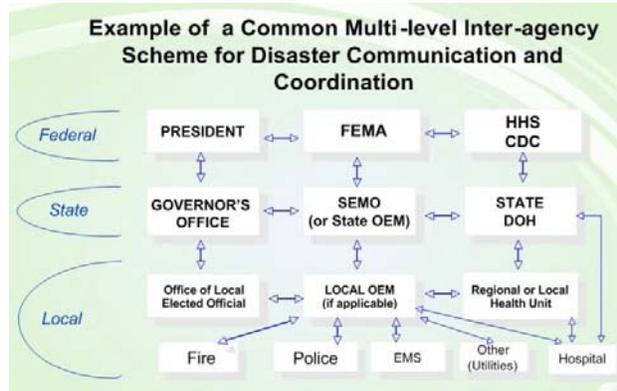
Part 2. Disaster Response by Health Care Professionals

A. Overview

1. Triage—Assessment—Treatment
 2. Case reporting/syndromic surveillance (especially important for bio-terrorism, chemical, and nuclear disasters)
3. Act upon information in DOH alerts (broadcast fax, e-mail)
4. New threats put health care providers on the frontline

B. The Disaster Response Network. Discuss the role of the health care provider in response and preparedness. Review “Emergency Preparedness Core Competencies for all Public Health Workers”

1. Inter-agency Plan for Disaster Communication



2. According to ‘Mental Health and Mass Violence Evidenced-based Early psychological Interventions for Victims/Survivors of Mass Violence,’ immediate health care responses common to most disasters include an assessment of the hierarchy of needs such as:

- Survival
- Safety
- Food
- Shelter
- Health (both physical and mental)
- Triage (mental health triage for emergencies)
- Orientation (orienting survivors to immediate local services)
- Communication with family, friends, and community
- Other forms of psychological first aid

3. Key aspects of early intervention include the following:

- Psychological first aid
- Needs assessment
- Monitoring the recovery environment
- Outreach and information dissemination
- Technical assistance, consultation, and training
- Fostering resilience, coping, and recovery (i.e., facilitating natural support networks)
- Triage
- Treatment

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C. **Emergency Preparedness Core Competencies for All Public Health Workers** (see References: Center for Health Policy, Columbia University School of Nursing)

- a) Describe the public health role in emergency response in a range of emergencies that might arise.
- b) Describe the agency chain of command in emergency response.
- c) Identify and locate the agency emergency response plan (or the pertinent portion of the plan).
- d) Describe his/her functional role(s) in emergency response and demonstrate his/her role(s) in regular drills.
- e) Demonstrate correct use of all communication equipment used for emergency communication (phone, fax, radio, etc.).
- f) Describe his/her communication role(s) in emergency response: within the agency; with the media; with the general public; personal (with family, neighbors).
- g) Identify limits to own knowledge, skills, and authority and identify key system resources for referring matters that exceed these limits.
- h) Recognize deviations from the norm that might indicate an emergency and describe appropriate action.
- i) Apply creative problem solving and flexible thinking to unusual challenges within his/her functional responsibilities and evaluate effectiveness of all actions taken.

D. Emergencies & Disasters Activity: In pairs, discuss and fill out *Emergencies and Disasters Activity, Handout #1*, on differences between emergencies and disasters; identifying disaster responders; and the competencies required by health care professionals. Review and discuss in large group.

E. **Public Mental Health Effects of Disasters:** Describe the factors that increase the effects of a disaster on public mental health. (See References: Norris, 2002)

1. Natural vs. man-made: (Note: These figures refer to prevalence rates of mental health problems in adult/non-geriatric groups.)
- a) Posttraumatic Stress Disorder (PTSD)
- | | |
|--------------------------|------|
| • Natural disaster | – 5% |
| • Mass shooting | 28% |
| • Plane crash into hotel | 29% |
| • Bombing | 34% |
- b) Acute Stress Disorder
- | | |
|-----------------------------|-----|
| • Industrial accident | 6% |
| • Typhoon | 7% |
| • Assault, burn, industrial | 13% |
| • Motor vehicle accident | 14% |
| • Violent assault | 19% |
| • Mass shooting | 33% |
2. Public mental health impact greatest when at least two of the following are present:
- a) Disaster caused extreme and widespread damage to property

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Section I – Overview of Disaster Preparedness and Response

- b) Disaster engendered serious and ongoing financial problems for the community
- c) Disaster was caused by human intent
- d) Impact was associated with a high prevalence of trauma in the form of injuries, threat to life, and loss of life

F. Types of Psychosocial Reactions to Disasters. (See References: Center for Health Services, 2000, Training Manual for Mental Health and Human Service Workers in Major Disasters; and Center for Health Services, 1999, Psychosocial Issues for Older Adults in Disasters, for more information.)

1. Common needs and reactions

- Concern for basic survival
- Grief over loss of a loved one and loss of valued and meaningful possessions
- Fear and anxiety about personal safety and the physical safety of loved ones
- Sleep disturbances, often including nightmares and imagery from the disaster.
- Concerns about relocation and related isolation or crowded living conditions
- Need to talk about events and feelings associated with the disaster, often repeatedly
- Need to feel one is a part of the community and its disaster recovery efforts

2. Physical reactions to disaster

- Fatigue, exhaustion
- Gastrointestinal distress
- Appetite change
- Tightening in throat, chest, or stomach
- Worsening of chronic conditions
- Somatic complaints

3. Emotional reactions to disaster

- Depression, sadness
- Irritability, anger, resentment
- Anxiety, fear
- Despair, hopelessness
- Guilt, self-doubt
- Unpredictable mood swings

4. Cognitive reactions to disaster

- Confusion, disorientation
- Recurring dreams or nightmares
- Preoccupation with disaster
- Trouble concentrating or remembering things
- Difficulty making decisions
- Questioning spiritual beliefs

5. Behavioral reactions to disaster

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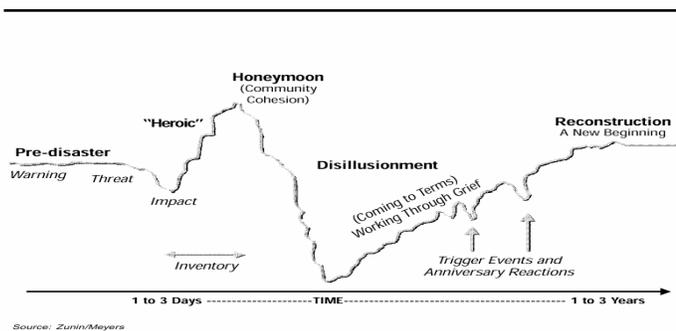
- Sleep problems
- Crying easily
- Avoiding reminders
- Excessive activity level
- Increased conflicts with family
- Hyper vigilance, startle reactions
- Isolation or social withdrawal
- Increase substance abuse

6. Psychological Reactions to Disaster*

Disasters unavoidably impact survivors both psychologically and socially.

Describe the phases of Disaster from “Pre-Disaster/Warning through the phase of Disillusionment and finally to Reconstruction: A new Beginning.”

Phases of Disaster Timeline



* Adapted from: Center for Mental Health Services. *Training Manual for Mental Health and Human Services Workers in Major Disasters (2nd Edition)*, Washington DC: DHHS pub #: 90-538, 2000.

- G. “Flo video” Activity:** Present video and then, discuss Flo’s experience and participants’ reactions. (See Resources: Flo video)

Show all or selected segments of videotape: *Surviving 9/11: A Conversation with Flo*. Discuss relevant aspects of the film and thoughts/reactions that arose for participants. Using the “Phases of Disaster Timeline” (shown above), ask participants:

1. What were the various phases of Flo’s psychological reaction to this disaster?
2. What were her physical reactions?
3. What were her emotional reactions?
4. What were her cognitive reactions?
5. What were her behavioral reactions?
6. What were some of the effects of long-term disaster stress on Flo’s well-being?

H. Special Considerations regarding the Care of Older Adults during a Disaster:

Distribute Handout #2 and review the Special Considerations.

1. Housing, evacuation & relocation
 - Vulnerable housing
 - Reluctance to evacuate
 - Transfer and relocation trauma
 - Mobility impairment or limitation
2. Following a disaster, the importance of pets, particularly to those older persons living alone, needs to be recognized. As appropriate, measures should be taken to locate separated pets and reunite them with their owners. Particularly after a stressful event, with all of the uncertainty that may follow, having one’s pet may mitigate negative reactions such as depression and anxiety.
(http://consensus.nih.gov/ta/003/003_statement.htm#3_Health accessed May 10, 2005).
 - Pets or companion animals, may be particularly significant for older person, especially those living alone or in nursing homes. Research has demonstrated the many benefits of animal companions, including reducing blood triglyceride levels, improved survival rates after a heart attack, and reduced anxiety and clinical depression. A Canadian survey of 1,000 older adults found that those with pets were more physically active than those without pets and better able to carry out their own activities of daily living. This is significant because isolation and loss of independence are known risk factors for depression. (<http://www.infoaging.org/d-depress-12-r-pet.html> accessed May 10, 2005): NIH Consensus Statement. The Health Benefits of Pets, NIH OMAR Workshop Report, September 10-11, 1987.
3. Transportation
 - Mobility impairment or limitation
 - Access to transportation

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4. Psychological issues
 - Fear of institutionalization
 - Fear of loss of independence
 - Multiple losses
 - Significance of losses
 - Welfare stigma
 - Mental health stigma
 - Isolation
5. Health issues
 - Sensory deprivation
 - Chronic health conditions
 - Delayed response syndromes
 - Hyper/hypothermia vulnerability
6. Other
 - Bureaucracy unfamiliarity
 - Crime victimization
 - Literacy
 - Financial limitations

I. Instant Aging Activity

“A good part of the morning is going to be spent involving you in an experiential simulation exercise called “Instant Aging” or what we prefer to call, “Instant Impairment”. What this means is that each of you will experience some temporary sensory impairments. The impairments will include: vision, hearing, touch and mobility. The intent is not to stereotype old people but to sensitize you to the fact that these are some of the more commonly observed age-related sensory impairments. We will break-up into pairs. Each of you will experience temporary sensory impairments and helping the member of the pair who is experiencing the impairment. Divide into pairs. After introducing each sensory impairment, ask: How did you feel as an impaired person? As a helper? How did you experience the relationship between impaired person and helper? How can you apply this simulation of impairment to your own life experience? Personally? Professionally? What relevance does this have to disasters and emergencies?”

“Voices of Wisdom” video (1st section on “Disasters”), followed by “Instant Aging” exercise. See Resources: “Voices of Wisdom” and Hickey, T. 1975) After video, describe instant aging activity to the group and tell them that they will be asked to perform tasks that older people would have to perform in an emergency. Tell participants that if anyone is claustrophobic or uncomfortable participating, that they can observe the activity or if they prefer, leave the room.

1. Instant aging: Participants receive glasses smeared with Vaseline and are asked to put dried beans in their shoes to simulate impaired vision and arthritis.
 - a) 1st task: walk to table and find phone number for emergency services in phone book
 - b) 2nd task: BLACKOUT—find flashlight in one of the 4 corners of the room
2. Sit down and discuss their performance of the tasks.
3. Discuss their feelings as an “older person” in a disaster. Debrief.

Resources

Bioterrorism and Emergency Readiness Competencies for All Public Health Workers.
<http://www.nursing.hs.columbia.edu/institute-centers/chphsr/btcomps.pdf>

“Flo” Video: In Production

Handout #1: Emergencies & Disasters Activity

Handout #2: Special Concerns of Older Adults in Disaster

Hickey T. Simulating Age-Related Sensory Impairments for Practitioner Education. *The Gerontologist*. 1975: 457-463.

“Voices of Wisdom: Seniors Cope with Disasters” Video

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- National Center for Post-Traumatic Stress Disorder
www.ncptsd.org/publications/disaster/dmh_html/Introductiona.html

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http://www.nyc.gov/html/doh/html/bt/bt_fact_chem.html Accessed 12 Feb 2004.

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O'Brien N. Emergency Preparedness for Older People. International Longevity Center Issue Briefs. January-February 2003.

Van der Kolk, B.A., McFarlane A.C. & Weisaeth L. (eds.) Traumatic Stress: The Effects of Overwhelming Experiences on Mind, Body, and Society. New York: The Guilford Press.

Handout # 1

Emergencies & Disasters Activity

1. Which of these statements is accurate?
 - A. Disasters are significant events, which require resources above and beyond the affected community
 - B. What is a disaster for one department of health may be a minor emergency for another department of health
 - C. Emergencies are events that can be handled with local resources
 - D. All of the above

2. In the United States, which agencies routinely respond to emergencies and disasters?
 - A. State and local departments of health
 - B. Federal Emergency Management Agency
 - C. American Red Cross
 - D. All of the above

3. What is preparedness?
 - A. the state of having been made ready or prepared for use or action
 - B. an unforeseen and often sudden event that causes serious disruption in the services that are essential for the normal operation of a society
 - C. the attempt to limit the impact of a disaster by structuring the response and affecting a quick and orderly reaction to the disaster
 - D. an unstable situation of extreme danger or difficulty

4. Identify the Emergency Preparedness core competencies listed below:
 - A. Recognize deviations from the norm that might indicate an emergency and describe appropriate action.
 - B. Demonstrate correct use of all communication equipment used for emergency communication (phone, fax, radio, etc.).
 - C. Define “emergency” and “disaster” and differentiate among them.
 - D. Identify limits to own knowledge, skills, and authority and identify key system resources for referring matters that exceed these limits.

5. List three services that are typically affected by a disaster:
 - a.
 - b.
 - c.

[Questions 1 & 2 adapted from Columbia University Center for Public Health Preparedness, Basic Emergency Preparedness Course.]

Handout # 2

Special Concerns of Older Adults in Disaster

Reluctance to evacuate – Research shows that older adults are less likely to heed warnings, may delay evacuation, or resist leaving their homes during disasters. Disaster planning and preparedness is especially critical with this group.

Vulnerable housing – Due to limited income, older adults tend to live in dwellings that are susceptible to disaster hazards due to the location and age of buildings.

Fear of institutionalization – Many older adults fear that if their diminished physical or emotional capabilities are revealed, they will risk loss of independence or institutionalization. They may under-report the full extent of their problems and needs.

Multiple losses – An older person may have lost their income, job, home, loved ones, and/or physical capabilities prior to the disaster. For some, these prior losses may build coping strength and resilience. For others, these losses compound each other. Disasters sometimes provide a final blow that makes recovery especially difficult.

Significance of losses – As a result of a disaster, irreplaceable possessions such as photograph albums, mementos, valued items, or sacred objects passed on through generations may be destroyed. Pets or gardens developed over years may be lost. The special meaning of these losses must be recognized to assist with grieving.

Sensory deprivation – An older person's sense of smell, touch, vision, and hearing may be less acute than the general population. As a result, they may feel especially anxious about leaving familiar surroundings. They may not be able to hear what is said in a noisy environment or may be more apt to eat spoiled food.

Chronic health conditions – Higher percentages of older persons have chronic illnesses that may worsen with the stress of a disaster, particularly when recovery extends over months. Arthritis may prevent an older person from standing in line for long periods of time. Problems with thinking and memory may affect the person's ability to remember or process information.

Medications – Older adults are more likely to be taking medications that need to be replaced quickly following disaster. Medications may cause problems with confusion or memory, or cause a greater susceptibility to problems such as dehydration.

Hyper/hypothermia vulnerability – Older persons are often more susceptible to the effects of heat and cold. This becomes critical in disasters when furnaces and air conditioning may be unavailable.

Transfer and relocation trauma – Frail adults who are dislocated without use of proper procedures may suffer illness or even death. Relocation to unfamiliar surroundings and loss of community may result in depression and disorientation.

Delayed response syndromes – Older persons may not react as fast to a situation as younger persons. In disasters, this may mean that deadlines for applications or eligibility timelines may need to be extended.

Mobility impairment or limitation – Older persons may not be able to use automobiles or have access to public or private transportation. This may limit the opportunity to relocate, go to shelters, Disaster Recovery Centers, or to obtain food, water, or medications when necessary.

Financial limitations – Because many older adults live on fixed and limited incomes, they can't take out a loan to fully repair their homes. They are unable to "start over" due to lack of money and time, as is more possible for younger people.

Literacy – Older persons have lower educational levels than the general population. This may present difficulties in completion of applications or understanding directions. Public information targeting this group must be disseminated in multiple ways, including by non-written means.

Isolation – Some older adults have limited social support systems and are not associated with local senior centers or churches. Their isolation may contribute to not learning about available resources. They may not have access to help with clean-up or repairs. Disaster outreach efforts should prioritize reaching these individuals.

Crime victimization – Con artists target older people, particularly after a disaster. These issues need to be addressed in shelters, housing arrangements, and when contractors are being selected to repair homes.

Bureaucracy unfamiliarity – Older adults often have not had experience working through bureaucratic systems. This is especially true for those who had a spouse who dealt with these areas.

Welfare stigma – Many older person will not use services that have the connotation of being welfare or a "handout". They may need to be convinced that disaster services are available as a government service that their taxes have purchased.

Mental health stigma – Older persons may feel ashamed because they experience mental health problems, or they may be unfamiliar with counseling as a form of support. Psychological stress may be manifested in physical symptoms, which some find as more acceptable. Mental health services should emphasize "support," "talking," and "assistance with resources," and de-emphasize diagnosis or psychopathology.

Resource Materials:

Diane Myers, RN, MSN Older Adults' Reactions to Disasters Handout. 1990.

U.S. Department of Health and Human Services. Action Plan of the *Administration on Aging to Strengthen the Disaster Response Capacity to Serve Older People*, 1994.

Appendix A

- A. Useful terms from the Office for Domestic Preparedness (ODP) (formerly The Office for State & Local Domestic Preparedness) is the program office within the Department of Justice (DOJ) responsible for enhancing the capacity of state and local jurisdictions to respond to, and mitigate the consequences of, incidents of domestic terrorism.
1. **Assessment** (Pre and Post-disaster) (sometimes Hazard, Risk, Damage or Needs Assessment). This is the process of determining the impact of a potential or real disaster or event on a society. It addresses the need for preparedness to prevent or mitigate the potential event, and/or immediate, emergency measures to save and sustain the lives of survivors, and the possibilities for expediting recovery and development. Assessment is an interdisciplinary process undertaken in phases and involving data gathering surveys and the collation, evaluation and interpretation of information from various sources concerning both direct and indirect estimated and/or real losses, short and long-term effects. It involves determining what could happen and/or what has happened and what assistance might be needed, but also defining objectives and how relevant assistance can actually be provided to the victims. It requires attention to both short-term needs and long term implications
 2. **Critical Incident Stress Management (CISM)**. Critical incident stress is a normal response of a healthy person to an abnormal event. Management is conducted through processes like defusing, debriefing and demobilization. The process takes a comprehensive, systematic and multi-component approach.
 3. **Emergency Operations Plan (EOP)**. A state or local document that describes actions to be taken in the event of natural disasters, technological accidents, or weapons of mass destruction attack. It identifies authorities, relationships, and the actions to be taken by whom, what, when, and where, based on predetermined assumptions, objectives, and existing capabilities.
 4. **Emergency Response**. Those organized actions taken by trained people to assist in controlling and/or reducing the level of losses and associated human suffering that has or could have resulted from an emergency incident.
 5. **Emergency Response Plan**. A written document that sets forth the task or actions that are to be taken once an emergency incident is reported to have occurred. The emergency response plan will usually contain contingency plans for the various types of emergencies that re anticipated to be encountered.
 6. **LEPC**. An abbreviation for a “Local Emergency Planning Committee” that has been required by EPA regulations and by SARA Title III. It is the local

community's committee that the State has established that is used to develop and maintain an emergency response plan covering all types of emergencies that may occur in the community.

7. **National Response Center (NCR)**. A US Coast Guard-operated communications center that is located in Washington, D.C. It is the location that all inadvertent or accidental spills or releases of reportable quantities or more are to be reported, it is manned 24 hours a day, seven days a week.
8. **National Response Team (NRT)**. Federal cabinet level agencies and selected independent Federal agencies within the Federal government that are involved in assisting in the handling of emergency responses to the incidents or assisting the states with handling emergency incidents. The NRT is co-chaired by the EPA and the US Coast Guard.
9. **Regional Response Team (RRT)**. The US is divided into 10 Federal regions and each has a response team made up of members from the same Federal agencies that make up the National Response Team (NRT). The RRT interfaces with the states within its region and provides support to the state and local community emergency planning and response efforts
10. **Debriefing Debate**. Debriefing is a popular, early intervention following disasters in which small groups of people involved in the disaster, such as rescue workers, meet in a single lengthy session to share individual feelings and experiences. The effectiveness of debriefing in preventing later mental health problems is much in debate. (www.usuhs.mil/psy.radiation.html)

Section II – Clinical Perspectives and Processes in the Care of Older Adults During Disasters

Introduction: Most disasters, whether natural or man-made, are neither predictable nor preventable. Nonetheless, with proper planning and preparation, many of the most serious aspects of a disaster and its aftermath can be mitigated. For older victims, the consequences of an unplanned or inadequate response to a disaster are particularly devastating and, as illustrated by the events before and after Hurricane Katrina in August 2005, potentially deadly. In fact, more than 70 percent of the deaths attributed to Katrina were among older adults 60 and older. ("Katrina affected the elderly the most", The Charlotte Observer, 12/30/05) This section of the curriculum discusses the important process, communication, and organizational issues which must be addressed for the proper health care of older adults before, during and after a disaster.

Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Acquire a greater understanding of what disaster work may entail, with a focus on frail older adults
- Determine how prepared their own organization is and what remains to be done to put a program of disaster preparedness in place
- Understand the timing and focus of interventions

Attitudes

- Examine personal attitudes and readiness to act in periods of possible confusion and even personal danger in order to help their older clientele
- Realize that recovery from disaster is ongoing, with treatment focused on “the possible” rather than an abstract ideal
- See problems as challenges rather than obstacles

Skills

- Acquire general skills appropriate to both the immediate and the ongoing effects of disasters
- Search for community disaster information and resources
- Develop specific skills around the importance of communication, rapid and appropriate response, assessment, and treatment interventions

Curricular Content

Philosophy and expectations related to health care of older adults during disasters

1. Emergency training and planning is essential for all staff involved with the care of older persons.
2. Frail older adults 85 and older are the most vulnerable older population
3. Frailty is defined both physically (e.g. problems in walking, hearing and visual difficulties, and the like) and mentally (e.g. confusional states, presence of Alzheimer’s and other dementias, psychiatric conditions such as severe depression and anxiety, and others)
4. Those defined as “sturdy” or well older adults can be enlisted and (ideally) trained to help staff with those older persons who need assistance in emergencies.
5. The frail elderly themselves can be educated and prepared for emergencies to whatever extent is possible and appropriate to their conditions.

Need for an interdisciplinary approach

1. All staff in every setting for older adults should be trained together in disaster preparation and training. This facilitates staff becoming clear about the role or roles they are to play and how they are to coordinate with each other.
2. Depending on the setting, other disciplines might have to be “on the ready” if they are not ordinarily on site, such as pharmacists, nurses, physicians, mental health professionals and others.
3. Drivers and vehicles need to be arranged and available in case of a need to evacuate. (Note: coordination with other agencies and organizations is necessary in order to avoid contracting with the same transportation system and ending up with too many depending on too few vehicles—a situation that has already been discovered in disaster-planning in New York City.)
4. “Sheltering-in-place” scenarios must also be planned and rehearsed, whether such sheltering takes place in agencies or in clients’ homes.

Ethical issues related to intervening during disasters

1. The most obvious ethical issue is to avoid any situation that leads to the abandonment or neglect of the most frail. This happened recently in Paris as well as other European locations during a heat wave in August 2003. Many frail elderly lost their lives while their families and even public and private services officials were vacationing and failed to quickly respond to the emergency. In addition to lives lost, France, for example, is still struggling publicly and privately to recover from this blow to its sense of ethical and moral responsibility.
2. Another major ethical issue is whether people can be confined and treated against their will in case of contagious disease outbreaks, whether the cause is natural or terrorism. Go to the U.S. Centers for Disease Control and Prevention website (www.cdc.gov) for current information regarding legal authorities for governmental entities to respond in serious public health emergencies.
3. One of the most profound dilemmas facing NYC regards triage during major citywide disasters. Who should be treated in case of shortages of supplies and equipment? Who should be evacuated when time is short and transportation is limited? Are the frail elderly considered to be as valuable as others are? Aging professionals and organizations should have an advocacy voice in determining citywide policy (now being formulated) for meeting such dire circumstances

Case finding

1. How do we know who needs our help?

The nature of the emergency and the nature of the agency involved will determine case finding. Staff can be trained in various scenarios, with understanding that novel situations may be as likely as known ones. The important factor here is that staff must understand their clientele well enough to know who is most likely to be vulnerable in a given situation and have a plan for meeting their needs.

2. Professional route to case finding

Although each health and social service professional has a range of usual skills and techniques for identifying cases needing help, disasters and other

emergencies often require “doing whatever is necessary” in the early stages, regardless of professional training. Thus flexibility and ingenuity are important traits until professional roles can once again be re-established.

3. Geographic route to case finding

In the World Trade Center bombings, case finding was most immediately intense in the geographic area known as the “Red Zone” surrounding the Trade Center. Thus, the location and extent of a particular disaster will determine case finding, at least in the immediate aftermath. (Later, many people, old and young, began having psychological reactions to the bombings even when they were not physically involved or nearby. Heavy exposure to the media as well as news of dead relatives, friends, or acquaintances were major risk factors for stress reactions, as were histories of previous trauma reactivated by 9/11.)

4. Social service routes

Case finding also occurs in connection with agencies and organizations already involved with older adults. For example, the Visiting Nurse Association immediately began assessing its roles of usual clientele to see who needed immediate services in the “Red Zone” following 9/11.

5. Case-finding kits

When staff must leave their offices in order to locate clients during an emergency, the following kit items should be considered:

- a. phone numbers of clients, nearby neighbors or friends, and interested relatives. Also phone numbers of doctors, pharmacies, ambulance services and other services that might be required
- b. subway and city maps with detailed street locations
- c. flashlights, portable battery radios (and extra batteries) or hand-crank radios, cell phones or blackberries (and chargers)

- d. identification cards (preferably with photos) from one’s employer as well as personal photo Ids
- e. bottled water and, depending on the disaster, N95 paper face masks
- f. enough cash and subway cards to meet travel and minor emergency needs.

E. Triage/Assessment

1. If chaos reigns, the first priority is survival of self and help for those immediately around one. But as circumstances calm, assistance to those most in physical danger, including the physically frail elderly, takes priority. (This assumes that the crisis is not ongoing—in such cases, panic reactions must be considered.) Mental health assistance tends to fall into place somewhat later than physical care, as soon as survival is more assured.
2. Triage/assessment of mental health conditions tends to be quite arbitrary at first, until enough time has passed to more accurately assess people’s response to the disaster. One of the best assessment techniques for post disaster settings has been a consequence of the Oklahoma City bombing and is called Practical Front Line Assistance and Support for Healing (PFLASH), developed by Carol North, M.D. and Barry Hong, Ph.D. of the Washington University School Medicine and Betty Pfefferbaum, M.D., JD of the University of Oklahoma School of Medicine. This is a one-day 6-hour training seminar for front-line responders that is useful for all professionals, including psychiatrists and other MDs, psychologists, social workers, and other counselors and service workers. Focus is on differentiating normal from pathologic responses (including PTSD) and reviewing the most appropriate therapeutic interventions.

F. Communication patterns and the need for a control center

1. Communication is critical. Staff should be trained in emergency communication using cell phones, blackberries, pagers and the like--Who to call, where to call, what to do if phones aren’t working and other scenarios. Staff should have access to battery powered or hand crank radios and know where to tune for emergency information. TV’s are useful as long as electricity is working.
2. Overall control centers include city agencies responsible for emergency preparation and response. Regular contact with the emergency websites of the NYC Department of Emergency Management, the NYC Health Department and the Department for Aging should be maintained for the latest communications instructions—I would recommend at least one staff person be held responsible for a continued updating of staff on what is being presented at these sites.
3. Plans (and backup plans, when things go awry) should be made for communication with clients and their families and neighbors in emergencies. Staff should know if older people have cell phones, as well as phone numbers

of nearby neighbors and family. It is especially important that plans be made in case regular phones and cell phones aren't working. It may be necessary for staff to physically travel, or even walk, to the client to find out what is happening.

G. Differential diagnosis

1. The essential differential diagnosis is between trauma-related responses versus mental health symptoms that were pre-existing or newly emerging and not related to the current disaster or emergency.
2. There is also a differential diagnosis in trauma response itself, ranging from normal trauma reactions (typical reactions of fear, anxiety, and other symptoms that resolve naturally) to PTSD (the specific symptoms of which are described in both psychiatric literature and trauma literature). It should be noted that even responses that fit the PTSD profile early in a disaster may self-resolve. Thus a diagnosis of chronic PTSD is generally thought to require at least 6 months or more of symptoms.

H. Prioritization

1. As described earlier, survival is the first priority during an emergency, with physical safety and emergency medical treatment primary. Mental health concerns fall into place as soon as emergency personnel have begun to have the psychic and physical capacity to focus on emotional reactions.
2. Ideally, frail older adults should receive special consideration since they are the most vulnerable.
3. As care becomes ongoing, staff should be alert to signs of stress in their entire clientele population, since not all will immediately display symptoms and others may demonstrate their distress in a less than obvious manner. Examples might be an increase in alcohol use, non-customary requests for medication, or subtle changes in mood and behavior.

Synthesis/goals and expected outcomes

1. The first goal is safety and stabilization of the older person.
2. Initial assessment of individual physical and emotional symptoms follows, with immediate supportive interventions.
3. Length and type of ongoing treatment and care will be based on a continuing diagnostic assessment of both the symptoms themselves and the individual's response to interventions.
4. Expected outcomes can be favorably influenced by the speed and quality of early interventions, the ongoing quality of care appropriate to trauma response, and the individual's capacity to use support and treatment. There is little trauma literature per se regarding outcomes for older adults, although we know from other mental health intervention studies that older people respond well unless overwhelming physical and mental conditions interfere. Such conditions are of course more frequent among older adults and thus constitute a special risk. This should be viewed as a challenge rather than an obstacle.

Interventions

1. In physically dangerous emergencies, getting the older person to a safe setting or treating them in place on an emergency basis is the obvious first step.
2. Once stabilization has been established and assessment of individual needs is underway, supportive provision of food and a comfortable place to rest in the company of familiar people is enormously reassuring to older adults, especially the frail. Familiar staff, along with family, neighbors, and friends, can provide support during early stages of intervention.
3. Immediate as well as ongoing interventions will depend on the character of the agency or organization involved and the capacity of their staff. At

minimum, staff should be trained in emergency first aid—(Red Cross classes are a useful place to start) and simple, supportive care.

4. Medical and mental health assessment may be rudimentary at first, but as soon as possible, competent and qualified staff should be made available to all older clientele who need them. If such staff is not available, they will need to be enlisted, either from known contacts or through organizations providing “first responders” like the Red Cross, Visiting Nurse Asso. and the like. Staff should have a list of such responders on hand.

K. Referrals

1. Each agency or organization must decide which disaster or emergency services it is qualified to offer in-house and which ones require bringing in services or taking clients to such services. Obviously this requires knowledge of emergency services in the community.
2. Emergency services are simpler to locate than, for example, ongoing mental health care. During September 11, 2001, only those older persons with direct involvement at or near the New York World Trade Center were eligible for free mental health care. Others were simply referred to low cost clinics—a spotty and difficult to access resource at best. Those who could afford to pay the user-required 1/2 of the Medicare allowable fee for mental health care found that private mental health practitioners tended to be reluctant to treat older people, for a variety of reasons. Thus mental health care is a challenge and one that agencies may be forced to address with in-house group treatment, support groups and access to individual treatment, usually in very limited form, by social workers and other in-house staff.

L. Follow-up and evaluation of treatment

1. Treatment of older persons during disasters should ideally involve follow-up and evaluation of treatment effectiveness. This is important not only for understanding what happens to individuals over time, but also “what can we learn for the next time,” to build a trauma literature that reflects experience with older adults.
2. Some agencies may have the capacity to build follow-up and evaluation into their programs, while others do not have the experience or funds for research. Options may include locating and applying for disaster-oriented grants (funds for disaster preparedness and “homeland security” are growing) or offering research opportunities to nearby medical, nursing, or social work schools who may be interested in disaster work.

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Section III: Overview of Aging and Mental Health

Introduction: The current demographic trend in the nation's population indicates that as a society, we are aging. The elderly population in the United States is growing rapidly in comparison to younger age groups. The proportion of the country's population age 65 and older, currently 13%, is projected to be 20% by 2030. It has also become evident that not only is the population aging, but also that most older adults can expect to develop one or more chronic illnesses with which they may live for many years, often with physical and psychological symptom distress and progressive functional dependence and frailty. As a result, the hospital presence of older adults is greater than their numbers in the general population. In 1995, for example, although only 13% of the population was older than 65, 38% of hospital admissions and 49% of hospital days were for persons over 65 years of age. These proportions have been growing and will increase sharply beginning in 2010, when the first of the Baby Boom generation turns 65.

In addition to physical disability, older people are at increased risk of serious mental illness, particularly depression and anxiety, in the face of bereavement, living alone, weak social supports, anxiety, physical function deficits and limitation of activities. Prevalence ratios of clinically significant depression have been estimated to be in the region of 10 to 15% of the general elderly population. Clinically significant depression refers to depressive symptoms of severity sufficient to warrant clinical intervention. Negative life events, particularly bereavement of loved ones, often precipitates episodes of depression. Risk for anxiety disorders also increased in elders who have been exposed to losses related to aging, such as physical frailty and death of a loved one. Anxiety symptoms have been reported to be near 40% among geriatric patients enrolled in in-patient and outpatient geriatric services.

This section of the curriculum introduces the learner to some of the key principles of gerontology and geriatric mental health which will lay the foundation for the more specific discussion of disaster-related individual and community mental health outcomes contained in Section IV.

Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Define terms used by practitioners in mental health and aging
- Distinguish between normal psychological changes of aging and mental illness
- Identify the continuum of long-term care for the elderly and the national, state and local network of aging
- Describe the cultural factors impacting on the well-being of older adults.
- Articulate spiritual dimensions of well-being in later life
- Delineate social factors contributing to well-being in late life
- Describe economic conditions impacting on older adults' well-being

Attitudes

- Describe individual and societal attitudes toward aging, older adults and mental health
- Differentiate between myths, stereotypes and realities of aging & mental health
- List three attitudes that the provider should be aware of in order to deliver culturally competent care

Skills

- Describe age specific risks to mental health of older adults
- Administer three geriatric mental health screening tools
- Demonstrate the incorporation of 3 cultural factors into an initial assessment
- Demonstrate the inclusion of 2 spiritual dimensions in an initial assessment
- Demonstrate the inclusion of 3 psychosocial factors in an initial assessment
- Demonstrate the inclusion of 2 economic or financial considerations into an initial assessment

Curricular Content

A. Definition of Terms

1. Introduce terms and definition used by practitioners in mental health and aging, Handout # 1.
2. Discuss how disasters and emergencies have led to the development of new terms and definitions especially as they relate to mental health, Handout #2.
3. Discuss “normal aging” in the context of mental health
4. Introduce the concepts of “psychological/psychiatric vulnerability” vs. “mental illness/ psychopathology” in older persons
5. Introduce the concepts of incidence and prevalence of mental illness
 - a) Examples: In the context of epidemiological and demographic information, describe the major mental health problems in older persons including dementia, delirium, depression, functional psychosis, and anxiety states
 - b) Discuss the relationship between illness and age changes
 - c) Define the Continuum of Long Term Care (Handout #3)

B. Most common mental health problems and related issues in older persons

1. Discuss most common types of mental health problems
 - Dementia
 - Depression with features unique to various life cycle stages
 - Functional disorders
 - The role of anxiety with increased age and relation to later life depression
 - The search for social and psychological causes of changes in functioning aside from physical problems

C. Diagnosis and assessment of mental health and related issues in older persons

1. Using the Aging Network Handout, describe the process of assessment, including an introduction to the concepts of social history, environmental analysis, Activities of Daily Living (ADL) and caregiver mental health risk
 - Learners are not diagnosticians
 - Learners may be screeners
 - Learners are always observers
 - Importance of psychological and neuropsychological testing to determine changes in memory and cognitive functioning
2. Introduction to commonly used instruments including tests for depression, cognitive functions, and functional abilities

- a) The Continuum of Long Term Care. Using Handout # 3, map the continuum of long-term care and discuss referral sources and criteria for eligibility for services along the continuum.
- b) Discuss the role of the health care provider as referral source for mentally frail older persons

D. Psychosocial Factors that Impact the Well-being of Older Adults

1. Background

- a) The relationship between psychosocial factors and health and well being in later life are well demonstrated. (1) Psychosocial and cultural factors influence differences in illness behavior between older and younger persons. (2) These differences in illness behavior interact with age-related physiologic organ change leading to delayed or altered disease presentation. (3) Variation in disease presentation and co morbidity profiles gives rise to different trajectories of recovery and clinical outcomes. These observations have led to “non-medical supports” to be viewed as important to health providers’ goals of maintaining and improving patient outcomes. Geriatric assessment, then, should include the client’s social, psychological, spiritual, cultural, and economic situation and history since it is an interdisciplinary area of practice. (Clipp and Howe, 2004). (4) There is a strong relationship between a low level of social support and both Post Traumatic Stress Disorder (PTSD) and depression. After a disaster, a low level of social support has been shown to be related to PTSD and depressive symptoms. (Galeo et al, Psychol. “Sequelae of the September 11 Terrorist Attacks in New York City”, 2002, NEJM, 346: 982-987)
- b) In settings specializing in geriatrics, there is often an interdisciplinary geriatrics team comprised of a physician, social worker, nurse, and often other professionals such as a pharmacist, nutritionist, psychologist, and rehabilitation specialist. Team members work together to undertake a comprehensive geriatric assessment (CGA) and develop a care plan aimed at enhancing function and quality of life. The scope of CGA is broad and addresses many dimensions.

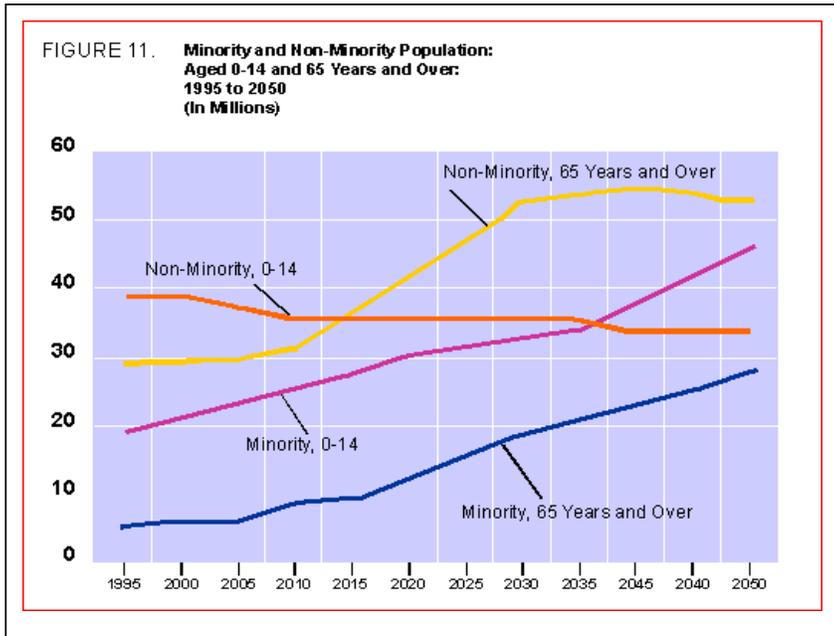
All members of the team should be qualified to expand the non-medical aspects affecting well-being. However, the social worker is particularly qualified to expand on these components, including social interaction and support, spiritual beliefs, community and financial resources, environmental, and cultural considerations, all factors likely to influence the clients’ present and future functioning.

If psychosocial needs go unmet through misdiagnosis, lack of detection, treatment or follow-up, older adults are at risk of further health problems resulting in decreased quality of life, reduced independence, physical deterioration, and the need for more intensive and expensive care.

2. Cultural Considerations

- a) In the future the percentage of minority elders will increase substantially, making it particularly important that health providers be sensitive to the culture of the client. The following table points to these projections

TABLE 1



http://business.rutgers.edu/rventures/Minority_Marketplace/minority_marketplace.html
accessed May 10, 2005.

Minority persons constitute the fastest growing segment of the older population, which is aging rapidly. The number of minority elderly is expected to increase more than 500% by the middle of the next century, from 4.3 million persons in 1990 to 22.5 million by the year 2050. Whereas minority elders currently represent only 10% of all older adults, they will account for more than 15% of older persons by 2020 and more than 21% of older persons by 2050. Although Whites will continue to represent the majority of the aged population, minority elderly will change the face of aging in America. (<http://socrates.berkeley.edu/~aging/ModuleMinority1.htm#anchor234883> accessed May 10, 2005.)

- b) “Culture” is defined as “the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people”. A culturally competent health professional is able to provide health care in ways that are acceptable and useful to older persons because it is congruent with

their cultural background and expectations. In delivering culturally competent care, it is important that the provider be aware of his or her own values and attitudes when relating to older persons, particularly those of a different racial or cultural background.

Flexibility and skill in responding and adapting to different cultural contexts enhances patient care. Issues that need to be considered in the patient-provider relationship to avoid misunderstandings are listed in Table 2.

TABLE 2

<p style="text-align: center;">Cultural Considerations for the Provider to be Aware of When Treating an Older Adult</p> <ul style="list-style-type: none">➤ Language and cultural barriers between providers, patients, and patients' families.➤ Explanatory models of illness.➤ Dietary habits.➤ Medication compliance.➤ Alternative (non-Western) practices (e.g. herbal medicines)/belief in existence of non-biomedical illnesses or in the efficacy of scientific treatments.➤ Role of religion, with ethical dilemmas of life-sustaining interventions conflicting with religious beliefs.➤ Cultural attitude of some communities and families concerning expectations that patients should be cared for at home.➤ Western emphasis on "independence" as a goal of therapy.➤ Unrealistic expectations.➤ Different expectations as to entitlement to good medical care.➤ Difficulty establishing trusting relationships.➤ Ignorance of how the American medical system works and lack of skills in navigating it.➤ Patient is unable to verbalize his or her symptoms in detail. (Clipp and Howe, 2004)
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3. Spiritual Considerations
 - a) Health care providers need to consider the spiritual dimension of healthcare and seek to establish a more compassionate and integrated system of care. Spirituality is the dimension of a person that seeks to find meaning in his or her life. Spirituality is a multidimensional construct that encompasses religion, spiritually based practices, coping, prayer, relationships with self, dietary restrictions, care philosophies, and other healing modalities. Findings suggest that gender and race may influence older person's spiritual practice and expression.

4. Social Factors

Social support system

- Informal network – this includes individuals such as family, friends, and neighbors with whom the older person is in contact. Exchange can be emotional, financial, and/or instrumental and may be reciprocal – provides social interaction as well as services
- Formal support system – this includes social welfare and health care delivery programs such as home health aides, medicare personnel and means-on-wheels. Medicare and Social Security are programs that provide financial assistance to older people. (www.medicare.gov and www.socialsecurity.gov)
- Semi-formal support system – this includes organizations such as church groups, clubs, neighborhood groups that the older person must initiate participation in because of interest in the activities offered.

Social support measurement instruments include:

- Norbeck Social Support Questionnaire
- Lubben Social Network Scale
- 3 important questions if formal instruments are too time-consuming or not practical for other reasons:
 - ✓ Does the patient have anyone to contact when he or she needs help and who is that person?
 - ✓ How many relatives other than children does the client feel close to and with whom does he or she have contact at least once a month?
 - ✓ How many friends does the patient feel close to and have contact at least once a month?

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Section III: Overview of Aging and Mental Health

5. Economic Domain

Economic considerations are a key component in an older person's quality of life. In an **economic assessment**, the primary goal is to determine if the older person will be hindered in a treatment plan because of financial circumstances.

Older people may not be aware of or signed up for services and programs that they are eligible for such as Medicaid, drug plans, senior centers, meal services, and transportation. Social workers are trained to link clients with services and should be consulted to assist in securing needed resources.

E. The Aging Network

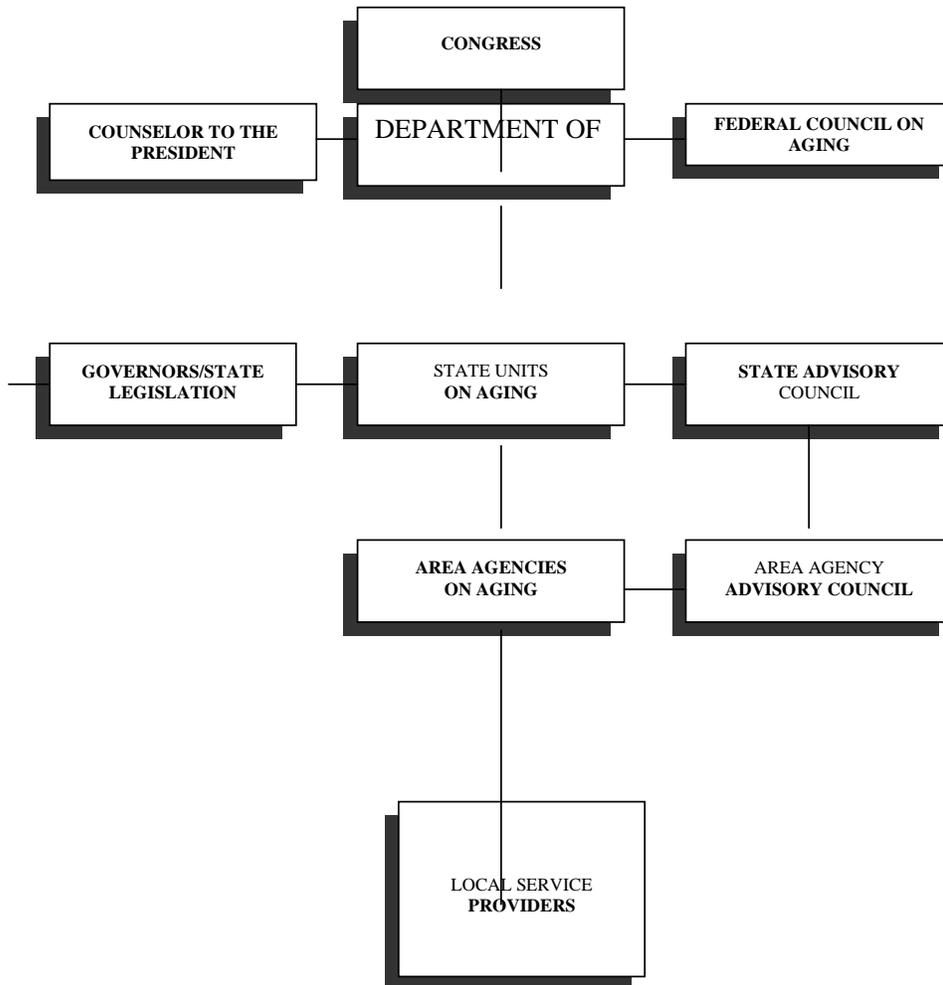
Professionals and other health care workers in health and social services use the terms "network on aging" or aging network" quite loosely, assuming that everyone understands what this network is. The most effective way to explain the complexities of how health care, including mental health care, service programs are developed and sustained is to review the network at all levels:

National/Federal, State, Area-Wide/Local, Direct Services AND Consumers.

Review Handout #7 and describe the key components of the Network.

Handout # 7

NATIONAL NETWORK ON AGING



Source: Toner, J. (1989). Long-term care service coordination: The evolving continuum. In D. Infeld & J. Kress (Eds.), Learning the continuum, AUPHA modules for management education. Arlington, VA: Association of University Program in Health Administration.

Resources

Bioterrorism and Emergency Readiness Competencies for All Public Health Workers.
<http://www.nursing.hs.columbia.edu/institute-centers/chphsr/btcomps.pdf>

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Handout # 1

Glossary of Terms

Activities of daily living (ADLs). Self-maintenance skills such as dressing, bathing, toileting, grooming, eating, and ambulating.

Affective lability. Rapidly changing or unstable expressions of emotion or mood.

Agnosia. Loss or impairment of the ability to recognize, understand, or interpret sensory stimuli or features of the outside world, such as shapes or symbols.

Aphasia. Prominent language dysfunction, affecting the ability to articulate ideas or comprehend spoken or written language.

Apraxia. Loss or impairment of the ability to perform a learned motor act in the absence of sensory or motor impairment (e.g., paralysis or paresis).

Cognition. The conscious faculty or process of knowing, including all aspects of awareness, perception, reasoning, thinking, and remembering.

Cognitive functions. Mental processes, including memory, language skills attention, and judgment.

Comprehensive mental status examination. Assessment of multiple cognitive functions that provides a detailed cognitive profile of the patient.

Confrontation naming. The ability to name an object when shown a picture of it.

Delirium. A temporary disordered mental state, characterized by acute and sudden onset of cognitive impairment, disorientation, disturbances in attention, decline in level of consciousness, or perceptual disturbances.

Dementia. A syndrome of progressive decline in multiple areas (domains) of cognitive function eventually leading to a significant inability to maintain occupational and social performance.

Direct costs. The expense of diagnostic, treatment, and care services.

Effect size. A summary statistic that provides an index of the ability of a screening or test instrument to discriminate between, in this case, persons with and without dementia.

Episodic memory. Memory of one's own experiences that is unique and localizable in time and space.

Executive functions. Goal formulation, planning, and execution of plans.

Factor analysis. A statistical procedure that is designed to determine if variability in scores can be related to one or more factors that are reliably influencing performance.

False-negative. Erroneous finding of not having a particular medical condition (e.g., dementia) for a person who does have it.

False-positive. Erroneous finding of a particular medical condition (e.g., dementia) for a person who does not have it.

Focused history. A patient history confined to questions designed to elicit information related to cognitive impairment or a decline in function consistent with dementia and to document the chronology of the problems.

Focused physical examination. A physical examination that seeks to identify life-threatening or rapidly progressing illness, while paying special attention to conditions that might cause delirium. The examination typically includes a brief neurological evaluation as well as assessment of mobility and of cardiac, respiratory, and sensory functions.

Further assessment. An additional evaluation, concluded after the initial assessment and intended to clarify information gleaned from that assessment, for the purpose of making a decision about the presence of a dementing disorder.

Incremental validity. The notion that information from multiple, reliable sources enhances the validity of the assessment.

Indirect costs. The expense of morbidity (the value of lost or reduced productivity—of a patient, an unpaid caretaker, or both—caused by illness) and mortality (the present value of future earnings lost because of premature death from disease).

Initial assessment (for dementia). An evaluation conducted when the patient, clinician, or someone close to the patient first notices or mentions symptoms that suggest the presence of a dementing disorder. This evaluation includes a focused history, focused physical examination of mental status and function, and consideration of confounding and comorbid conditions.

Instrumental activities of daily living (IADLs). Complex, higher-order skills such as managing finances, using the telephone, driving a car, taking medications, planning a meal, shopping, and working in an occupation.

Meta-analysis. Any systematic method that uses statistical analysis to integrate data from a number of independent studies.

Nonreversible dementias. Term used to distinguish cognitive disorders that cannot be treated effectively to restore normal or nearly normal intellectual function from those that can.

Polypharmacy. The administration of many drugs together.

Praxis. The doing or performance of an action, movement, or series of movements.

Procedural memory. Memory for certain ways of doing things or for certain movements.

Psychometric. Relating to systematic measurement of mental processes; psychological variables such as intelligence, aptitude, and personality traits; and behavioral acts.

Reversible dementias. Term used to distinguish cognitive disorders that can be treated effectively to restore normal or nearly normal intellectual function from those that cannot.

Semantic memory. What is learned as knowledge; it is timeless and spaceless (e.g., the alphabet or historical data unrelated to a person's life).

Sensitivity (of a test instrument). Ability to identify cases of a particular medical condition (e.g., dementia) in a population that includes persons who do not have it. Also called diagnostic sensitivity.

Specificity (of a test instrument). Ability to identify those who do not have a particular medical condition (e.g., dementia) in a population that includes persons who do have it. Also called diagnostic specificity.

Standard deviation unit. A measure of an approximate average of the amount by which each number in a set deviates from the mean of the set. The most commonly used measure of dispersion of statistical data.

Vascular dementia. Dementia with a stepwise progression of symptoms, each with an abrupt onset, often in association with a neurologic incident. Also called multi-infarct dementia.

Visuospatial ability. Capacity to produce and recognize three-dimensional or two-dimensional figures and objects.

Word fluency. Ability to generate quickly a list of words that all belong to a common category or begin with a specific letter.

Source: Costa, P., Williams, T., Somerfield, M., et al.. Recognition and Initial Assessment of Alzheimer's Disease and Related Dementias. Clinical Practice Guideline No. 19. Rockville, MD: US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. AHCPR Publication No. 97-0702. November 1996. pp. 95-97; pp. 93-94.

Acronyms

ADLs	Activities of daily living
AHCPR	Agency for Health Care Policy and Research
AIDS	Acquired immunodeficiency syndrome
ALS	Amyotrophic lateral sclerosis
APA	American Psychological Association
ApoE	Apolipoprotein E
BIMC	Blessed Information-Memory-Concentration (Test)
BOMC	Blessed Orientation-Memory-Concentration (Test) (also “short OMC”)
CERAD	Consortium to Establish a Registry for Alzheimer’s Disease
CES-D	Center for Epidemiological Studies Depression Scale
CSDD	Cornell Scale for Depression in Dementia
CUSPAD	Columbia University Scale for Psychopathology in Alzheimer’s Disease
DSM-IV	<i>Diagnostic and Statistical Manual of Mental Disorders.</i> Fourth edition.
FAQ	Functional Activities Questionnaire
GDS	Geriatric Depression Scale
HAM-D	Hamilton Depression Rating Scale
HIV	Human immunodeficiency virus
IADLs	Instrumental activities of daily living
ICD-9-CM	International Classification of Diseases, 9 th revision, Clinical Modification
MMSE	Mini-Mental State Examination

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**NINCDS-
ADRDA**

National Institute of Neurological and Communicative
Disorders and Stroke-Alzheimer's Disease and Related
Dementias Association

Source: Costa, P, Williams, T., Somerfield, M., et al.. Recognition and Initial Assessment of Alzheimer's Disease and Related Dementias. Clinical Practice Guideline No. 19. Rockville, MD: US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. AHCPR Publication No. 97-0702. November 1996. pp. 95-97; pp. 93-94.

Glossary

Acute Treatment. Formally defined procedures used to reduce and remove the signs and symptoms of depression and to restore psychosocial function.

Adequate Treatment Analysis. Analysis of data in terms of the relationship between the number of patients who received a predetermined minimum amount of treatment and the number who responded.

Agoraphobia. A disorder characterized by a fear of open, public places or of situations where crowds are found.

Anhedonia. An absence of or the inability to experience a sense of pleasure from any activity.

Behavioral Therapy. A form of psychotherapy that focuses on modifying observable problematic behaviors by systematic manipulation of the environment.

Bipolar Disorder. A major mood disorder characterized by episodes of major depression or mania or hypomania, formerly called manic-depressive psychosis, circular type. The diagnosis of bipolar I disorder requires one or more episodes of mania. The diagnosis of bipolar II disorder requires one or more episodes of hypomania and is excluded by the history or presence of a manic episode. Current episode may be manic, depressed, hypomanic, or mixed manic type.

Clinical Management. Education of and discussion with patients and, when appropriate, their families about the nature of depression, its course, and the relative costs and benefits of treatment options. It also includes assessment and management of the patient while in treatment, along with resolution of obstacles to treatment adherence, monitoring and management of treatment side effects, and assessment of outcome.

Cognitive Therapy. A treatment method that focuses on revising a person's maladaptive processes of thinking, perceptions, attitudes and beliefs. Cognitive therapy has been developed for different specific disorders, including depression.

Completer Analysis. Analysis of data in terms of the relationship between the number of patients whose condition improved and the number who completed the treatment protocol.

Continuation Treatment. Treatment designed to prevent the return of the most recent mood episode.

Cyclothymic Disorder. A mood disorder of at least 2 years' duration characterized by numerous periods of mild depressive symptoms not sufficient in duration or severity to meet criteria for major depressive episodes interspersed with periods of hypomania. Some view this condition as a mild variant of bipolar disorder.

Dementia. A group of mental disorders involving a general loss of intellectual abilities, including memory, judgment, and abstract thinking. There may be associated poor impulse control and/or personality change. Dementias may be progressive, reversible, or static and have a variety of causes.

Dysthymia. A mood disorder characterized by depressed mood and loss of interest or pleasure in customary activities, with some additional signs and symptoms of depression, that is present most of the time for at least 2 years. Many patients with dysthymia go on to develop major depressive episodes.

Electroconvulsive Therapy. A treatment method usually reserved for very severe or psychotic depressions or manic states that often are not responsive to medication treatment. A low-voltage alternating current is sent to the brain to induce a convulsion or seizure, which accounts for the therapeutic effect.

Hypomania. An episode of illness that resembles mania, but is less intense and less disabling. The state is characterized by a euphoric mood, unrealistic optimism, increased speech and activity, and a decreased need for sleep. For some, there is increased creativity, while others evidence poor judgment and impaired function.

Intent-to-Treat Analysis. Analysis of data in terms of the relationship between the number of patients randomized to treatment and the number whose condition improved.

Interpersonal Psychotherapy. A time-limited psychotherapeutic approach that aims at clarification and resolution of one or more of the following interpersonal difficulties: role disputes, social isolation, prolonged grief reaction, or role transition. The patient and therapist define the nature of the difficulty and work to its resolution.

Maintenance Treatment. Treatment designed to prevent a new mood episode (e.g., depression, mania, hypomania).

Major Depressive Disorder. A major mood disorder characterized by one (single) or more (recurrent) episodes of major depression, with or without full recovery between episodes.

Mania. An episode of illness usually seen in the course of bipolar I disorder and characterized by hyper excitability, euphoria, and hyperactivity. Rapid thinking and speaking, agitation, a decreased need for sleep, and a marked increase in energy are nearly always present. During manic episodes, some patients also experience

hallucinations or delusions. Manic episodes can also be caused by selected general medical disorders.

Melancholic Features. Symptoms usually found in severe major depressive episodes, including marked loss of pleasure, psychomotor retardation or agitation, weight loss, and insomnia.

Mood Disorders. A grouping of psychiatric conditions that have as a central feature a disturbance in mood (usually profound sadness or apathy, euphoria, or irritability). These disorders may be episodic or chronic.

Obsessive-Compulsive Disorder. A condition that is characterized by the presence of obsessions and/or compulsions. Obsessions are recurrent, intrusive thoughts—usually irrational worries—that often necessitate behaviors to prevent untoward consequences (e.g., fears of contamination from dirt requiring the individual to wear gloves at all times). Compulsions are recurrent behaviors beyond the normal range that the individual feels compelled to undertake, usually to preserve personal safety, to avoid embarrassment, or to perform adequately (e.g., checking multiple times to see that the gas is turned off before leaving home). The disorder affects 1 to 2 percent of the population.

Open Trial. A trial of a treatment in which both patient and practitioner are aware of the treatment being used.

Panic Disorder. An anxiety disorder characterized by discrete intense periods of fear and associated symptoms. Panic disorder may be accompanied by agoraphobia.

Remission. A return to the asymptomatic state, usually accompanied by a return to the usual level of psychosocial functioning.

Somatization Disorder. A disorder characterized by multiple, often long-standing somatic complaints of bodily dysfunction (e.g., pain complaints, gastrointestinal disturbances). The disorder usually begins before the age of 30 and has a chronic, albeit fluctuating, course.

Supportive Therapy. Psychotherapy that focuses on the management and resolution of current difficulties and life decisions using the patient's strengths and available resources.

Symptom Breakthrough. The return of symptoms in the course of either continuation or maintenance phase treatment.

Vegetative Symptoms. A group of symptoms that refer to sleep, appetite, and/or weight regulation.

Source: Depression Guideline Panel. Depression in Primary Care: Volume 1. Detection and Diagnosis. Clinical Practice Guideline, Number 5. Rockville, MD, US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, Publication Number 93-0550. April 1993. pp. 101-103)

Handout # 2

Glossary of Terms

The following is an abridged version of a Center for Mental Health Services glossary explaining terms often used in disaster mental health response. The reader may encounter these (and other) words and acronyms while reviewing literature on disaster response recovery.

Center for Mental Health Services (CMHS)

CMHS is a center within the Substance Abuse Mental Health Services Administration (SAMHSA) and located in Rockville, Maryland. CMHS advises the Federal Emergency Management Agency (FEMA) on disaster mental health. SAMHSA is part of the Department of Health and Human Services (DHHS).

Community Mental Health Organization (CMHO)

A CMHO is the administrative agent that contracts with the state mental health authority to provide mental health services to clients in a specified service area, usually covering one or more counties. CMHOs are either state-run or private, not-for-profit agencies. Most CMHOs may be classified as one of three categories: (1) freestanding psychiatric outpatient clinics, (2) freestanding partial care organizations, or (3) multi-service mental health organizations that emphasize outpatient services but also serve persons in partial care services and/or in inpatient/residential treatment services.

Crisis Counseling Assistance and Training Program

The Crisis Counseling Assistance and Training Program (commonly referred to as the Crisis Counseling Program) is funded by the Federal Emergency Management Agency (FEMA) through the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 93-288 as amended by Public Law 100-707). Services offered by the Crisis Counseling Program involve direct interventions, as well as crisis counseling to individuals and groups impacted by a major disaster or its aftermath. Educational activities and public information on disaster mental health issues are another component of the Crisis Counseling Program. In addition, disaster mental health consultation and training are also provided.

The Crisis Counseling Program includes two separate funding mechanisms: Immediate Services (IS) and Regular Services (RS). States must apply for the IS within fourteen calendar days after the Presidential disaster declaration. FEMA may fund the IS for up to sixty-days after the declaration date. The RS is designed to provide up to nine months of crisis counseling services, community outreach, and consultation and education services to people affected by the disaster. Although states must submit an application for RS funds to FEMA within sixty-days of the disaster declaration, the RS funding is awarded through CMHS based on a formal review of the grant application.

Emergency Services and Disaster Relief Branch (ESDRB)

ESDRB is the branch within the Division of Program Development, Special Populations and Projects of CMHS, that provides disaster mental health technical assistance to FEMA and the State Mental Health Authority during the IS. A project officer is assigned to the state for RS and monitors the program. ESDRB is located at 5600 Fishers Lane, Room 17C-20, Parklawn Building, Rockville, Maryland 20857. The telephone number is 301-443-4735. FAX 301-443-8040.

Federal Emergency Management Agency (FEMA)

Lead Federal agency in disaster response and recovery. The Stafford Act provides the authority for the Federal government to respond to disasters and emergencies in order to provide assistance to save lives and protect public health, safety, and property. Provides funding for crisis counseling grants to state mental health authorities following Presidentially declared disasters.

Indigenous Workers

Crisis counselors who come from within the local community, cultural, or ethnic group that is targeted for crisis counseling services. They are members of , familiar to, and recognized by their own communities. They may be spouses of community leaders, natural leaders in their own right, or have a nurturing role in their communities. Examples of indigenous workers may also include retired persons, students, active community volunteers, etc. Indigenous workers may or may not have formal training in counseling or related professions; they may be paraprofessionals or professionals.

Major Disaster

The following definition comes from Section 102 of The Robert T. Stafford Disaster Relief and Emergency Assistance Act. “Major disaster means any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought) that in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act to supplement the efforts and available resources of states, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.”

Outreach

Outreach is a method for delivering crisis counseling services to disaster survivors and victims. It consists primarily of face-to-face contact with survivors in their natural environments in order to provide disaster-related crisis counseling services. Outreach is the means by which crisis counseling services are made available to people.

Paraprofessional

People who work as crisis counselors and have a bachelor’s degree or less in a specialty that may or may not be related to counseling are referred to as paraprofessionals. They have strong intuitive skills about people and how to relate well to others. They possess good judgment, common sense, and are good listeners. Paraprofessionals may or may not

be indigenous workers. Paraprofessionals will do outreach, counseling, education, provide information and referral services, and work with individuals, families, and groups. Successful programs train the paraprofessionals regarding the human response to disaster and methods for working with people who are experiencing the psychological sequelae of disasters.

Professionals

People who have advanced degrees in psychology, social work, counseling, and related professions. Advanced degrees are at a master's level or higher. They have experience in the mental health or counseling fields and the experience and expertise to provide clinical supervision and training to crisis counselors. Typically, a professional coordinates and supervises the local outreach team for the Crisis Counseling Program. In addition, the professional may provide crisis services directly or offer consultation and support to crisis counselors who are working with complex or difficult situations. They clinically evaluate clientele to determine whether their needs exceed the scope of the Crisis Counseling Program or they may work directly with individuals, families, and groups whose problems are unusually challenging or complex.

Professionals often need training on how crisis counseling with disaster survivors differs from traditional mental health or counseling practice. An in-depth understanding of the normal human response to disaster and techniques for helping survivors integrate these experiences in ways that help them return to pre-disaster levels of functioning are essential.

Special Populations

Special populations are targeted group in the disaster-impacted community or area with unique needs and require specific attention by the crisis counseling program. Examples of special populations include the following: children, the elderly, ethnic and cultural groups, migrant workers, severely mentally ill/seriously emotionally disturbed (SMI/SED--for disaster-related issues only), the homeless, etc. Other special populations may be identified that are unique to the area being served by the Crisis Counseling Program.

Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act)

The Stafford Act is the legislation that enables Federal emergency response and services to be provided following a disaster. Section 416 authorizes the President to provide Crisis Counseling Assistance and Training for disaster victims following Presidentially declared disasters.

State Mental Health Authority (SMHA)

The lead state government organization for providing mental health services is referred to as the SMHA. Because this organization may be a department, division, or branch depending on the state government system, CMHS and FEMA use the acronym SMHA to denote the lead mental health organization.

Substance Abuse Mental Health Services Administration (SAMHSA)

The Department of Health and Human Services houses SAMHSA which is divided into three centers: Center for Mental Health Service (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). CMHS provides the technical assistance to FEMA for the crisis counseling program.

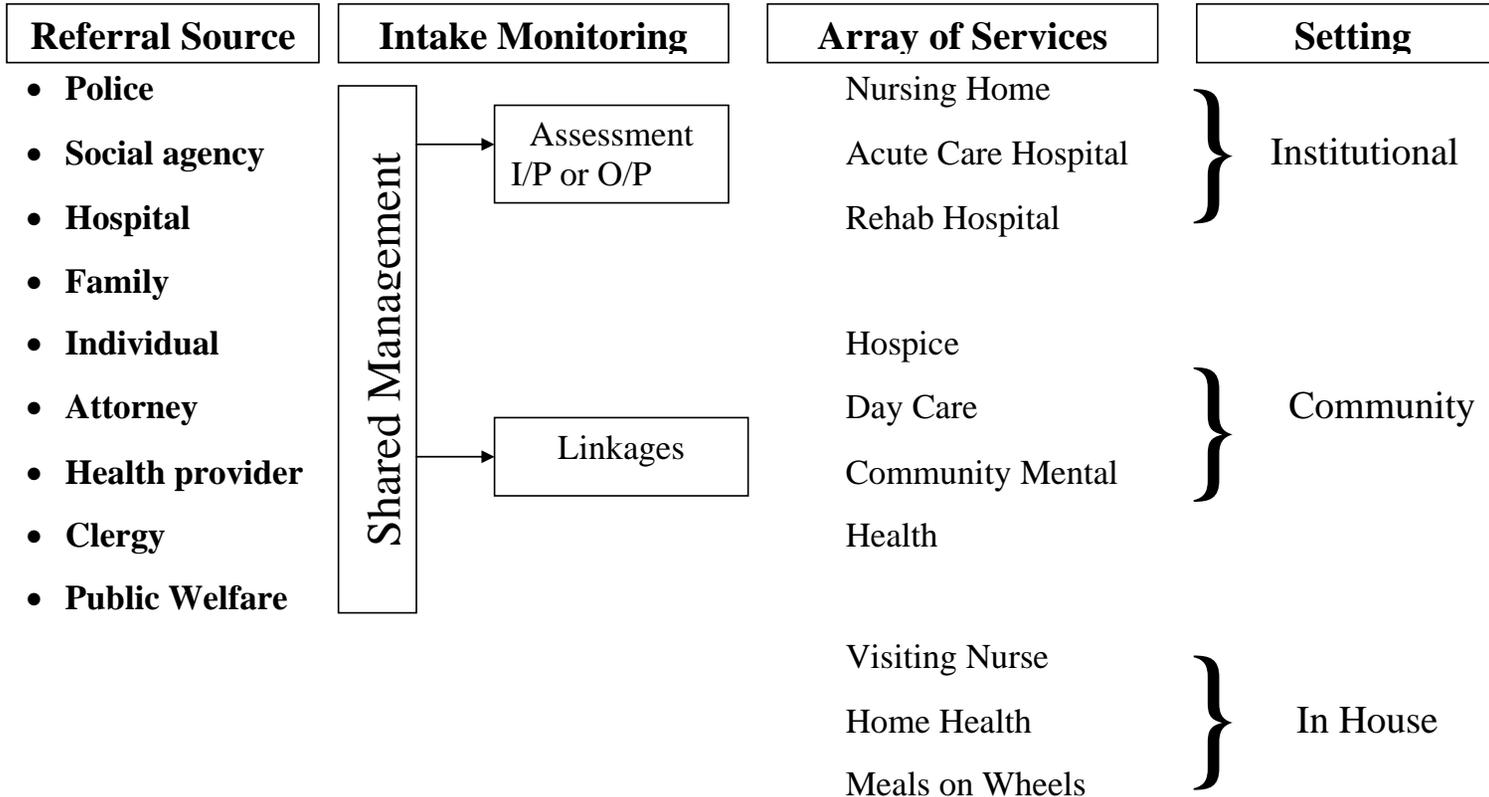
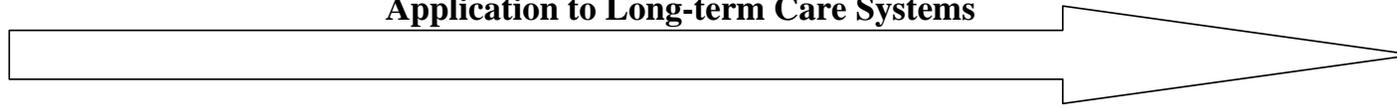
National Voluntary Organizations Active in Disaster (NVOAD)

NVOAD is a group of voluntary organizations that have made disaster response a priority. State VOADs also exist and can direct local organizations and governments to resources within their area. If unable to determine the state VOAD coordinator, contact the national VOAD coordinator at 301-270-6782.

Source: Psychosocial Issues for Older Adults in Disasters, DHHS Publication #. ESDRB SMA 99-3323.

Handout #3

Developing a Versatile Curriculum for Application to Long-term Care Systems



Toner, J. (1989). Long-term care service coordination: The evolving continuum. In D. Infeld & J. Kress (Eds.), Learning the continuum, AUPHA modules for management education. Arlington, VA: Association of University Program in Health Administration, p. 9.

Section IV: Geriatric Mental Health and Disasters: Individual and Community Mental Health Outcomes

Introduction: Mental health and social service providers in a variety of settings reported a growing sense of anxiety among their older clients in the aftermath of September 11, 2001 and during the war in Iraq. These concerns may be even more marked for certain older cohorts such as holocaust survivors and veterans, who may be particularly susceptible to the effects of later traumatic events, such as terrorist attacks. For instance, after the Oklahoma City bombing, World War II, Korean War, and Vietnam War veterans reacted by experiencing more symptoms than before the bombing. Prevalent symptoms included depression, general distress, posttraumatic stress disorder (PTSD) syndromes and memories of the war experience (Monson, 2003).

More recently, Americans were profoundly affected by the heavy loss of life, widespread destruction of property, and evacuation-related hardship experienced by those in the paths of Hurricanes Katrina and Rita. It is important to note that older adults appear to have been disproportionately affected by these storms. A Knight Ridder analysis of Katrina victims, for example, found that 74% of the dead were 60 or older. Nearly half were over 75. Many of those were at nursing homes and hospitals, where nearly 20% of the victims were found.

This section of the curriculum identifies and discusses a range of normal reactions typically experienced by older adults during and after traumatic events such as terrorist attacks and natural disasters. It also provides a comprehensive outline of pathological responses which require prompt assessment and treatment.

Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Identify the various types of normal vs. pathological reactions to disasters
- **Describe anticipated reaction to immediate threats, situational and long term effects.**
- Discuss normal grief responses as they apply to physical, cognitive, behavior, and social behavior
- Differentiate between symptoms of acute stress and post traumatic stress disorders and understand the variable course, presentation and functional impairment associated with each
- Appreciate the relationship between underlying psychopathology and the impact of disasters on relapse and exacerbation of symptoms.

Attitudes

- Recognize that mental disorders in the elderly are treatable and intervention may be life-saving
- Understand the concept of cumulative lifetime trauma in the context of disasters in such groups as combat veterans and Holocaust survivors
- Realize that unique affective, behavioral, cognitive and perceptual disturbances that present during disasters

Skills

- Recognize the clinical features of delirium, depression, dementia and anxiety disorders
- Diagnose the major mental disorders presenting in the elderly during and after a disaster
- **Incorporate understanding of normal vs. pathological reactions to disasters into assessment of older adults**

Curricular Content

A. Normal vs. Pathological Reactions to Disasters

1. Definition of normal reaction vs. pathological reaction to disasters
“However much they may vary in terms of intensity and origin, disasters tend to follow certain patterns. In terms of emotional reactions of those affected, disaster phases are classified as follows” (National Institute of Mental Health, 1983)

According to Substance Abuse & Mental Health Services Administration (SAMHSA), a wide range of reactions to disaster can be expected in the over sixty-five population, just as it can be expected among other age groups. (p. 25) The maxim no one who has seen a disaster is unaffected by it is especially true of older persons many whom may take anywhere from a few days to several months merely to sort out the details of their experiences during the emergency

Apathy or helpless stoicism may be among the likely reactions, based largely on the attitude that they will never be able to recover or replace losses ranging from property damage to death of friends or family. (P.27-28).

Warning and Threat Phase

Impact Phase

Rescue or Heroic Phase

Remedy or Honeymoon Phase

Inventory Phase

(See SAMHSA Psychosocial Issues for Older Adults in Disasters pp. 7-9)

Cooperstein (1999), states of PTSD – “its essential features include intrusive and avoidance symptoms, and symptoms of hyper-arousal, for greater than 1 month and causing clinically significant distress or impairment in the important life areas”. (An Outline for the Identification and Treatment of Post Traumatic Stress Disorder)

Cook (2003), affirms “It is well documented that persons who have a history of severe and prolonged trauma, such as exposure to combat, captivity, or torture, may continue to experience physical and mental health problems as they age. Possible psychiatric consequences include depression, anxiety, and symptoms of posttraumatic stress disorder (PTSD). Given the neurochemical, neurological, and neuropsychological impairments that appear to accompany PTSD several investigators have suggested that severe and prolonged trauma or a history of PTSD may place aging individuals at increased risk of cognitive decline and onset of dementia.”

2. Key concepts of disaster mental health (SAMSHA Field Manual for Mental Health and Human Service Workers in Major Disasters)
 - No one who sees a disaster is untouched by it.
 - There are two types of disaster trauma – individual and community.
 - Most people pull together and function during and after a disaster, but their effectiveness is diminished.
 - Disaster stress and grief reactions are normal responses to an abnormal situation.
 - Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.
 - Most people do not see themselves as needing mental health services following disaster and will not seek such services.
 - Survivors may reject disaster assistance of all types.
 - Disaster mental health assistance is often more practical than psychological in nature.
 - Disaster mental health services must be uniquely tailored to the communities they serve.
 - Mental health workers need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.
 - Survivors respond to active, genuine interest, and concern.
 - Interventions must be appropriate to the phase of the disaster.
 - Social support systems are crucial to recovery.

3. Anticipated Reaction to:
 - a. Immediate threat – may experience sudden terror and feel overwhelmingly vulnerable.

 - b. Situational effects – Depending of the loss experienced and scope of the disaster emotional reactions to trauma are likely to include anxiety, depression, anger, difficulties in concentration, short-term memory loss, sleep disorders, feelings of isolation from family and familiar patterns of life, and regressive behavior (p. 39-40 – SAMHSA handbook)

 - c. Long-term effects – According to the NIMH (1994) anniversary events “can generate mixed reactions of memory and grief, introspection and

reflection, and relief and pride in having survived the first year” (p. 40

SAMHSA handbook)

4. Normal grief responses (physical, cognitive, behavioral, social reactions) see Table 1.

Older persons’ sense of smell, touch, vision, and hearing are likely to be less acute than that of the general population causing potential difficulties in emergencies. (see pp. 25-27 SAMHSA Psychosocial Issues Handbook)

- Sensory Deprivation
- Delayed Response
- Chronic Illness and Dietary Consideration
- Multiple Loss Effect
- “Welfare” Stigma and Unfamiliarity with Bureaucracy
- Hyper/hypothermia Vulnerability
- Transfer Trauma
- Language and Cultural Barriers

The Voices of Wisdom videotape (Project COPE, 1992b) offers older adults recovering from a major disaster the following advice:

- Physical reactions to a disaster are normal.
- Acknowledging our feelings helps us recover.
- Asking for what we need can help heal us.
- Focusing on our strengths and abilities will help.
- Accepting help from community programs is healthy.
- We each heal at our own pace.
- We each have different needs and different ways to cope.

5. Complicated/pathological grief reactions

Referral to mental health and other health care professional are made as workers encounter survivors with severe disaster reactions or complicating conditions. The following reactions, behaviors, and symptoms signal a need for the worker to consult with the appropriate professional and, in most cases, to sensitively refer the survivor for further assistance. (Taken from SAMHSA Field Manual for Mental Health and Human Service Workers in Major Disasters pp. 13-14)

- Disorientation – dazed, memory loss, inability to give date or time, state where he or she is, recall events of the past 24 hours or understand what is happening.
- Depression – pervasive feelings of hopelessness and despair, unshakable feelings of worthlessness and inadequacy, withdrawal from others, inability to engage in productive activity

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Section IV - Geriatric Mental Health and Disasters: Individual and Community Mental Health Outcomes

- Anxiety – constantly on edge, restless, agitated, inability to sleep, frequent frightening nightmares, flashbacks and intrusive thoughts, obsessive fears of another disaster, excessive ruminations about the disaster
- Mental Illness – hearing voices, seeing visions, delusional thinking, excessive preoccupation with an idea or thought, pronounced pressure of speech (e.g., talking rapidly with limited content continuity)
- Inability to care for self – not heating, bathing or changing clothes, inability to manage activities of daily living
- Suicidal or homicidal thoughts or plans
- Problematic use of alcohol or drugs
- Domestic violence, child abuse, or elder abuse

TABLE 1
Complicated Pathological Grief Reactions

Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
<ul style="list-style-type: none"> - Withdrawal and isolation - Reluctance to leave home - Mobility limitations - Relocation adjustment problems 	<ul style="list-style-type: none"> - Worsening of chronic illnesses - Sleep disorder - Memory problems - Somatic symptoms - More susceptible to hypo-and hyperthermia - Physical and sensory limitations (sight, hearing interfere with recovery) 	<ul style="list-style-type: none"> - Depression - Despair about losses - Apathy - Confusion, disorientation - Suspicion - Agitation, anger - Fears of institutionalization - Anxiety with unfamiliar surroundings - Embarrassment about receiving "hand-outs" 	<ul style="list-style-type: none"> - Provide strong and persistent verbal reassurance - Provide orienting information - Use multiple assessment methods as problems may be under reported - Provide assistance with recovery of possessions - Assist in obtaining medical and financial assistance - Assist in reestablishing familial and social contacts - Give special attention to suitable residential relocation - Encourage discussion of disaster losses and expression of emotions - Provide and facilitate referrals for disaster assistance - Engage providers of transportation, chore services, meal programs, and home health, and home visits as needed

B. Differential Diagnosis of Mental Disorders in the Elderly in Disasters

(The Process of Assessment, Handout #1)

1. Clinical unifying themes
 - a. Concept of new onset, relapse or uncovering of underlying psychopathology
 - Vulnerability and frailty of segments of the geriatric population
 - Disruption of equilibrium and homeostasis by disasters
 - Extent of pre-morbid physical and psychological pathology as risks for decompensated functioning in disasters
 - Regression and use of inadequate coping strategies
 - Non adherence to treatment plans
 - b. Intensity of affective response unique to disasters
 - Fear, terror, helplessness
 - Rage
 - Guilt, survivorship
 - Despair, depression, hopelessness
 - c. Behavioral disturbances
 - Psychomotor agitation, withdrawal
 - Verbal and physical violence
 - Self-harm, suicidal thinking
 - Attention or help seeking
 - Avoidance, isolation, withdrawal
 - d. Cognitive disturbances
 - Confusion, bewilderment, “stunned” response
 - Impaired memory, concentration, or global impairment
 - Disorganization of thought process
 - Psychotic thought content, delusional beliefs
 - Somatic preoccupation
 - e. Perceptual disturbances
 - Auditory hallucinations
 - Visual, tactile hallucinations
2. Rationale behind differential diagnostic process
 - a. Disorders and syndromes tend to overlap
 - b. Avoidance of premature diagnosis
 - c. Organic, medical problems and delirium need to be ruled out first as they

may be life-threatening
3. Acute Stress Disorder
 - a. Exposure to a traumatic event

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- Threat of death, serious injury or threat to physical integrity of others
- Response involved intense fear, helplessness or horror

- b. Dissociative symptoms
 - Numbing, detachment, absence of emotional response
 - Reduced awareness of surroundings
 - Derealization
 - Depersonalization
 - Dissociative amnesia

- c. Re-experiencing the traumatic event
 - Recurrent images, thoughts, dreams
 - Distress on exposure to reminders of the event
 - Reliving the experience

- d. Avoidance of stimuli
 - i. Human contact
 - ii. Sensory stimuli
 - Hot, cold or inclement weather
 - iii. Intellectual stimuli
 - Radio
 - Television

- e. Anxiety and arousal
 - Sleep disturbances
 - Poor concentration, cognitive decline
 - Startle response
 - Hyper vigilance and reactivity to reminders

- f. Disturbance lasts at least 2 days up to 4 weeks and occurs within 4 weeks
of the traumatic event

- g. Reactivation of previous traumatic experiences
 - Combat veterans
 - POWs
 - Holocaust survivors
 - Victims of natural disasters
 - Victims of abuse

- h. Risk factors
 - Severity of exposure
 - Symptom profile
 - Loss of family, friends, housing, finances
 - Prior physical or psychiatric illness

4. Post Traumatic Stress Disorder (PTSD)
 - a. Differentiate between acute and post traumatic stress disorders
 - PTSD-duration more than 1 month
 - Acute PTSD less than 3 months
 - Chronic PTSD- 3 months or more
 - b. Exposure to a traumatic event
 - Intense fear, helplessness or horror
 - Actual or threatened death, serious injury or threat to physical integrity
 - c. The event is re-experienced
 - Recurrent and intrusive distressing recollections of the event through images, thoughts or perceptions
 - Recurrent distressing dreams
 - Flashbacks
 - Psychological distress at exposure to internal or external cues that remind of the event
 - d. Avoidance and numbing of responsiveness
 - Avoiding thoughts, feelings, conversations
 - Avoiding activities, places, people that arouse recollections
 - Inability to recall important aspects of the event
 - Diminished interest in pleasurable activities
 - Detachment
 - Sense of foreshortened future
 - e. Increased arousal
 - Difficulty falling or staying asleep
 - Irritability
 - Cognitive impairment (pseudo-dementia)
 - Hyper vigilance
 - Exaggerated startle response
 - f. Significant clinical distress or impairment in function
 - g. Symptoms can be intermittent, persistent, time-limited or chronic
 - h. The elderly do not appear more predisposed to develop PTSD than younger population
 - i. Current PTSD severity appears to be related to cumulative lifetime trauma in studies of Holocaust survivors

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- j. WWII veterans admitted for other major psychiatric disorders
 - 54% had prior PTSD
 - 27% had current PTSD in addition to other major psychiatric disorder
 - k. The elderly may likely have some features of PTSD and show significant functional impairment
5. Delirium or Acute Confusion States
- a. Community elderly are at risk for delirium
 - b. Vulnerability of the frail elderly in the community
 - Inadequate self-care or supervision
 - Compromised nutrition, hydration, electrolyte disturbances
 - Improper medication administration
 - Excess sedative, analgesics, digoxin, steroids
 - Failure to take thyroid hormone
 - Unwitnessed falls, trauma
 - Inadequate management of diabetes, Chronic Obstructive Pulmonary Disease (COPD)
 - Hypoxia
 - Substance abuse
 - Alcohol (ETOH)
 - Sedatives
 - Intoxication and withdrawal
 - Infections
 - Urinary Tract Infection(UTI)
 - Pneumonia
 - Influenza
 - Dangerous behavior
 - c. Clinical features of delirium
 - Acute mental status change
 - Inattention
 - Global cognitive impairment
 - Withdrawal, agitation or mixed presentation
 - Perceptual disturbances-visual, tactile hallucinations
 - d. Delirium is a medical emergency with over 15% mortality from all causes
6. Dementia
- a. Vulnerability
 - Trauma does not cause dementia but can exacerbate symptoms of cognitive impairment due to increased anxiety, lack of care and available supervision

Geriatric Mental Health: Disaster Preparedness and Response Curriculum

Section IV - Geriatric Mental Health and Disasters: Individual and Community Mental Health Outcomes

- Community elderly with early phase of dementia may significantly worsen in disaster setting
 - b. Clinical features
 - Global cognitive impairment with gradual deterioration over years
 - Memory
 - Language
 - Spatial orientation
 - Predisposition to delirium
 - Attention usually unaffected until late stages
 - c. Dementia of the Alzheimer's Type
 - Over 50% of all dementias
 - Patients have a linear decline in function usually over 8-10 years
 - 40% of population over 80 year olds have some form
 - d. Vascular or multi-infarct dementia
 - 35% of dementia cases
(The remaining 15% is Alzheimer's Disease and associated disorders.)
 - Shows a stepwise deterioration in function
 - Associated with multiple medical risk factors
 - Hypertension
 - Diabetes
 - CVA, vascular disease, heart disease
 - e. Victims of prior trauma such as veterans of combat, Holocaust survivors

may have uncovering of PTSD symptoms with the onset of cognitive decline.
 - Behavioral disturbance may relate to nature of traumatic experience. For example, combat veterans with dementia are more likely to be aggressive and violent.
7. Depression
- a. Vegetative disturbances of PTSD such as insomnia and loss of appetite are

found in depressive illness and may be co-morbid
 - b. Clinical features of major depression
 - Persistent feelings of intense sadness or emptiness
 - Anhedonia, inability to experience pleasure
 - Disturbance of sleep, appetite and sexual drive
 - Marked ambivalence and diminished energy
 - Indecisiveness
 - Sense of guilt, hopelessness and helplessness

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- Suicidal thinking
 - c. These symptoms are common features of PTSD but are persistent
 - d. Major depression is a recurrent disorder and can likely be triggered or uncovered by disaster trauma
 - e. Bipolar mania and depression can also be triggered by trauma
8. Somatoform disorders
- a. Co-morbid with anxiety and depression in the elderly
 - b. Need to differentiate from psychotic depression with somatic delusions
 - c. Preoccupation with one or a list of physical symptoms
 - Headache
 - Chronic pain
 - Gastrointestinal distress
 - d. Risk of excessive reliance on opiate analgesics and sedatives
 - e. Over-utilization of emergency rooms and repeated visits to primary care MDs
 - f. Depression and anxiety often overlooked - just “complainers” or “difficult patients”
 - g. Psychologically distressed, frightened, in need of attention and care
 - h. Somatization, hypochondriasis, conversion disorders
9. Schizophrenia and Psychotic disorders
- a. Review of the clinical features
 - Positive and negative symptoms
 - Thought disorder
 - Co-morbid physical illness and cognitive impairment
 - b. Functional status and need to review treatment plans and providers in the community

Geriatric Mental Health: Disaster Preparedness and Response Curriculum

Section IV - Geriatric Mental Health and Disasters: Individual and Community Mental Health Outcomes

- c. Risk for relapse in disasters
 - Paranoid delusions
 - Hallucinations
 - Functional impairment

- 10. Other anxiety disorders
 - a. Differentiate panic anxiety with its discreet episodes
 - b. Chronic, generalized anxiety
 - c. Phobias
 - d. May be difficult to discern in the context of PTSD
 - e. Understand the risk of increased substance and ETOH use
 - f. Timely referral for medical evaluation of anxiety which may be a

manifestation of
 - Coronary artery disease
 - COPD and hypoxic states
 - Excessive caffeine, stimulant use

Changes in Function

- 1. Disturbance causes clinically significant distress
 - a. Impaired functioning and self-care
 - b. Vulnerability of frail and marginally functioning elderly
 - c. Regressive behavior
 - d. Impairment of Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)

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Further Reading:

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Case 1 – Mrs. C.

Time 1 - Acute Stress Disorder

Mrs. C is a 62-year old Dominican female who was brought by her son to the psychiatric emergency room on the evening of the September 11, 2001 terrorist attack. That morning, as had been her routine, she was serving coffee and doughnuts from her stand a few blocks from the Trade Towers. She had heard the explosion of the first plane and remembers that she stood nearly paralyzed as people began to jump from the tower to their death. She does not recall how she made her way home to Corona, Queens. She knows she was nearly trampled in the wave of people rushing from the area. “I think someone took hold of me and we just kept walking over the bridge.”

Once home she was inconsolable and said she kept seeing the bodies falling from the sky. She screamed nearly continuously despite her son’s efforts to calm her. In the emergency room, she begged the staff to help the images of the falling bodies go away. She feared closing her eyes when she would again see the images of horror.

On examination in the ER, the staff agreed that they had never seen anyone as frightened as this woman. She appeared dazed and nearly catatonic with fear.

Time 2 - Post Traumatic Stress Disorder

Mrs. C returns to the outpatient mental health clinic after 1 year. After initial referral for treatment consisting of supportive therapy and short-term trial of an SSRI, she had stopped coming to the clinic. During this time, she has been unemployed like so many others who had worked in the shadows of the World Trade Towers. She refuses to go near Ground Zero and avoids any discussion of the 9/11 tragedy. When she sees images of the Towers on the television, she quickly changes the channel.

Most nights she has nightmares of the bodies falling from the buildings. At most, she sleeps 3-4 hours per night. She is riddled with chronic anxiety and prefers to stay in her apartment. She fears that she is “going crazy”. She feels that the world is a different place and often feels apart and different from others. She rarely smiles and finds little enjoyment in usual pleasures like the company of her family.

She has developed a chronic pain in her lower back and is applying for disability without success. Her 63-year old husband also lost his job as a laborer in downtown Manhattan.

The treatment team urges her to reestablish outpatient counseling and medication to relieve her symptoms.

Case 2

Mr. R is an 80-year old WWII veteran who was diagnosed with paranoid schizophrenia at age 29. He has been living at an adult home and reliably was adherent with medication and treatment programs which included supportive therapy and group activities. He had not been hospitalized for his psychiatric illness for over 15 years.

The adult home staff sent him to the psychiatric emergency room 4 weeks after the 9/11 terrorist attacks. For days after the attacks, he had followed the television coverage of the attacks and then was noted to retreat into his room, becoming more isolated and uncharacteristically withdrawn. Mr. R had a recurrence of vivid auditory hallucinations of 2 men plotting to blow up the residence. He was convinced that a terrorist group now was persecuting him and he would die in a matter of hours. He stopped his medication as he was convinced it was poisoned and refused to eat for similar fears. He required inpatient hospitalization for safety.

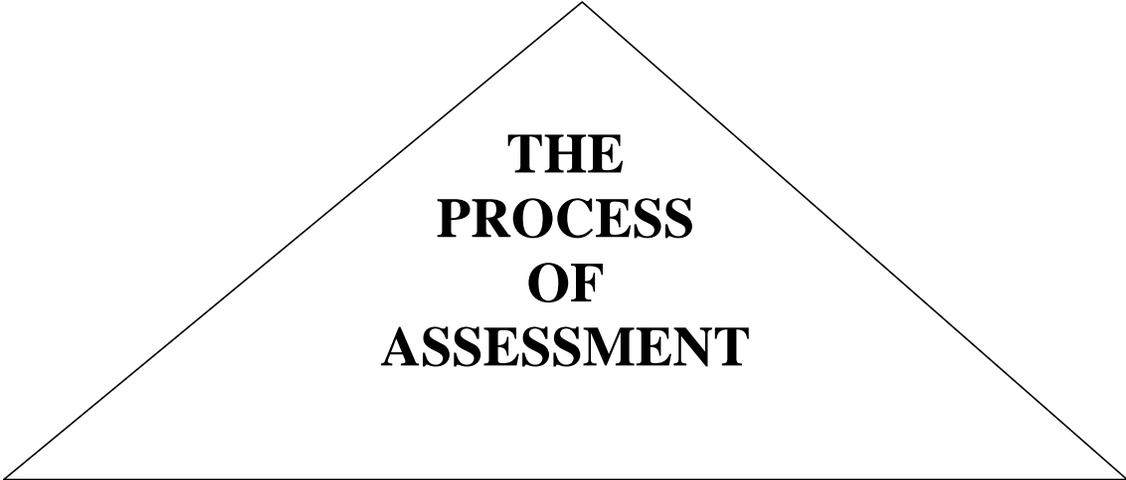
Case 3

Mrs. G is an 84-year old female living at home with 24-hour home attendant services. She has been diagnosed with dementia, probably Alzheimer's type, 3 years previously. She is a Holocaust survivor, having lost her parents and 2 siblings in the concentration camps. She made her way to the United States after the war, married and raised 2 children. She suffered from chronic depression but was able to work and care for her family. Her husband died 5 years ago from lung cancer. Her 2 children live within an hours drive from her and visit on a weekly basis. They have been concerned that she may need nursing home placement.

Mrs. G has become increasingly paranoid and believes that her home attendant is a Nazi prison matron. She has been more restless and aggressive, striking out at the home attendant. She rarely sleeps, paces her room like a caged animal and screams that she is being held prisoner. The home attendant agency feels that they can no longer provide attendants.

In the psychiatric ER, a locked unit, her agitation worsens in the presence of the security staff. She is inconsolable and demands to be released.

Handout #1



**THE
PROCESS
OF
ASSESSMENT**

ELICITING

- Obtaining Information
- Interviewing
- Testing

CLASSIFYING

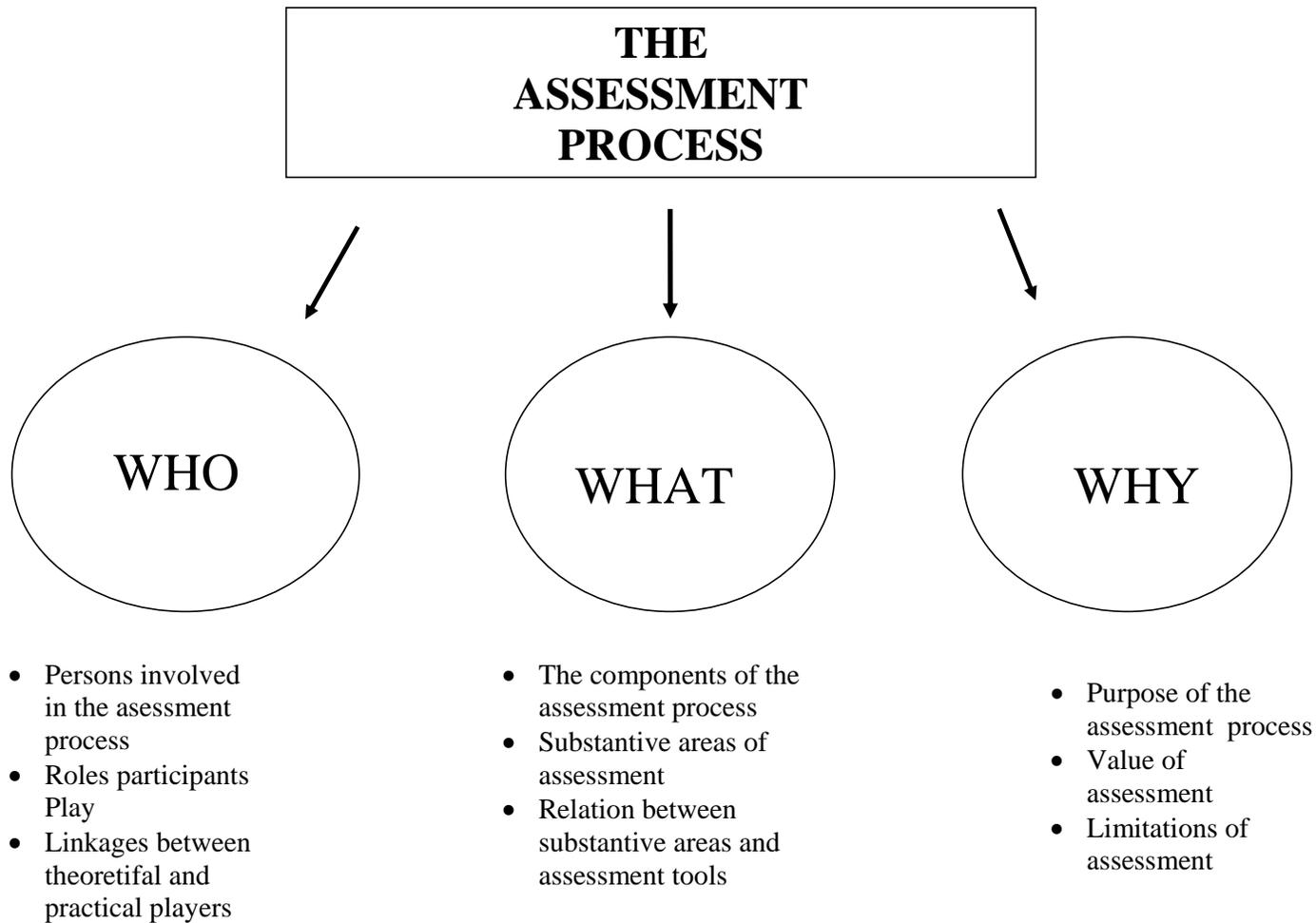
- Identifying Crucial Information
- Weeding Out Unnecessary Information

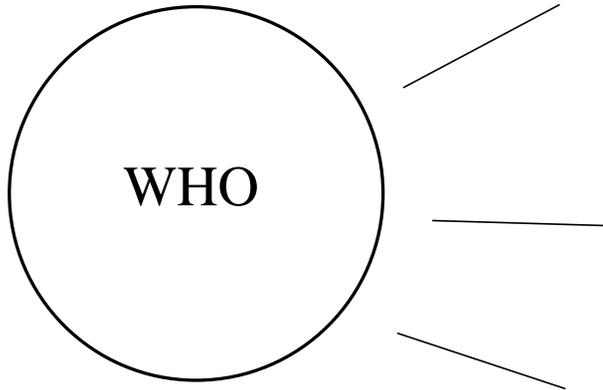
RECORDING

- Locating Appropriate Forms
- Recording Information on Forms

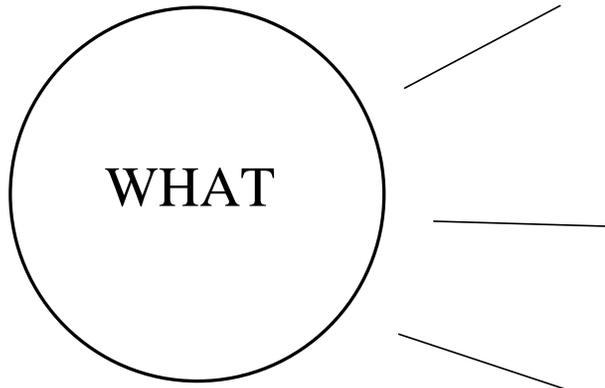
INTEGRATING

- Synthesis of Information
- Formulating Treatment Decisions





1. PATIENT / CLIENT
2. PRACTITIONERS
 - PHYSICIANS
 - NURSES
 - SOCIAL WORKERS
 - THERAPY AIDES, ETC...
3. GERIATRIC SPECIALISTS
 - PERSONS WHOSE RESPONSIBILITY FOCUSES ON PROBLEMS AND NEEDS OF THE ELDERLY
4. CASE MANAGERS
 - PERSONS RESPONSIBILITY FOR NEEDS ASSESSMENT AND ALLOCAITON OF RESOURCES TO THE ELDERLY PERSON
5. RESEARCHERS / PROGRAM EVALUATION SPECIALISTS
 - PERSONS RESPONSIBLE FOR DEVELOPING ASSESSMENT TOOLS, APPLYING TOOLS TO EXPERIMENTAL SETTINGS, USING TOOLS FOR PROGRAM EVALUATION, ETC...



1. PHYSICAL FUNCTIONING

- PHYSICAL HEALTH
- ACTIVITIES OF DAILY LIVING (ADL)
- INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

2. MENTAL FUNCTIONING

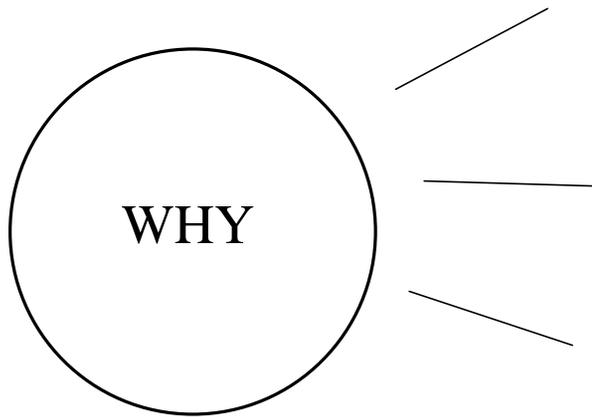
- METHODS OF MEASURING MENTAL FUNCTIONING
- ASSESSING COGNITIVE SKILLS
- ASSESSING AFFECTIVE FUNCTIONING
- ASSESSING GENERAL MENTAL HEALTH

3. SOCIAL FUNCTIONING

- IDENTIFYING THE SOCIALLY ISOLATED
- ASSESSING THE QUALITY OF SOCIAL INTERACTIONS
- ASSESSING NEED FOR SOCIAL RESOURCES

4. MULTIDIMENSIONAL ASSESSMENT

- PURPOSE OF MULTIDIMENSIONAL ASSESSMENT
- MULTIDIMENSIONAL ASSESSMENT TOOLS



1. PURPOSE

- DESCRIPTION
- SCREENING
- SYNTHESIZING
- MONITORING
- PREDICTION

2. VALUE

- PROVIDES INFORMATION ON HEALTH STATUS
- ASSISTS PRACTITIONER IN DETERMINING NEED FOR SERVICE
- PROVIDES INFORMATION ON THE EFFECTIVENESS OF SERVICES BEING DELIVERED

3. LIMITATIONS

- ASSESSMENT TOOLS ARE AIDS ONLY
- CLASSIFICATION OFTEN RESULTS IN LABELLING

Section V: Disaster Related Elder Mistreatment

Introduction: The elderly, especially those who are frail, face extraordinary physical and mental health challenges in the event of a disasters such as the New York World Trade Center attack and Hurricanes Katrina and Rita. In addition to the expected range of mental health consequences of possible future attacks, health care workers should remain vigilant for signs of disaster related elder mistreatment (DREM).

Elder Mistreatment (EM) is a serious and prevalent health problem that affects between 700,000-1.2 million Americans. EM is a complex phenomenon that is often hidden and extremely difficult to detect without specific advanced training. The syndrome typically can include abuse, neglect, exploitation and abandonment of an older person and often results in tragic outcomes for the older victims. Social stigma, fear of retribution, and shame are all examples of why there are barriers to reporting and intervening. The prevalence of EM is increasing with the aging of America, and without adequate training of health professionals and allied healthcare workers needless suffering will continue and potentially increase.

Although the focus of this section is on the mistreatment of elders in connection with disasters, many of the same abusive behaviors toward older and frail adults were unfortunately widespread in the Southeastern United States during and after Hurricanes Katrina and Rita.

Learning Objectives

At the conclusion of this session, the learner will be able to:

Knowledge

- Discuss the fundamental theoretical principles of elder mistreatment in different physical and social environments
- Describe the potential impact of disasters on physical and social geriatric environments leading to the vulnerability of older adult
- Identify and discuss risk factors of possible occurrence of elder mistreatment, abuse and neglect during and after disasters

Attitudes

- Realize that older adults require special consideration as they are more vulnerable to physical and psychological mistreatment
- Recognize the older adults' needs as they varies depending on their emotional, cognitive, physical, interpersonal and spiritual states
- Understand the role of the health care worker in identifying elder mistreatment during a disaster
- List three attitudes that the healthcare first responder or worker has to identify in order to assess for elder mistreatment during an act of terror or disaster

Skills

- Perform assessments of relative risk of elder mistreatment and neglect or abuse employing a logical, systematic approach
- Apply knowledge about disaster related elder mistreatment (DREM) to develop prevention, intervention, amelioration and follow up strategies as part of a preparedness initiative

Curricular Content

Definition and Typology of DREM

1. Disaster Related Elder Mistreatment refers to (a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm, during a time of terror.

During a disaster, such actions as: a) abuse, b) neglect, c) exploitation or d) abandonment, lead to trauma responses that can engender the life of the older adult. Disasters are serious traumatic events that can create new physical and psychological barriers, for older adults (Oriol, 1999).

DREM High Risk Situations

1. In analyzing DREM high-risk situations, the interaction between the elderly (victim of mistreatment) and a responsible actor (a trusted other, typically the caregiver) is commonly characterized by the victim's (change in health status, dependency, competencies) and those of the responsible actor (care burden, stress, financial dependence). Contextual risk factors, such as those referring to location (type of institution, at home, etc.), social relationship (e.g., spousal, adult child caregiver, formal role caregiver like lawyer, nurse), and the broader sociocultural context (defined by race, ethnicity, religion, region, urban/ rural location, and socioeconomic status), may set different generic levels of risk for the individuals embedded in them, especially when including the terror trauma factor
2. Risk Factors: It is possible to categorize risk factors for elder abuse into three general groups:
 - a. Risk factors validated by substantial evidence, for which there is unanimous or near-unanimous support from a number of studies. i.e. living arrangement; social isolation; dementia.
 - b. Possible risk factors, for which the evidence is mixed or limited.
 - c. Contested risk factors, for which potential for increased risk has been hypothesized, but for which there is a lack of evidence.
3. Among the high risk situations that need to be analyzed are the following:
 - a. Drug and alcohol addiction
 - b. Isolation
 - c. Psychiatric problems
 - d. Familial and caregivers stress
 - e. Dependence on stimulants
4. Some risk factors (preferably called "risk indicators") may be "markers" for unmeasured/unobserved causes (confounders); or risk factors may modify the

relationship between causal factors and elder mistreatment (effect modifiers). For example, depression in a caregiver may be a causal risk factor in that a depressed caregiver may be more likely to neglect the care of an elder by virtue of the fatigue, social withdrawal, and lack of interest associated with depression. Living with others has been associated with an increased probability of mistreatment. However, this may not be a direct causal relationship, because living with others is a contextual factor in which mistreatment is more likely to occur; it would be possible to reduce the risk of mistreatment by modifying other factors associated with living with others and not changing the living circumstances of the older person (which is often difficult and disruptive).

Needs Assessments – Baseline anticipations during and after disasters

1. An outline of a disaster event representative typology can guide the needs assessment by identifying the period/s of action (needs) for the healthcare professional when facing a mistreated older adult.
 - a. Incubation – long term warning stage of a disaster, could be prior or after the disaster.
 - b. Impact – upon occurrence of the disaster.
 - c. Immediate post-impact – priority action taken right after immediate first defense/ alert of impact.
 - d. Recovery – disaster relief (transitional shift towards reorientation).
 - e. Reorientation – resetting the clock and setting new guidelines, standards and benchmarks.

How older adults and their communities are affected by disasters is closely related to their capacities and vulnerabilities. Vulnerability is the degree to which people are susceptible to loss, damage, suffering and death. Being vulnerable generally comprises physical, economic, social, and or political weaknesses.

2. Awareness toward internal and external environment needs to be spear-headed by:
 - a. Emergency services (Ambulance Services, EMS, Fire Dept, Law Enforcement, Voluntary Services (VOAD's), Governmental and Social Services) should be aware and able to identify EM in a time of disaster or terror.
 - b. Care providers: 1) hospital and hospital-based services: OP, IP and ED; 2) Acute Nursing Care; 3) nursing homes; 4) Long-term care facilities; 5) Home health care providers; 6) food delivery services; 7) Outpatient health centers and clinics; 8) Day care and community centers, should also be able to identify EM especially post a disaster situation where elderly are more traumatized and vulnerable to abuse.

- Older adults exposed to physical, psychological or social maltreatment or abuse, will respond to disasters in a variety of ways, given the unique nature of individuals. Slower physical reaction times and sensory impairment will impact the response capacity. Older adults with cognitive impairment will be especially vulnerable and advanced care planning must take place. Table 1 shows older adult reactions to terror. More detail on older adults' needs assessment is provided in Table 3.

Table 1

Older Adult reactions to terror	
Emotional (feeling) reactions	feelings of shock, disbelief, anxiety, fear, grief, anger, resentment, guilt, shame, helplessness, hopelessness, betrayal, depression, emotional numbness (difficulty having feelings, including those of love and intimacy, or taking interest and pleasure in day-to-day activities)
Cognitive (thinking) reactions	confusion, disorientation, indecisiveness, worry, shortened attention span, difficulty concentrating, memory loss, unwanted memories, repeated imagery, self-blame
Physical (bodily) reactions	tension, fatigue, edginess, difficulty sleeping, nightmares, being startled easily, racing heartbeat, nausea, aches and pains, worsening health conditions, change in appetite, change in sex drive
Interpersonal reactions	neediness, dependency; distrust; irritability, conflict, withdrawal, isolation, feeling rejected or abandoned, being distant, judgmental, or over-controlling in friendships marriages, family, or other relationships.
Spiritual (meaning) reactions	wondering why, why me, where was God; feeling as if life is not worth living, loss of hope.

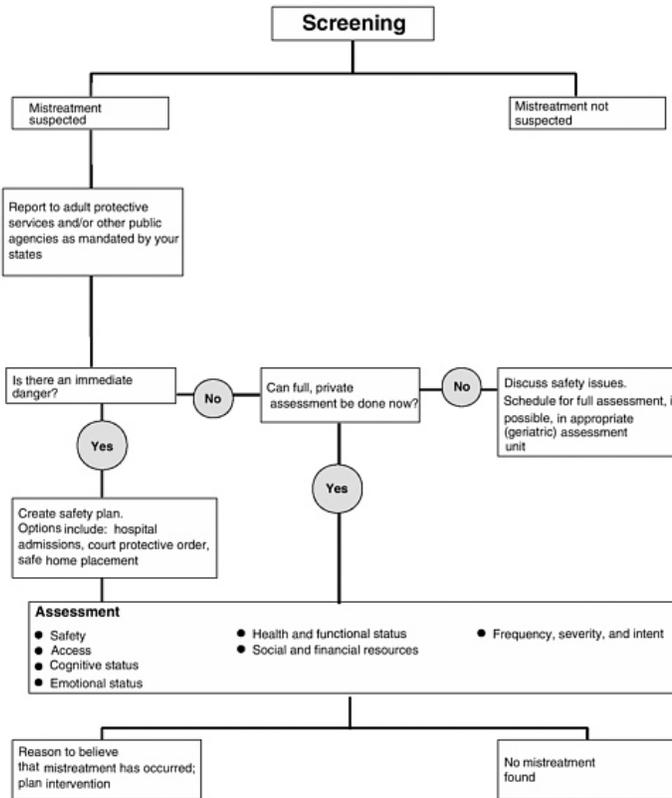
Adapted from Source: The International Society of Traumatic Stress Studies (ISTSS). Mass Disasters, Trauma, and Loss. [Web Page] 2005: Available at http://www.istss.org/terrorism/disaster_trauma_and_loss.htm (Accessed 20 February 2005).

Prevention & Ameliorative Strategies against DREM

- Prevention & Screening: In the case of DREM and elder mistreatment research doesn't show a specific set of guidelines to use as it is an area at it's infancy. But by following Table 2, the American Medical Association's (AMA) *Diagnostic and Treatment Guidelines on Elder Abuse and Neglect* (1992) an urge is noted of how to utilize protocol for the detection and assessment of elder mistreatment, following a "routine pattern". Implementation of such a structured protocol to DREM, however well intentioned, could be costly and counterproductive in the absence of careful planning and training to first responders and the health care workforce.

TABLE 2

Diagnostic and Treatment Guidelines on Elder Abuse and Neglect



SOURCE: American Medical Association (1992:13).

Planning and Management for DREM

1. Documentation of Indicators: An appropriate planning structure should be the platform to a detail oriented elder mistreatment assessment. Possible markers of neglect and abuse include bruises, pressure sores, fractures, burns, and abrasions are not the only identifiers of abuse. It is important to note and document every particular as a key to interpretation of these markers is not merely their presence but their characteristics—such as anatomic location, extent, morphology, severity, and multiplicity—which may help differentiate between an intentional injury and an avoidable one.
2. Intervention: Training and education for both health care personnel (clinical, behavioral, and forensic assessment) and the elderly individual would help identify circumstances that would constitute evidence of having been caused by the conduct (acts or omissions) of another person (abuser).

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Table 3

The American Red Cross and Center for Disease Control (CDC) have documented how after a disaster, an older adult may experience symptoms and disorders as outlined in Table 1. Thorough assessment by the clinician will ensure that older adults are diagnosed and triaged appropriately.

<p><i>Adapted from:</i> ¹ American Red Cross. <i>Special Needs & Concerns. Disaster Preparedness for Seniors.</i> American Red Cross [Web Page] 2005 Available at http://redcross.org/services/disaster/beprepared/seniors.html (Accessed 20 February 2005). ¹ Centers for Disease Control and Prevention (CDC). <i>Emergency Preparedness and Response.</i> [Web Page] CDC 2004; Available at http://www.bt.cdc.gov/ (Accessed 20 February 2005).</p>	
Table 6: Older Adult's Assessment Needs	
<p>1) Psychological and Emotional</p> <ul style="list-style-type: none"> A. Anxiety B. Fear C. Grief D. Denial E. Loss of emotional control F. Sense of Failure G. Blaming others or self H. Feeling overwhelmed I. Irritability, restlessness, over excitability J. Depression, moodiness, crying K. Anger, blaming L. Feelings of apathy, diminished interest in usual activities M. Feelings of isolation, detachment, estrangement N. Feelings of guilt about surviving O. Denial or constriction of feelings P. Flashbacks or unwelcome memories of the disaster Q. An exaggerated reaction to being startled R. Recurrent nightmares about the disaster or about other traumatic events S. Inability to fall or stay asleep T. Sleeping excessively 	<p>2) Physical</p> <ul style="list-style-type: none"> A. Difficulty breathing B. Shock symptoms C. Dizziness D. Profuse sweating E. Thirst F. Visual difficulties G. Clenching of jaw H. Rapid heart rate I. Headaches J. Weakness K. Nausea, upset stomach, other gastrointestinal problems L. Muscle soreness M. Hot or cold spells; sweating or chills N. Numbness or tingling in body parts O. Heavy feeling in arms and/or legs P. Feeling a "lump" in your throat Q. Chest pains R. Trouble catching your breath; rapid breathing S. Tremors T. Fatigue U. Increase in allergies, colds, or flu V. Heart palpitations W. Non-Specific aches and pains

Section VI: Geriatric Mental Health and Disasters: Clinical Response

Part One: Non-pharmacological approach

Introduction: It is virtually impossible to generalize on the subject of how a natural or "man-made" disaster will affect the psychological health of elders who are impacted by the trauma and shock of the event (or its aftermath). The geriatric population is remarkably heterogeneous, and thus general treatment recommendations and guidelines must be applied only in the context of a comprehensive geriatric assessment that can identify the individual patient's biological age, functional abilities, and cognitive status. In addition, comprehensive assessment of each disaster victim should address the psychological, emotional, environmental, spiritual and social domains which are key factors in maintaining and improving mental health outcomes for older patients.

The material in this section will explore the two main approaches, which are typically utilized in the clinical response to older adults who have survived a disaster, i.e. non-pharmacological and pharmacological strategies.

Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Discuss the concepts of successful aging, resilience, crisis, and human needs as they relate to older adults during a disaster.
- Describe the rationale for geriatric mental health screening and assessment.
- Discuss two interdisciplinary non-pharmacological approaches to mental health assessment.
- List one screening tool for cognitive impairment and one screening tool for depression in older adults.
- Delineate the immediate goals of stabilization of older emergency patients.
- Describe two common pre-existing medical problem in older adults.
- Describe why hospitalization can be a critical life event for the elderly.

Attitudes

- Understand the implications of successful aging, resilience, crisis, and human needs as they relate to older adults during a crisis.
- Appreciate the complex issues related to mental health conditions in the elderly and the need to screen for these conditions.
- Demonstrate awareness of the particularly vulnerable state of older people compared to younger people in an emergency situation.

Skills

- Apply knowledge of successful aging, resilience, crisis theory, and human needs in developing interventions which support older adults during a disaster.
- Conduct a screening for cognitive impairment and depression.

Curricular Content

A. Concepts related to Geriatric Mental Health

1. Successful Aging (Flood, 2002)
 - a. Definition: Having a sense of purpose, interactions with others, personal growth, self-acceptance, autonomy and health (Fisher & Specht, 1999).
 - b. Antecedents: The opportunity to age and the cognitive ability to evaluate his or her life and determine if they have successfully aged.
 - c. Consequences: Acceptance of one's life, ability to remain actively engaged physically, psychologically, and socially to the extent the person desires, and the ability to comfortably anticipate what lies beyond.
 - d. Defining Attributes: Desired or favorable outcomes, cumulative changes associated with physical deterioration and purpose and meaning in life.
 - e. Empirical referents which allow one to determine the existence of successful aging:
 - Life satisfaction
 - Physical ability
 - Spirituality
 - Gerotranscendence

Gerotranscendence is defined as a shift in meta-perspective, from a materialistic and rationalistic perspective to a more cosmic and transcendent one that accompanies the process of aging. It is a developmental process in which the individual gradually experiences a new understanding of fundamental existential questions, often experiencing a feeling of cosmic communion with the universe and a redefinition of the self and relationships with others (Tornstam, 1997). Gerotranscendence theory deals with the maturity and wisdom and the reconstruction of the identity through use of more mature patterns of

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coping, increased life satisfaction as a result of natural movement toward transcendence and the life crises that accelerate the process of gerotranscendence (Tornstam, 2000).

2. Resilience

- a. Definition: Ability to overcome the odds or make remarkably successful adaptations (Fraser, Richman, & Galinsky, 1999).
- b. Attributes: personal strengths, empathy, intellectual skills, hope and faith, insight, independence, love, initiative, morality, humor and creativity (Garmezy, 1993; Wolin & Wolin, 1993).
- c. Antecedents: Emotional support, strong role models, and religious affiliation (Grotberg, 1995).
- d. Defining Characteristics: Seek consistency, remain connected to human events, and search for spiritual meaning (Lifton, 1993). Processes of resilience include: belief systems (making meaning of adversity and having a positive outlook, transcendence and spirituality; organizational patterns (flexibility, connectedness, social and economic resources); and communication processes (clarity, open emotional expression, and collaborative problem solving).
- e. Consequences: Facilitates people's ability to overcome challenges of stressful life events and family transitions. Resilience is best comprehended by examining how people respond to stress across the life span (Gilgun, 1996).

3. Crisis

- a. Definition: Crisis has been defined as an acute emotional upset arising from situational, developmental, or social sources and resulting in a temporary inability to cope (Hoff, 1989). Crisis involves homeostatic balance (affective and cognitive functioning) and the relationship of coping processes to stable psychological functioning. When balances are upset, self-regulatory mechanisms are triggered that help the individual return these balances to healthy levels for that individual.

"Healthy balance requires stable psychological functioning with a minimum of dysphoric affect and the maintenance of reasonable cognitive perspective on experience and the retention of problem solving skill" (Baldwin, 1981, p. 44). An emotionally hazardous situation is when there is a change in the person's

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psychosocial environment that results in changes in relationships with others or expectations of the self and is perceived negatively (Caplan, 1964).

- b. Coping processes are self-regulatory mechanisms to facilitate the return of homeostatic balance following an emotionally hazardous situation. Coping is the process of mastery over a particular problematic situation (Baldwin, 1981, p. 44).
- c. Causes of Crisis: Crisis occurs when person is unable to use previously effective coping mechanisms or is unable to reduce stress using novel problem-solving approaches (Baldwin, 1981). Crisis is the result of an interaction of a stress event and a perceived lack of resources to overcome it or to accommodate to it (Silverman, 1977).
- d. Perspectives on Crisis: A crisis event can be viewed from two perspectives, that of a danger or that of an opportunity (Aguilera & Mesick, 1986).
- e. Areas of assessment for an individual in crisis (Caplan, 1971):
 - i. Reaction to stress: what is the ego's ability to maintain equilibrium when faced with a challenge.
 - ii. Problem solving methods: Are solutions to problems based on reality?
 - iii. Adjustment to reality: What coping mechanisms does the person usually use to maintain biopsychosocial homeostasis?
- f. Crisis Resolution occurs when an individual defines issues, deals with feelings, makes decisions or learns new problem solving or coping behaviors (Baldwin, 1981, p. 44). Underlying conflicts are partially resolved, and internal and external sources of support are mobilized. Uncomfortable feelings are reduced and the person returns to the pre-crisis level of functioning. Maladaptation occurs when people don't seek adequate help and deal with feelings and underlying conflicts go unresolved and the person is in a less adaptive state than pre-crisis level.
- g. Post-Crisis Adaptation: The individual learns new coping behaviors or problem solving skills and there may be growth and maturation. Maladaptation occurs if the individual becomes more vulnerable as a result of the crisis or has learned maladaptive behaviors.
- h. Corollaries of Crisis Theory
 - Each individual has a different tolerance for stress and emotional crises have no relationship to psychopathology.

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- Emotional crises are self-limiting events in which either adaptive or maladaptive crisis resolution occurs in 4 to 6 weeks.
 - During a crisis, psychological defenses are absent or weakened and the person has cognitive or affective awareness of material previously well-defended or less accessible. At this point, there may be enhanced awareness of feelings and memories.
 - During crisis, there is increased capacity for cognitive and affective learning because of the motivation produced by this state.
 - Adaptive crisis resolution frequently allows underlying conflicts to be resolved.
 - A small external influence during a crisis can lead to a disproportionate amount of changes in a short period of time.
 - The resolution of an emotional crisis is not necessarily determined by previous experience but is shaped by the unique socio-psychological influences operating in the present.
 - Each crisis involves actual or anticipated loss that must be reconciled as part of the resolution.
 - Every crisis is an interpersonal event involving at least one other person, directly, indirectly or symbolically.
 - Effective crisis resolution prevents future crisis of a similar nature by removing vulnerabilities of the past and increasing the scope of coping behaviors (Baldwin, 1981).
- i. Three types of crises as determined by their origin (Silverman, 1977):
- Physical-environmental in origin (fires, accidents, natural disasters)
 - Social-environmental in origin (discrimination, bioterrorism)
 - Personal in origin (marriage, birth, divorce).
- j. Six classes of crisis (Baldwin, 1981):
- Dispositional defined by distress resulting from a problematic situation.
 - Crisis of anticipated life transitions that reflect anticipated but usually normative, live transitions over which the person may or may not have control (ie. Retirement, becoming a parent).
 - Crisis resulting from sudden traumatic stress which is unexpected and uncontrolled and emotionally overwhelming (sudden death, rape)
 - Maturation/Developmental Crisis resulting an interpersonal situation that reflect a deeper struggle (sexual identity, power issues, dependency)
 - Crisis resulting from psychopathology which was pre-existent and instrumental in precipitating the crisis.
 - Psychiatric emergencies that result when functioning is severely impaired (Baldwin, 1981).

- k. The Process of Crisis Intervention
Most crisis intervention take place in 1 to 8 hours of therapy.

Stage 1: Catharsis/assessment

- Client expresses feelings related to crisis and explores meaning of the event. Therapist helps to restore realistic perspectives of the crisis and identify options or courses of action.

Stage 2: Focusing/contracting

- Client helped to develop an awareness of feeling that impair adaptive coping behaviors.
- Therapist develops a therapeutic alliance with client with encouragement on client responsibility for change.
- Therapist helps identify the core conflict and defines a time an goal for crisis resolution.

Stage 3: Intervention/resolution

- Therapist defines and support client's strengths and coping skills and is helped to work through feelings and learn new or more adaptive responses to stress. The therapist helps client to identify progress.

Stage 4: Termination/Integration

- Therapist elicits and responds to client termination issues and reinforces changes in client's coping behaviors and affective functioning. Therapist helps client of integrate adaptive changes and helps prepare the client to meet future similar situations more effectively. Therapist provides information about additional services or community resources.

4. Maslow's Hierarchy of Needs (Maslow, 1968, 1970)

- a. Maslow's hierarchy of human needs may be relevant to the prioritization of needs of individuals who have experienced an emergency or disaster. Maslow ranks order needs which he believes are critical to survival and proposes that one level of need must be met before needs at the next level can be met. In many situations, several needs may need to be addressed at the same time or a person may not perceive a specific need. Needs on any one level can be completely met, partially met, or not met at all. Socioeconomic status and cultural backgrounds may change the way a person rank orders their needs.
- b. Maslow's five levels of need in hierarchical order are:

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- i. physiologic needs (air, food, water, shelter, rest, and sleep)
 - ii. safety and security needs (physiological and psychological needs to be safe and feel safe)
 - iii. love and belonging needs (both giving and receiving love and affection, and belonging)
 - iv. self-esteem needs (feelings of independence, competence, and respect) and esteem from others.
 - v. self-actualization needs (person realizes their full potential and has the ability to connect the past and future to the present. Self-actualization can be seen as a product of maturity. People who are self-actualized may possess doubts and fears but are able to deal positively with their fears, doubt and failure.
- c. Application of Maslow's Hierarchy of Needs during a Disaster:
- i. Health professionals need to understand their own and other peoples needs and the relation between needs and human behavior, particularly during times of crisis and disaster.
 - ii. Knowledge of basic needs can:
 - provide a framework for assessing, assigning priorities to problems, and planning interventions;
 - alleviate distress; and
 - be applied to help people become aware of needs that are only partially met or unmet thereby assisting the individual to achieve a state of maximal function and well-being.

B. Geriatric Mental Health Screening and Assessment

(The Process of Assessment, Handout #1)

1. Screening Methods
 - a. Background: Screening services should help preserve health and enhance function in older adults. Screening should be for clinical problems where it has been demonstrated that early therapy is more effective than late therapy or no therapy at all. Screening recommendations from health care agencies (e.g. USPSTF) must be applied to an elderly patient based on age, other co-morbidities and wishes.

 - b. Incidence and Prevalence: At least 20% of persons older than age 65 years suffers from a mental disorder (Jeste DV, Alexopoulos GS, Bartels SJ, et al: Consensus statement on the upcoming crisis in geriatric mental health: research agenda for the next two decades. Archives of General Psychiatry 56: 848-853, 1999). That number will grow as the population ages; hence, the requirement for health care services will continue to grow. There is a substantial unmet need for these services. Older adults with mental disorders are more likely than younger adults to receive inappropriate or inadequate treatments (Bartels SJ: Quality, costs, and effectiveness of services for older adults with mental disorders: a selective

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overview of recent advances in geriatric mental health services research.
Current Opinion in Psychiatry, 15: 411-416, 2002)

- c. Cognition: The prevalence of dementia increases with age. It is estimated that up to 50% of people over age 85 years have the diagnosis of dementia. (Evans DA, Funkenstein H, Albert MS, et al. Prevalence of Alzheimer's disease in a community population of older persons. Higher than previously reported. JAMA. 1989; 261:921-923). Early dementia often remains undetected without specific screening. (McLean, S. Assessing Dementia. Part I: Difficulties, definitions, and differential diagnosis. Aust N Z J Psychiatry 1987; 21:142).
 - i. The USPSTF concluded that there is insufficient evidence for or against screening for dementia in older adults. (Screening for dementia: recommendation and rationale. Ann Intern Med 2003; 138: 925. Boustani, M, Peterson, B, Hanson L, et al. Screening for dementia in primary care: a summary of the evidence for the U.S. Preventive services task force. Ann Intern Med 2003; 138:927.)
 - ii. Despite medications available for slowing the progression of Alzheimer's disease, it has not been shown that early detection will improve outcome.
- d. Depression: Depression in older adults is often undiagnosed, and thus untreated, even though it is often treatable.
 - i. Depression significantly increases morbidity and mortality associated with many other illnesses. Depression is also associated with reduced functioning and increased health care costs.
 - ii. USPSTF recommends screening all adults for depression (Screening for depression: recommendations and rationale. Ann Intern Med. 2002 May 21;136(10):760-4.)

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2. **Interdisciplinary Approach**

- a. Nonpharmacologic approaches: These approaches to mental health problems in older adults often require the involvement of other health care disciplines, such as nursing, social work, psychology, and pastoral care.
 - i. Psychological counseling, supportive counseling, education, and life review are treatment methods that require other health care disciplines.
 - ii. Evidence has found the most support for community-based, multidisciplinary, geriatric mental health treatment teams (Draper B. The effectiveness of old age psychiatry services. *International Journal of Geriatric Psychiatry* 15: 687-703, 2000)

3. **Assessment Tools**

- a. Screening for cognitive impairment: This is conducted with the Folstein Mini Mental Status Exam (MMSE) (Tombaugh, TN, McIntyre, NJ. The mini-mental state examination: a comprehensive review. *J Am Geriatr Soc* 1992; 40:922).
 - i. Other methods include the clock drawing test (Sunderland T et al. *J Am Geriatr Soc* 37:725-729, 1989 and Wolf-Klein GP et al. *J Am Geriatr Soc* 37:730-734, 1989) , verbal fluency ie. Animal naming, (Monsch AU et al. *Arch Neurol* 1992; 49: 1253-1257, Rosen W. Verbal fluency in aging and dementia. *J Clin Neuropsychol* 1980;2: 135-146.) and the Mini Mental Status Questionnaire (Folstein MF et al. *J Psychiatr Res* 12:189-198,1975)
 - ii. Screening tools for depression include the Geriatric Depression scale (30 item or 15 item) or the USPSTF states that two simple questions can be asked “ Over the past two weeks have you felt down, depressed, or hopeless?” and “ Over the past two weeks have you

felt little interest or pleasure in doing things?” If a positive answer is given, further evaluation should be pursued.

- iv. In addition to cognitive and affect evaluations, special attention should be paid to the patients medical history, medications (both prescription, over the counter, and friends’/families’).

C. Interventions and Treatment Plans

1. Primary Interventions

- a. Incidence and Prevalence: In 1992 14% of the 90 million emergency room visits in the US were by patients over age 65¹. (McCaig LF. National Hospital Ambulatory Medical Care Survey: 1992 Emergency Department Summary. Advance Data from Vital and Health Statistics, No. 245. Hyattsville, MD: National Center for Health Statistics; 1994).ⁱ Geriatric patients make up the majority of all seriously ill emergency patients; 45% of emergency patients over age 75 are admitted to the hospital compared with only 18% of younger patients. (Sanders A. Care of the elderly in emergency departments: where do we stand? Ann Emerg Med. 1992; 156:197-200)ⁱⁱ. When an older patient suffers from trauma, the individual suffers different types of injuries and dies six times as often than younger trauma patients (Mueller MS, Gibson RM. Age difference in health care spending. Soc Sec Bull. 1976; 36:18)ⁱⁱⁱ. Not unlike the usual medical problems in geriatric patients, older trauma victims can present atypically. In addition, elderly patients have multiple medical problems, take many medications, and can have underlying cognitive impairment, making history taking difficult. This means that the older patient often takes more physician and nursing time, and requires more laboratory, radiological, and possibly surgical evaluation. Immediate goals of stabilization of the geriatric patient are the same as the younger patient. This includes the basic ABC’s: airway, breathing, and circulation. After this is accomplished, the emergency assessment must be tailored to the geriatric patient. Attention must be paid to the mental, social and functional aspects of elderly emergency room patients.
- b. Treatment of Pre-existing and Current Co-morbidities: Older patients also have multiple coexisting medical problems that require close monitoring and medications. The most common ones include cardiac disease, diabetes, pulmonary disease, and dementia. It must be emphasized that these conditions can be exacerbated by an acute medical problem and often present atypically. Therefore, treating clinicians must have a high level of suspicion for these problems.

2. Behavioral interventions

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Triage is a critical process in disaster management. It functions to link people to appropriate support services or, if necessary, to the appropriate emergency mental health care services.

Referral to specialist services may be made for cases of severe dissociation, severe intrusive re-experiencing of the event(s), severe hyperarousal, debilitating anxiety, severe depression, problematic substance use or psychotic symptoms.

3. Immediate Interventions

- a. These interventions can be viewed as risk-reducing factors, contributing to the prevention of more long-term problems.
- b. Psycho-education, regarding common and “normal” reactions to disaster
 - i. Inform victims that many people show resilience and adaptation following a disaster. The majority of individuals who experience a disaster find ways in which to cope and get back to their lives relatively quickly. They usually make full psychological and social recoveries quite spontaneously.
 - ii. “Normal” emotional reactions may include shock, terror, irritability, blame, anger, guilt, grief and sadness, emotional numbing, helplessness, loss of pleasure, difficulty feeling happy and/or loving.
 - iii. “Normal” cognitive reactions may include impaired concentration and decision making, problems in memory, disbelief, confusion, nightmares, decreased self-esteem, self-blame, intrusive thoughts/memories, worry, increased dependency, dissociation.
 - iv. “Normal” physical reactions may include fatigue, insomnia, startle response, hyperarousal, increased physical pain, reduced immune response, headaches, gastrointestinal upset, decreased appetite, decreased libido, vulnerability to illness.
 - v. “Normal” interpersonal reactions may include increased relational conflicts, social withdrawal, reduced relational intimacy, feelings of alienation, impaired work/school performance, decrease in satisfaction, externalization of blame, externalization of vulnerability, feelings of abandonment and rejection, distrust, overprotectiveness.

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- vi. Psychological first-aid may be offered but remember - the basic techniques and essentials of good psychotherapy apply.

 - viii. One needs to establish rapport. From a psycho-educational point of view, one should explain how the procedures will work in order to demystify the process. The victim's willingness to participate in these procedures, a crucial aspect of one's intervention(s), will be more likely if these first steps occur.
- c. Being present
The first and most effective thing one can do is just to be present and to listen. Assist with basic needs (physical comforts) while helping with initial steps in securing housing or benefits, if necessary. Gather basic information. Call upon any available family members. This is especially important for dealing with elderly victims.
- d. Education and reassurance
- Provision of information is critical because it can help to diminish levels of stress.
 - For people with a psychiatric disorder, past effective treatments are in order.
 - Coping and stress management
 - Help people change their "victim" role into an active role as "survivor."
 - Help people link up with their natural social supports or to be effective in communicating their needs.
 - If the person wishes to talk about his or her experience, this can be supported but it is not a good idea to probe for psychological reactions at this early stage.
- e. Problem solving
Help the person to work through the decisions that will address his or her most immediate problems.
- f. Finding meaning and perspective
Do not make any assumptions about the values of the person to whom you are giving psychological first-aid. Guide each person in his or her struggle to find meaning (or not) within the event.
- g. Critical Incident Stress Debriefing (CISD)
This is a routine and somewhat formalized part of review of an organizational response to a disaster.

At this point it is NOT recommended as an appropriate mental health intervention for victims of a disaster.

4. Longer Term Interventions (Symptom management tools)
Elderly patients may be very responsive to a variety of psychological interventions, if they are tailored to the ways in which issues brought about by aging interact with the trigger or stressor that created the need for the intervention in the first place.
 - a. Attention must be paid to specific developmental tasks and challenges associated with aging.
 - b. An especially active array of therapeutic interventions must be used in order to overcome patient, family and health care system barriers to treatment.
 - c. The nature of the transference and countertransference reactions and resistance must be explored.
 - d. Specialized psychotherapeutic approaches for the frail, demented, and personality disordered patient must be employed when dealing with the elderly.
 - e. A flexible approach must be applied because the patient's clinical status may change and therefore require a shift from one treatment approach to another.
 - f. Symptoms may be categorized into two major kinds:
 - i. intrusive re-experiencing of the trauma and hyper-arousal
 - ii. avoidance and numbing
5. Cognitive-behavioral Techniques
In order to address the first type of symptom formation (intrusive thoughts about the trauma and hyperarousal), one utilizes specific cognitive-behavioral techniques.

The therapist initiates procedures in response to the specific symptoms that are described by the patient. Clinical studies and experience have shown that cognitive therapy is quite efficacious for cognitively intact and motivated elderly patients, with both minor and major depressions.

- a. Modifications of cognitive therapy have been suggested to address the special problems of the elderly. These modifications might include:
 - i. presenting therapy in a non-threatening, acceptable manner-as a way, for instance, to learn to adjust to the trauma and subsequent symptoms and encouraging active participation in the therapeutic process.
 - ii. Empathically understanding the patient's hesitation to try therapeutic suggestions, for example, by suggesting that one never knows until one tries a new solution.
 - iii. Terminating the therapy gradually, by anticipating future problems with the patient and leaving the door open for him or her to return. In this way, an elderly patient does not feel abandoned by the termination process.

- b. Cognitive reframing - one might assist the person to find better, more rational thoughts than current self-defeating ones or one might suggest positive memories and/or thoughts with which to replace the painful ones.
- c. Thought-stopping - involves concentrating on an unwanted, feared or annoying thought. They are interrupted with either the word “STOP” or a loud noise that interrupts the flow of the negative thoughts.
- d. Systematic desensitization - during which individuals are taught to relax or calm themselves and, at the same time, imagine a hierarchy of fears or anxious situations.
- e. Relaxation - deep breathing
- f. Guided imagery exercises
- g. Assertiveness training
- h. Establishment of a regular sleep-wake routine
 - i. Lucid dreaming - which involves teaching the victim to become conscious of his or her (bad) dreams and to subsequently enable him or her to control the ending of them.
 - ii. Avoidance and numbing.
 - The goal is to replace the dysfunctional cognitions, emotions and behaviors from a traumatic event with more positive cognitions, emotions and behaviors from past experiences.
 - With practice, the positive attachments automatically weaken and displace the traumatic cognitions, emotions and behaviors.

6. Family Therapy

The practice of family therapy with older individuals has taken on considerably more prominence, especially with the current scarcity of resources for the elderly. Researchers have found that the family is the most important social group for older people and that families, in general, do not abandon their elder members. The occurrence of a disaster would most likely mean calling upon any available family members to assist with their elderly relative(s).

The role of a mental health worker in dealing with an older person in a crisis requires ongoing flexibility. One needs to be well acquainted with clinical assessment and treatment of the elderly from a biopsychosocial perspective, which includes the assessment and treatment of any available family members.

7. Group Psychotherapy

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The therapist must be flexible in conducting group therapy for the elderly, particularly in instances of response to disaster. Conceptual orientation may run from insight-oriented to more supportive, within the same session, depending on the issues that come up. The following types of groups may be drawn upon:

- Psychodynamic
- Life Review
- Cognitive Behavioral
- Resocialization/Remotivation
- Reality Oriented
- Creativity/Activity Centered

8. Countertransference with Elderly Patients

A broad range of countertransference reactions may emerge when treating the elderly. This may be particularly intense in instances of disaster, when priorities are being discussed and established. If the therapist begins to identify with a position of hopelessness, for instance, the result may be a pervasive feeling that a group of old, useless people can be ignored or at least placed on the back burner. It is important that the elderly are not indeed ignored, but rather viewed as a resource with which to review a long-term perspective of survival.

The second type of symptom formation involves avoidance and numbing.

- The goal is to replace the dysfunctional cognitions, emotions and behaviors from a traumatic event with more positive thoughts, emotions and behaviors from past experiences.
- With practice, the positive attachments automatically weaken and displace the traumatic thoughts, emotions and behaviors.

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Section VI: Geriatric Mental Health and Disasters - Clinical Response (cont'd)

Part Two: Pharmacological approach

Introduction: The proper use of medications represents one of the most crucial ways in which the practice of geriatric medicine differs from conventional medical care. Pharmacotherapy is probably the single most important medical intervention in the care of elderly patients, and its appropriate implementation requires a special understanding of the unique pharmacologic properties of drugs in this population, as well as a grasp of the clinical, epidemiologic, sociocultural, economic, and regulatory aspects of medication use in aging.

This section of the curriculum presents the most common psychopharmacological therapies that would be typically used for elderly patients who have suffered through a disaster event, or who have been traumatized by the threat of a disaster (such as a hurricane or terrorist attack) which did not actually materialize. In addition, there is discussion of key clinical strategies for prescribing in older adults, including the following topics: taking an accurate and thorough medication history, minimizing overmedication, maximizing compliance, and prevention of potentially life-threatening adverse side effects.

Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Understand the general principles of prescribing psychopharmacologic agents in the elderly, using low doses and observing for side effects
- Differentiate between the various classes of medication used for psychosis, depression and anxiety disorders
- Understand that psychotropic medications are potent agents and should only be prescribed when clinically indicated

Attitudes

- Psychotropic medications are potent and should be used cautiously in the elderly with mental disorders
- Alternative treatments should be considered including behavioral techniques, individual and group therapies
- Serious mental disorders including major depression, psychosis and disabling anxiety can be effectively treated with psychotropic medication

Skills

- Formulate a treatment plan which may include using a psychotropic medication if clinically indicated
- Determine the safest agent to use given the symptoms of the disorder and the medication side effect profile
- Monitor the patient carefully for potentially dangerous side effects including excessive sedation, confusion, and gait disturbance
- Determine when patients should be referred to a specialist for further evaluation and treatment of a major mental disorder

Curricular Content

A. Pharmacological Therapies - Overview

1. General principles of psychopharmacology in the elderly
 - a. Normal elderly have slower rates of metabolism in the liver and kidney of all medications
 - b. Chose medications with shorter half lives to avoid accumulation of effects
 - c. Start with a low dose and increase slowly until clinically effective
 - i. Antidepressants
 - ii. Antipsychotic agents
 - iii. Sedatives
 - d. Do not use medications when other forms of treatment such as supportive and group therapy are equally effective
 - i. Grief reactions
 - ii. Situational anxiety and depression
 - e. All psychotropic medications have significant side effects and in the elderly we are concerned about:
 - i. Confusion
 - ii. Excess sedation
 - iii. Falls from balance and gait disturbance
 - iv. Constipation leading to impaction
 - v. Orthostatic hypotension
 - vi. Worsening sensory impairment
 - vii. Possibility of toxicity and overdose
 - f. Treat serious disabling disorders aggressively
 - i. Psychosis
 - ii. Major depression
 - iii. Anxiety disorders

B. Pharmacology

1. Anxiolytics
 - a. Use agents such as lorazepam (Ativan) which has a short half life and does not have active metabolites which can accumulate in the body
 - b. Avoid longer acting agents
 - i. Barbiturates

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- ii. Diazepam
 - iii. Meprobamate
 - iv. Clonazepam
 - c. Consider these agents for only a short-term course of therapy and utilize SSRIs for more chronic conditions

 - d. Psychoeducation about addictive properties

 - e. Consider use of non-addictive agents such as buspirone

 - f. Patients must be tapered off these medications to avoid rebound anxiety and seizures

 - g. Consider for initial treatment of severe anxiety from
 - i. Acute and post-traumatic stress disorders
 - ii. Panic and generalized anxiety
 - iii. Major depression with prominent anxiety

 - h. Monitor for worsening confusion and cognitive impairment
2. Hypnotics
- a. In general try to educate the patient about sleep hygiene and the elimination of late meals and caffeine

 - b. Consider trazodone 25-50mg at bedtime for chronic insomnia

 - c. Avoid other addictive agents such as Dalmane which worsen confusion and cause daytime sedation

 - d. Benadryl 25-50mg at bedtime may be of short-term help but it is not benign

 - e. Insomnia associated with depression will improve with antidepressant medication over time

 - f. Monitor for worsening confusion and cognitive impairment
3. Antidepressants and Mood Stabilizers
- a. Use for serious depressive and anxiety disorders
 - i. Major depression, first episodes and recurrences
 - ii. Bipolar depression
 - iii. Chronic anxiety associated with significant functional impairment
 - iv. Chronic pain syndromes

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- b. Choose based on side effect profile as all antidepressants are equally effective

- c. Continue treatment for at least 6 months after symptom resolution and reevaluate
- d. Monitor for worsening confusion, hypotension, sedation, and gait disturbance

- e. Selective Serotonin Reuptake Inhibitors (SSRI), which may include:
 - i. Treatment of choice in the elderly population
 - 1) Well-tolerated with low side effect profiles
 - GI upset
 - Worsening anxiety
 - Insomnia
 - Weight loss and gain
 - Sexual dysfunction
 - 2) Once daily dosing which improves adherence
 - 3) Non addictive and easy to change to other agents

 - ii. Paxil, Celexa, Zoloft are typical agents
 - 1) Starting doses of Paxil and Celexa 5-10mg in the morning,
 - 2) Zoloft 25-50 mg
 - 3) Increase doses cautiously
 - 4) Educate regarding latency of response for up to 8 weeks

 - iii. Wellbutrin, Effexor
 - 1) Tend to be more stimulating in the elderly
 - 2) Consider for withdrawn, psychomotor retarded types of depression

- f. Tricyclic Antidepressants
 - i. Imipramine (Tofranil), nortriptyline (Pamelor), amitriptyline (Elavil)
 - 1) Useful in the elderly at lower doses
 - 2) Obtain baseline EKG to monitor for conduction delays
 - 3) Benefit in chronic pain syndromes
 - 4) Side effects relate to Anticholinergic effects
 - Dry mouth
 - Blurred vision
 - Constipation
 - 5) Can cause orthostatic hypotension and tachycardia

- g. Depakote
 - i. Treatment of choice for bipolar mania
 - ii. Can cause significant weight gain, hepatic toxicity and sedation
 - iii. Requires frequent blood monitoring

- h. Lithium

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- i. Continues as effective treatment of bipolar mania
 - ii. Can cause significant renal and thyroid toxicity
 - iii. Requires frequent blood monitoring
- i. An adequate trial of one agent is 6-8 weeks; if no improvement or side effects consider change to another class

4. Antipsychotic Agents

- a. Clinically used for treatment of psychosis including:
 - i. Delusional thinking
 - ii. Hallucinations
 - iii. Thought disorder
- b. Indicated in psychosis associated with depression, dementia, delirium and schizophrenia
- c. Used for sedative properties in agitation and behavioral disturbances of dementia
- d. Typical antipsychotics
 - i. Haloperidol - Side effects include EPS, Parkinsonism, restlessness (akathisia)
 - ii. Decanoate injections-rationale for use (Haldol and Prolixin)
 - iii. Chlorpromazine (Thorazine)
- e. Newer atypical agents

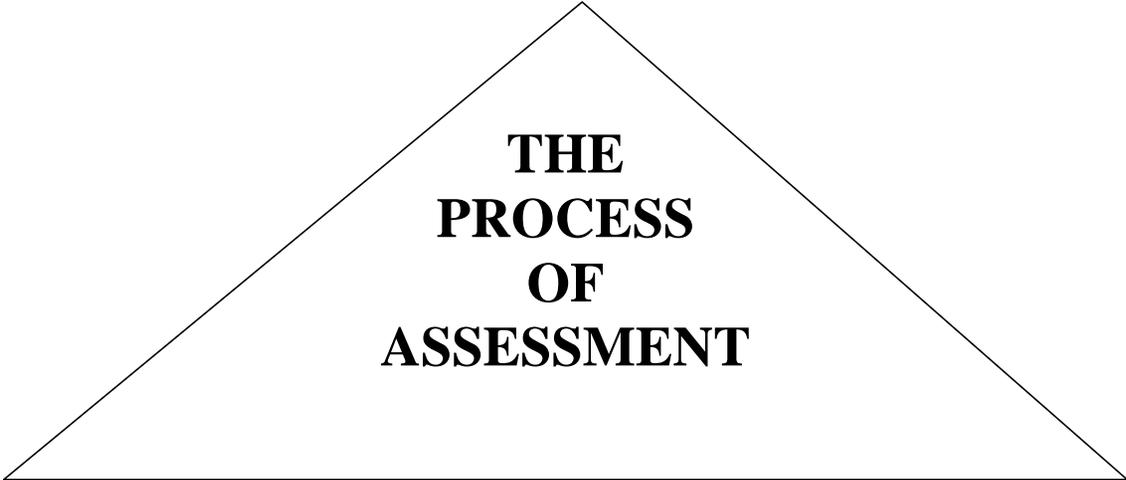
Atypical because they lack the side effect profile of Haldol and do not cause chronic neurological syndromes (tardive dyskinesia)

 - i. Risperidone-can cause EPS and Parkinsonism
 - ii. Geodon-more sedating, cardiac arrhythmias
 - iii. Seroquel-sedating, hypotension
 - iv. Zyprexa-significant weight gain and increased blood sugar
- f. These agents are potent and should be used cautiously using lowest doses possible and attempt to discontinue when clinically stable

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Handout #1



**THE
PROCESS
OF
ASSESSMENT**

ELICITING

- Obtaining Information
- Interviewing
- Testing

CLASSIFYING

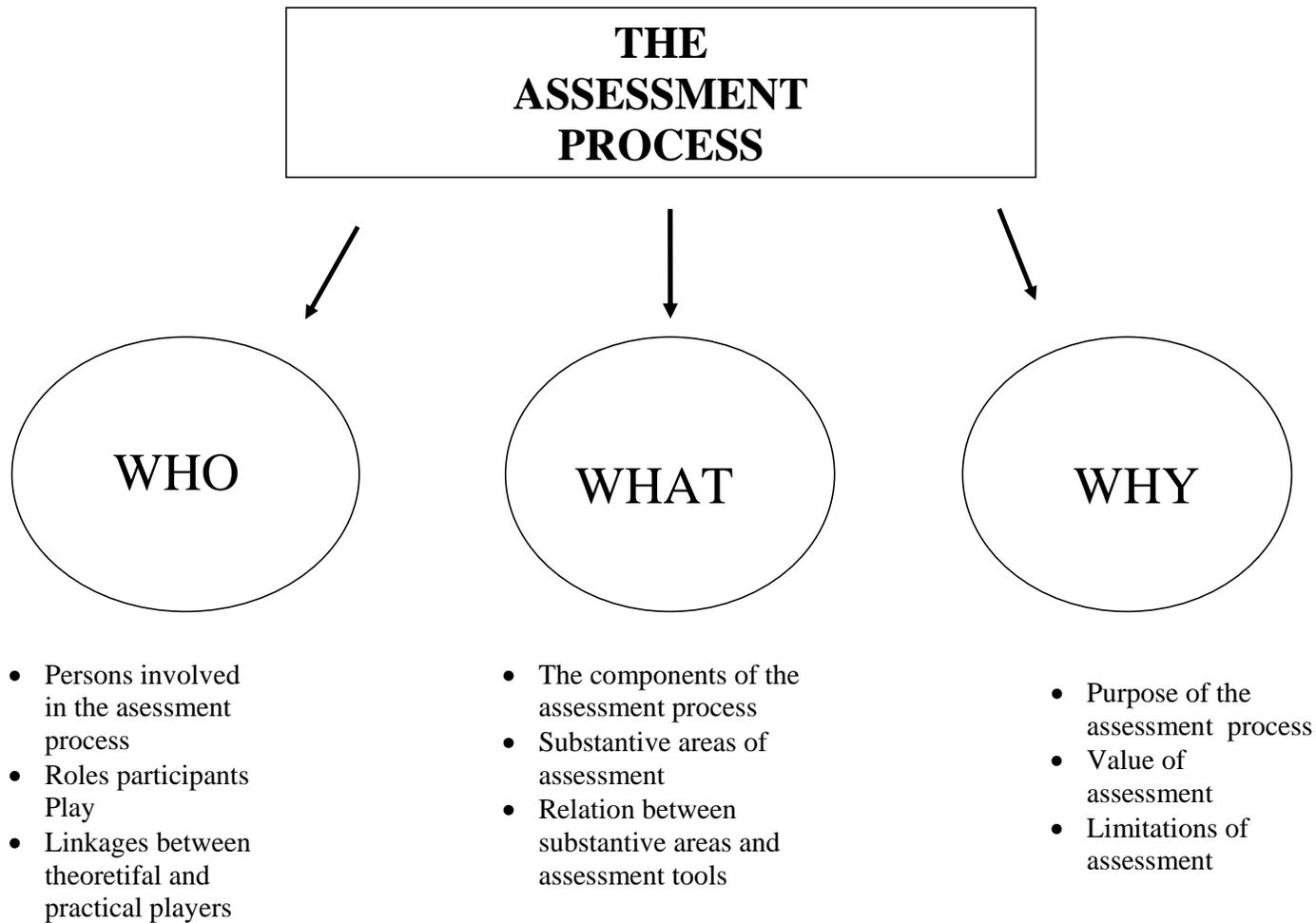
- Identifying Crucial Information
- Weeding Out Unnecessary Information

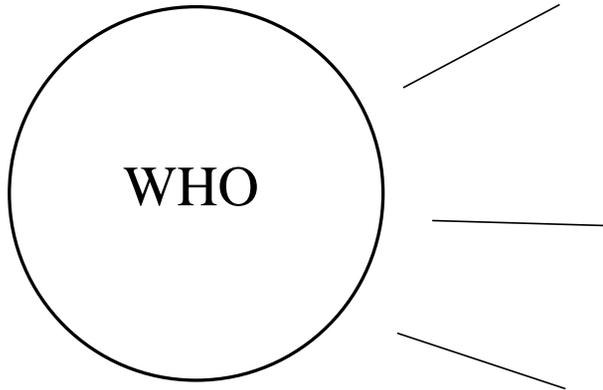
RECORDING

- Locating Appropriate Forms
- Recording Information on Forms

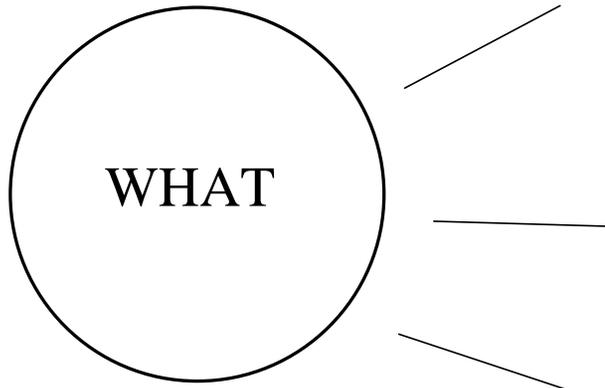
INTEGRATING

- Synthesis of Information
- Formulating Treatment Decisions





1. PATIENT / CLIENT
2. PRACTITIONERS
 - PHYSICIANS
 - NURSES
 - SOCIAL WORKERS
 - THERAPY AIDES, ETC...
3. GERIATRIC SPECIALISTS
 - PERSONS WHOSE RESPONSIBILITY FOCUSES ON PROBLEMS AND NEEDS OF THE ELDERLY
4. CASE MANAGERS
 - PERSONS RESPONSIBILITY FOR NEEDS ASSESSMENT AND ALLOCAITON OF RESOURCES TO THE ELDERLY PERSON
6. RESEARCHERS / PROGRAM EVALUATION SPECIALISTS
 - PERSONS RESPONSIBLE FOR DEVELOPING ASSESSMENT TOOLS, APPLYING TOOLS TO EXPERIMENTAL SETTINGS, USING TOOLS FOR PROGRAM EVALUATION, ETC...



1. PHYSICAL FUNCTIONING

- PHYSICAL HEALTH
- ACTIVITIES OF DAILY LIVING (ADL)
- INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

2. MENTAL FUNCTIONING

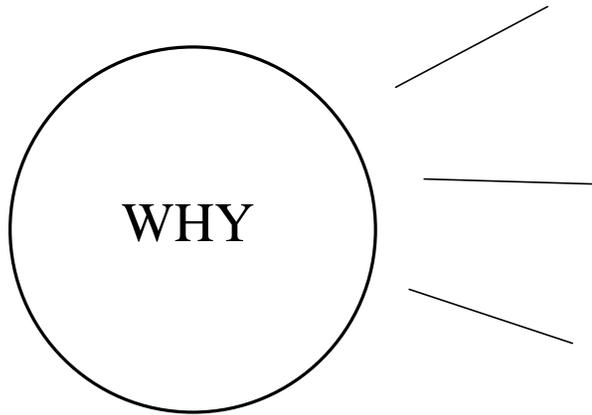
- METHODS OF MEASURING MENTAL FUNCTIONING
- ASSESSING COGNITIVE SKILLS
- ASSESSING AFFECTIVE FUNCTIONING
- ASSESSING GENERAL MENTAL HEALTH

3. SOCIAL FUNCTIONING

- IDENTIFYING THE SOCIALLY ISOLATED
- ASSESSING THE QUALITY OF SOCIAL INTERACTIONS
- ASSESSING NEED FOR SOCIAL RESOURCES

5. MULTIDIMENSIONAL ASSESSMENT

- PURPOSE OF MULTIDIMENSIONAL ASSESSMENT
- MULTIDIMENSIONAL ASSESSMENT TOOLS



1. PURPOSE

- DESCRIPTION
- SCREENING
- SYNTHESIZING
- MONITORING
- PREDICTION

2. VALUE

- PROVIDES INFORMATION ON HEALTH STATUS
- ASSISTS PRACTITIONER IN DETERMINING NEED FOR SERVICE
- PROVIDES INFORMATION ON THE EFFECTIVENESS OF SERVICES BEING DELIVERED

3. LIMITATIONS

- ASSESSMENT TOOLS ARE AIDS ONLY
- CLASSIFICATION OFTEN RESULTS IN LABELLING

Section VII: Self-Care for the Health Care Provider

Introduction: Contending with personal stress while caring for the needs of others is a common challenge for all health care providers, especially those caring for trauma survivors. This type of stress has numerous devastating effects, including the risk of secondary traumatization (i.e. a condition which results from helping a traumatized or suffering person). This section provides an overview of the risk factors and symptoms of secondary traumatization, and offers several spiritual, emotional, physical, mental and relationship strategies that health care workers can use to prevent burnout.

Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Identify the signs and symptoms of secondary traumatization
- Describe the risk factors for secondary traumatization
- Discuss self-care areas for health care providers

Attitudes

- Acknowledge the reality of stress in the health care environment
- Understand how this stress can influence one's health and well-being, and compromise the ability to help others

Skills

- Assess their personal and professional sources/symptoms of stress
- Develop strategies/solutions to prevent burnout and secondary traumatization

Curricular Content

A. Secondary Traumatization

1. Definition: Secondary Traumatization (ST) occurs when professionals listen to clients' accounts of fear, pain, rage, despair, hopelessness and suffering and then themselves feel similar fear, pain, rage, despair and suffering. It is often the stress resulting from knowing about a traumatizing event undergone by another or from helping or wanting to help a traumatized or suffering person (Figley, 1995).

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2. Risk Factors of Secondary Traumatization

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Traumatic events are painfully real and part of our larger world and society. We cannot protect ourselves from acknowledging this reality as we listen to client's stories. As a therapist to trauma survivors, one inevitably becomes aware of the potential for trauma in one's own life. Traumatic events can happen to any one at any time. Lives can be permanently changed in a moment. The presence of a survivor client is an inescapable reminder of one's own personal vulnerability to traumatic loss. For many therapists, the survivor client is a reminder of the therapist's own painful experience.

Trauma therapists must also be, in effect, bystanders and helpless (although not silent) witnesses to damaging and often cruel events. This helplessness to change what happened can transform and challenge helper identities, and can lead one to devalue survivor clients. In addition, often helpless witnesses to current reenactments of traumatic memories, which can be an excruciating experience. The rage and grief one may feel about the intentional harm done to clients must be contained and used constructively. The therapist must work with them to enable them first to understand, and then to conduct, their own struggles in their own ways. This limitation can place a strain on the trauma therapist, whose identity may include a sense of self as rescuer.

Trauma results in permanent change in one's frame of reference, or enduring ways of understanding self and the world. The reality of a permanent loss, whether of innocence, loved ones, bodily integrity, hope, or trust, cannot be denied. Trauma survivor clients continuously invite us to acknowledge this painful reality, and in doing so, open us up to our own grief. (Figley, 1995)

Empathy is a major resource for trauma workers to help the traumatized. Yet, empathy is a key factor in the induction and traumatic material from the primary to the secondary victim. The process of empathizing with a traumatized person helps to understand the person's experience of being traumatized, but, in the process, the trauma worker may be traumatized as well.

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Most trauma workers have experienced some traumatic event in their lives. It is inevitable that they will work with traumatized people who experienced events that were similar to those experienced by the trauma worker. There is a danger of the trauma worker's over-generalizing his or her experiences and methods of coping to the victim and over-promoting those methods.

Unresolved trauma of the worker will be activated by reports of similar trauma in clients. Trauma workers who are survivors of traumatic events may harbor unresolved traumatic conflicts. These issues may be provoked as a result of the traumatic experiences of a client.

Like crisis workers whose response is to the immediate effects of a catastrophic event on the survivor, trauma workers are faced with the prolonged, and often compounded, aftermath of the trauma. The trauma worker's exposure to trauma has far more complex ramifications than does exposure to the traumatic event itself. Through exposure to the concept of "trauma," therapists not only become aware of their clients' pain, but also come to the realization that a particular traumatic event can occur; has occurred, perhaps repeatedly; and may recur. It is for these reasons that it is possible for trauma worker exposed to the graphic details of a traumatic event, even if only once, to become traumatized. Trauma workers are further challenged with dealing simultaneously with the aftermath of prior traumatic events and the threat of continuing tragedy. (Figley, 1995)

3. Symptoms of Secondary Traumatization (Gaffney, 2000; Figley, 1995)

a. Avoidance/Numbing of Reminders of Events

- Avoiding thoughts/feelings
- Avoiding activities/situations
- Psychogenic amnesia, dissociation
- Diminish interest in activities
- Detachment/estrangement from others
- Diminished affect
- Sense of foreshortened future

b. Persistent Arousal

- Difficulty falling/staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hyper vigilance
- Exaggerated startle response
- Physiologic reactivity to cues

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- c. Physiological symptoms
 - Exaggerated startle response
 - Appetite changes
 - Shock
 - Sweating
 - Palpitations
 - Breathing difficulties
 - Aches and pains

- d. Addictive or compulsive behaviors
 - Alcoholism
 - Workaholism
 - Compulsive eating

- e. Performance of Job/Work Tasks
 - Decrease in quality and quantity of work
 - Low motivation
 - Increase in mistakes
 - Setting perfectionist standards
 - Obsession about details
 - Absenteeism
 - Faulty judgment
 - Overwork
 - Frequent job changes

TABLE 1

Symptoms of Secondary Traumatization

Other symptoms of secondary traumatization include:

- Taking your clients/patients “home” with you.
- Feeling very emotional during or after working with a survivor
- Sleeplessness
- Generalized anxiety including sadness, grief, dread and horror, fear, shame.
- Feelings of being overwhelmed
- Feeling of incompetence
- Listlessness, low-grade depression, the blahs, loss of interest
- Re-experiencing the Traumatic Event: Intrusive thoughts of patients, families and traumatic events: dreams, nightmares, daydreaming, recurring images, vivid mental replaying of client’s trauma
- Anger or pervasive cynicism at patients, families, the system, self and/or at staff culture
- Hyper-aroused or over-reacting to insignificant events (especially at home)
- Revenge fantasies
- Emotional detachment to significant others (numbing, flat affect, loss of humor)
- Lack of interest in sex or romance, self-care
- Tendency to talk about client trauma all the time
- See all clients as potential victims or abusers
- Fear of the possibility of personal tragedy
- Haunting memories of ones own traumatic events
- Survivor guilt
- Questioning the meaning/purpose of life
- Anger at God

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B. Burnout

1. Definition: Burnout occurs when past and present problems from the job continuously pile up. Burnout will normally occur slowly, over a long period of time. It may express itself physically/emotionally/behaviorally/at work/and interpersonally. It can be thought of as a “syndrome of physical and emotional exhaustion involving the development of negative self-concept, negative job attitudes, and a loss of concern and feelings for clients”. Human service workers may be more prone to burnout as a result of conflicts between idealistic “professional mystique” and the harsh realities of working in the human services (Kristi, 2001). When these reactions occur, individuals in the helping professions may develop negative and cynical attitudes and feelings toward clients and may not be as supportive as needed.

2. Risk Factors of Burnout
 - a. Role ambiguity. Lack of clarity concerning rights, responsibilities, methods, goals, status, and accountability
 - b. Role conflict. Demands that are incompatible, inappropriate, and inconsistent with values and ethics.
 - c. Role overload. The quantity and quality of demands have become too great.
 - d. Inconsequentiality. A feeling that no matter how hard one works, the outcome means little in terms of recognition, accomplishment, appreciation, success.
 - e. Isolation. Little social support either in the institution or outside of it.
 - f. Autonomy. The ability to make decisions and how one will deal with clients is co-opted by the bureaucracy of their place of employment. (James & Gilliland, 2003)

Burnout and Secondary Traumatization can occur simultaneously.

3. Symptoms of Burnout
 - a. Physical symptoms. Fatigue and physical depletion/exhaustion, sleep difficulties, specific somatic problems such as headaches, gastrointestinal disturbances, colds, and flu, immune breakdown.
 - b. Emotional symptoms. Irritable, anxiety, depression, guilt, sense of helplessness, anger, mistrust.
 - c. Psychological symptoms. Feeling lack of control over commitments, an incorrect belief that you are accomplishing less, a growing tendency to think negatively, loss of a sense of purpose and energy, and increasing detachment from relationships that causes conflict and stress, adding to burnout.

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- d. Behavioral symptoms. Aggression, callousness, pessimism, defensiveness, cynicism, substance abuse, stereotyping, sick humor, hypercritical, scapegoating.
- e. Work-related symptoms. Quitting the job, poor work performance, absenteeism, tardiness, misuse of work breaks, thefts.
- f. Interpersonal symptoms. Perfunctory mechanistic communication with clients, inability to concentrate/focus, withdrawal from clients/ co-workers, and then dehumanizing, intellectualizing clients. (Figley, 1995)

TABLE 2

Symptoms of Burnout

Other symptoms of burnout include:

- Complaining
- Loss of employment
- Loss of control
- Vacillation between extremes of over-involvement and detachment
- Accident proneness
- Errors in setting therapeutic boundaries
- PTSD-like symptoms of intrusive thoughts, numbing of affect, and hypervigilance
- Insomnia, nightmares, excessive sleeping
- Increased use of tobacco and caffeine
- Over – and under-eating
- Withdrawal from family
- Breaking up of long-lasting relationships
- Overreacting to comments of friends
- Allowing clients to abuse privacy of home by calls or visits at any time
- Feeling of emptiness, meaninglessness
- Compulsiveness and obsessiveness
- Entrapment in job and relations
- Free-floating feelings of inadequacy, inferiority, and incompetence
- Loss of faith, meaning, purpose
- Sense of grounding, inner balance lost
- Increased sense of vulnerability to world at-large

(James & Gilliland, 2003)

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C. Self-Care Areas

Roach and Nieto (1997) identify five self-care areas and questions which include:

1. **Spiritual Self-Care.** Is spirituality important in my life; what is my relationship with God or a higher power; why am I here and what is my purpose; what is my relationship to the universe?
2. **Emotional Self-Care.** Can I identify my emotions; how do I deal with them; am I usually in control; can I discuss my emotions; am I open to others and do I respect the feelings of others or do I jump to conclusions; when do my emotions get out of control?
3. **Physical Self-Care.** What areas of my lifestyle are unhealthy or do I have a healthy lifestyle; what can I do to improve my lifestyle?
4. **Mental Self-Care.** Am I knowledgeable and do I continually increase my knowledge; am I satisfied with the status quo or am I open to new ideas; what am I doing to stimulate my mind?
5. **Relationships Self-Care.** Am I open and honest with myself and others; do I have satisfying relationships with others; am I willing to accept the thoughts and feelings of others even though they are different from my own or am I judgmental; must I have all the control or can I share it; do I have a balance between work, home, and leisure?

D. Preventing Secondary Traumatic Stress Disorder – (Janet Yassen. 1995)

1. Physical

a. Body Work - Maintaining the health of our bodies.

Choose a form of exercise that fits one's lifestyle, and that may meet some other needs (e.g., desire to have time alone or, conversely, to spend some time with a friend, or to be competitive through team sports and doing it regularly). Other physical nurturing techniques are massage, warm baths, therapeutic body work, wearing clothes that feel good, and buying household/office furniture and accessories that are pleasant to look at and are comfortable to live with.

b. Adequate sleep is essential to well-being.

Sleep deprivation has debilitating effects, including impaired cognitive and neurological functioning and irritability. Be aware of how much sleep you need to function well. In experiencing specific kinds of sleep disturbances

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(e.g., inability to fall asleep, early rising, waking in the middle of the night, regular nightmares), be sure to address these problems before they become a pattern.

c. Nutrition

Eating balanced meals at regular intervals with selections from the four basic food groups. Stress can be exacerbated by the intake of refined white sugar, caffeine, or nicotine. Appetite also can be affected by stress. Some overeat, some undereat, others substitute eating for having feelings. Become aware of what your eating patterns are now compared with what they were in the past, keeping in mind what, when, how, and why one eats and decide if changes are desired or needed.

2. Psychological

a. Life Balance

Important to maintain a life that is marked by diversity of activities as well as a moderate pace emphasizing the value of striving for an overall balance of work, outside interests, social contact, personal time, and recreation.

b. Relaxation

Those involved in trauma work find it difficult to relax because of the nature of this work and because they may feel a mission to absolve the world of violence. Daily relaxation, “downtime,” can be short in duration, so long as it is regular.

c. Contact with Nature

Nature can give us a larger view of the world and our place in it; trips to the park, watching the night sky, swimming, climbing, hiking, camping, skiing, caring for pets or plants can also be restorative.

d. Creative Expression

This can include writing, drama, photography, cooking, drawing, painting, dancing, handicrafts, utilizing one’s sense of humor, or playing a musical instrument.

e. Skill Development

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- Assertiveness training – having the belief and self-confidence to stand up for oneself or to say “No” when necessary
- Stress reduction – techniques that reduce physical and mental effects of stress e.g. relaxation, meditation, guided imagery
- Cognitive restructuring – how you view your situation and the world and learn more effective problem-solving strategies
- Community organizing – to be more successful and satisfied in social action
- Time management – effectively set priorities and organize your time in a productive manner.

f. Meditation/Spiritual Practice

Can be healing to the body and the spirit. Such practice does not change the reality of the external traumatic events, but it does minimize the wear and tear on the body, and assists in developing healthy coping strategies. It means paying attention to one’s breathing and approaching life with an attitude of mindfulness. The spiritual damage, or loss of meaning, connection, and hope, that can signal vicarious traumatization is profoundly destructive. Developing a spiritual life entails finding a way to restore faith in something larger than oneself, whether by reconnecting with the best of all that is human, with nature, or with spiritual entity. There is great restorative value in stepping back from one’s work and putting it in perspective. The impact of trauma can be such as to shatter or impel one to reevaluate one’s spiritual belief system. It may mean a questioning of previously held beliefs, or turning for comfort and community to religious groups, or expanding their beliefs in new ways. We need to learn how to derive meaning from what we have personally experienced or to which we are bearing witness.

g. Self-Awareness

An assessment of oneself is an important component of prevention. Evaluating one’s health and energy, existential beliefs, problem-solving skills, social skills, social supports, and material resources. Understand which work or client situations may be particularly difficult for you. Evaluate whether you are really able or want to be objective in this situation. This self-evaluation should acknowledge personal resources, identify areas in which one would like to change, explore who we are not, and help establish the importance of a cultural-social-political analysis of ourselves and this self-awareness in providing care. Self-awareness denotes a nonjudgemental and compassionate attitude toward oneself, an understanding of one’s current life circumstances, and a level of maturity that enables one to accept oneself. It involves a willingness adduce personal meaning from traumatic experiences, and to incorporate these lessons into a self view. It also means accepting the small ways in which one can take control in the face of powerlessness. Self-awareness means knowing when outside help is needed.

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h. Humor

Maintaining a sense of humor and using humor as a coping strategy are vital prevention techniques. Humor can reduce stress, release tensions, and allow us to keep an emotional distance. Humor gives the “ability to laugh at oneself and to see lightness in everyday joyful and tragic events”

3. Social/Interpersonal

a. Social Supports

Social supports are a central component of the prevention of personal and professional PTSD, and it is important to expand one’s interventions beyond a focus on the individual to a focus on one’s social network. Evaluate your supports’ understanding of and belief systems concerning trauma; their availability, resourcefulness, and ability to give and receive feedback; and their receptivity to change. It is crucial to build in regular time with loved ones, friends, and acquaintances in order to nurture our connections with others and fight against isolation and the stress of secondary victimization. Time with children bring a fresh view of life and demand that one be in the moment with them. They offer feelings of hope, joy, beauty, and playfulness to counteract the more heinous aspects of human nature to which we are exposed in our work.

b. Getting Help

Accepting and accessing help in a timely manner has been associated with preventing the long-term effects of post-traumatic stress. Getting help is a sign of personal strength. Identify specific people in one’s personal and professional life who are viewed as helpful, and become familiar with professional resources should one choose to use them.

c. Social Activism

Another way to maintain a sense of hope and purpose in doing trauma work is to be involved in social activism. This has the effect of combating the feeling of powerlessness that results from PTSD, as well as of providing a sense of shared mission with others, which can mitigate social isolation. Social activism can also be an outlet for frustration. Letting the public know your views, beliefs, and ideals can be an antidote to the secretive and silencing nature of trauma. What may seem like small acts of activism can also combat powerlessness.

4. Professional

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a. Balance

Balance is important regarding how much work to do – the number of work hours per week and the proportion of the work that relates to direct trauma treatment. It is important to have diversity in one's work life. Pay attention to the effects that your work is having on you and create a pace that will maximize your emotional and physical health. Taking regular breaks, making time for meals, and taking vacations.

Limit exposure to traumatic material by not watching violent movies or not reading detailed amount of gruesome events. Be selective about what conferences we want to attend or journal articles we read.

b. Boundaries/Limit Setting

i. Time Boundaries

Time boundaries include being on time for appointments and being careful not to go over the specified time. Overworking or taking on too many responsibilities, working overtime on a regular basis, constantly bring work home or taking calls at home, and being unable to separate from the work emotionally and excessive reading can be an attempt to overcome feelings of inadequacy, incompetency, or helplessness.

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ii. Therapeutic/Professional Boundaries

The aftermath of trauma can bring up feelings on the part of the client that are not always understood. Some of the feelings of rage, helplessness, and so on, might be projected onto the caregiver. It may be hard not to take these feelings personally. Understanding the nature of the therapeutic or helping relationship can help to depersonalize possible abuses by those receiving care.

iii. Personal Boundaries

It is important to resolve how much of oneself to disclose to clients and under what circumstances. Human service workers who live and work in traumatized communities may have to be extremely creative in creating boundaries for themselves. Service providers must understand the importance and implications of physical touch for trauma survivors. This affects their own as well as their clients' personal boundaries. It can have different meanings, depending on the kind of trauma must decide what role physical touch should play in their clinical practices.

c. Realism

Knowing our limits in doing this work is important as well as humbling. We don't have the power to eliminate all violence. The time to appreciate what we actually are doing and the contributions that we are making to help the world become a better place.

d. Getting Support/Help

The key element in developing a support structure is that it be emotionally safe to be able to talk honestly about the impact of one's work on one's own life. The timing of support is also important. The development of trusting professional relationships ensure that there will be those who will notice that one is having difficulties, and will be available for support or to make recommendations. Peer support helps one receive from and give support to colleagues who are involved in similar work tasks. In order to address the sense of disconnect that is characteristic of vicarious traumatization, we need to reconnect with others. Building a sense of professional connection can mean attending workshops, using support groups, meeting with colleagues to share coping strategies, and giving supervision. The work is too difficult to do alone. Remaining connected to the community of trauma therapists helps to affirm one's commitment. The benefits of peer support include nurturing collegiality, as well as relieving isolation. Caregivers need to have a variety of peer support resources to allow easy access to the immediate, uncensored ventilation of feelings, and to be able to share with others the burden of

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bearing witness to traumatic events. Peer support can help with finding an equilibrium and can assist with the elimination of STS symptoms.

e. Supervision/Consultation/Therapy

No matter how experienced we are it is important to build in supervision or consultation on a regular basis. It is crucial to get an outside perspectives from someone trusted or to receive guidance in facing a new challenge. Supervision provides the opportunity to have someone listen solely to us, as we have had to do with our clients. For the trauma therapist, personal psychotherapy can be extremely helpful. Among other things, it provides a regular opportunity to focus on oneself, one's own needs, and the origins of one's responses to the work. The explicit acknowledgement of oneself as deserving of care and of one's needs as valid and important is essential.

f. Job Commitment

One needs to evaluate regularly the commitment to the work we do. Analyzing personal motivations for doing trauma treatment such as desire to achieve social and political goals, survivor guilt, or the ability to empathize with people who come from similar situations. It is necessary to consider exactly why one is doing this type of work. The intensity of doing trauma work can become a reinforcer in itself. There may be a time when one needs to take a sabbatical from trauma work. The trauma therapist must be continuously aware of our feelings, our needs, and our resources and make conscious decisions about one's commitment.

g. Replenishment

Those who have chosen human services as a profession are involved in giving care to others. We must be sensitive to our own needs for professional, as well as personal, replenishment. There needs to be continual professional opportunities to challenge oneself, to be exposed to other points of view and updating ourselves with new information.

h. Attend to the Physical Setting

The availability of a safe, private, comfortable, therapy space is very important. The traumatic worker's space is part of his or her self-care; it is important that one's office be comfortable, soothing, and grounding. You may want to have personally meaningful items in the office that express his or her identity.

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Section VIII: Disaster Recovery for Older Adults: Holistic Integrative Therapies

Introduction: Complementary and Alternative Modalities (CAM) have become increasingly popular among Americans. The 2005 National Health Interview Survey revealed that 62% of American adults used some form of CAM therapy in the preceding year. The popularity of CAM has triggered the development of courses on the subject in some health professional schools, and the reevaluation of health insurance coverage provided by insurance carriers, as billions of dollars are spent on these interventions in the US on a yearly basis. This section introduces the learner to the basic CAM domains, and describes several CAM practices which may be helpful to older adults recovering from traumatic or disaster-related experiences.

Learning Objectives

At the conclusion of the session, learners will be able to:

Knowledge

- Identify the various types of alternative/complementary therapies
- Discuss CAM modalities most useful in traumatic/disaster situations
- Describe key benefits of using CAM with older adults
- Discuss the relevance of spirituality within the context of a disaster experienced by older adults
- Understand the role of rituals in disasters
- **Identify key benefits of developing rituals for disaster recovery**
- Enumerate the benefits of rituals in disaster recovery
- Describe types of rituals
- Relate the importance and function of symbols and the senses to ritual

Attitudes

- Be supportive of older adults and their needs during a disaster
- Enable older adults and their healthcare providers to find meaning in the trauma and long term consequences of disaster
- Accept the role of ritual in helping an individual understand or make meaning out of disaster
- Understand that rituals can enable older adults and healthcare providers to find meaning during and after disaster
- **Perceive the ongoing contemporary need and of ritual and its place in individual and community history**

Skills

- Incorporate select CAM modalities into practice for older adults in disaster recovery
- Conduct a spiritual assessment of older adults who have experienced a disaster.
- Employ effective spiritual and CAM interventions to promote the well-being of older adults during a disaster
- Incorporate healing rituals to build community and provide comfort and trust
- Identify the components of ritual
- Describe items that might be included in a ritual “toolkit”
- Develop commemorative rituals to mark disasters
- Develop relief rituals for older adults, first responders and health care providers
- Incorporate healing rituals to build community and provide comfort and trust

Curricular Content

A. Complementary/Alternative Modalities (CAM)

1. Definition

Complementary/alternative modalities, also known as integrative therapies, are defined as those healing philosophies and therapies that are not often integrated into the prominent health care model or conventional Western allopathic medicine and are not usually taught widely in medical schools or are not commonly accepted or made available in U.S. healthcare. The emphasis is on both prevention and treatment focusing on the mind/body/spirit connection, healing and wellness rather than an exclusive focus on illness and disease. Holistic health care is a system of care that stresses the whole person – physical, emotional, spiritual, environmental, nutritional, and life-style.

2. Categorization

The National Center for Complementary and Alternative Medicine has categorized CAM into five areas:

- a. Alternative Medical Systems (e.g. acupuncture, ayurveda, homeopathic and naturopathic medicine, cultural practices such as Native American and rural practices, and traditional chinese medicine)
- b. Biologically based therapies using substances found in nature such as herbs, foods and vitamins (e.g. nutritional supplements, herbology, megavitamins, Chelation therapy, therapeutic diets)
- c. Manipulative and body-based methods (e.g. acupressure, massage, chiropractic, reflexology, Alexander and Feldenkrais techniques)
- d. Energy therapies (e.g. Reiki, therapeutic touch, magnets, Qi gong)
- e. Mind-body interventions (e.g. biofeedback, meditation, relaxation techniques, guided imagery, psychotherapy, support groups, prayer, yoga and music and art therapy)

3. Value of CAM with older people: Use of holistic complementary/alternative modalities with the elderly is most effective as they are safe, non-invasive, usually cost-effective, and have few if any side-effects. They also are useful during traumatic/disaster situations, as the underlying mechanism of most CAM is relaxation and these modalities elicit the relaxation response. A valuable aspect of these holistic modalities is that their use can empower clients and families. When clients, especially the elderly, learn to heal themselves, they are empowered. When they learn these techniques, they can do it themselves, often times giving them a sense of control (Mariano, 2004). And when families are taught to use these modalities, they feel as if they are contributing something to the care of their older family member.

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4. Specific Complementary/Alternative Modalities:

a. Relaxation

Relaxation is a state where there is an absence of physical, mental, and emotional tension. A pleasant sensation and the lack of stressful or uncomfortable thoughts also accompany it. It is often referred to as the opposite of the “fight or flight” response. “Relaxation makes it possible to quiet the body/mind and focus inward. One learns to retreat mentally from one’s surroundings, still thoughts, relax muscles, and maintain the state of relaxation . . . to reap the benefits of decreased tension, anxiety, and pain. Regardless of the approach [use of meditation, yoga, muscle and breathing exercises, hypnosis, prayer, and other forms of stress management], the end result is a movement of the person toward balance and healing” (Kolkmeier, 1995, p. 575). Relaxation techniques are the basis of many holistic modalities.

Relaxation has three aims (Payne, 2000):

- i. As a prevention to protect body organs from unnecessary stress and wear;
- ii. As a treatment to alleviate stress in numerous conditions, for example, hypertension, tension headache, insomnia, asthma, immune deficiency, panic, pain; and
- iii. As a coping skill to calm the mind and to help thinking to become more clear and effective. Positive information in memory also becomes more accessible when a person is relaxed.

There are numerous benefits to the relaxed state, including lowered blood pressure, decreased heart rate, increased body temperature, decreased anxiety associated with painful situations, easing muscle tension pain such as in contractures, a general sense of intense calm, decreased symptoms of depression and stress, decreasing fatigue, but also helping the client to sleep, increasing the effects of medications, improvements in side effects of cancer therapy (decreased nausea, vomiting and anxiety) and AIDS therapy, assisting in preparation for surgery or other treatments, and helping to dissociate from pain (Payne, 2000, Freeman, 2004).

Breathe work provides an individual an immediate means of stress reduction. Diaphragmatic breathing can be easily taught to older persons. While taking a deep breath in, the belly should expand. While exhaling completely, the belly should contract. This can be done five or six times whenever the individual feels stressed or out of control.

b. Imagery

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Imagining is a powerful technique of focusing and directing the imagination. One uses all the senses – vision, sound, smell, taste, movement, position, and touch. Imagery influences an individual's attitudes, feelings, behaviors, and anxiety which can either lead to a sense of hopelessness or promote a perception of well-being that assists in changing opinions about disease, treatment, and healing potential. "Imagery [is the] internal experience of memories, dreams, fantasies, and visions—sometimes involving one, several, or all the senses that serve as the bridge for connecting body, mind, and spirit" (Shaub and Dossey, 2005, p. 567). Imagery can affect people physically, emotionally, mentally and biochemically and the body and mind respond as if the event is actually occurring.

Guided imagery and interactive guided imagery (having the client directly interact with the image) are techniques to access the imagination through a guide. There are numerous types of imagery: receptive imagery (inner knowing or "bubble-up" images); active imagery (a focus on the conscious formation of an image); correct biological imagery (recognizing the impact of negative images on physiology and creating positive correct biological images); symbolic imagery (images emerging from both the unconscious and conscious which shape attitudes, belief systems, and cultural experiences, often mythic symbols); process imagery (a step-by-step rehearsal of any procedure, treatment, surgery, or other event prior to its occurrence); end-state imagery (rehearsal of an image of being in a final, healed state) general healing imagery (images that have a personal healing significance such as a wise person, an animal, the sun, etc.); packaged imagery (another person's images such as commercial tapes); and customized imagery (images specific to an individual) (Schaub and Dossey, 2005).

Guided imagery has many applications in crises, including relaxation, stress reduction, pain relief, symptom management, grief work, and assisting clients to comprehend meaning in their experience (Van Kuiken, 2004). Not only is it useful in mobilizing latent, innate healing abilities of the client by intensifying the impact of healing messages that the autonomic nervous system sends to the immune system and other bodily functions, it also is very useful in the self-care of the health provider. It has been found helpful in relieving chronic pain and headaches, stimulating healing, tolerating medical procedures, exploring emotions that may have caused illness, solving difficult problems, envisioning and planning for the future, and listening to our inner advisor.

c. Meditation

Meditation is a quiet turning inward. It is the practice of focusing one's attention internally to achieve clearer consciousness and inner stillness. There

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are numerous methods and schools of meditation, all having an individual interpretation of the practice. However, all methods believe in emptying the mind and letting go of the mind's chatter that preoccupies us.

Meditation originated in the eastern tradition and is integral to Hinduism, Taoism, and Buddhism and is both a state of mind and a method. The state is one where the mind is quiet and listening to itself. The practitioner is relaxed but alert. The method involves the focusing of attention on something such as the breath, an image, a word, or action such as Tai chi or Qigong. There is a sustained concentration but it should be effortless. The objective of meditation is to detach the mediator from external events as well as one's own mental activity.

There are various reasons for practicing meditation: to find peace, achieve awareness and enlightenment, find oneself, and to experience true reality, and enhance a sense of well-being. Research has demonstrated that relaxed forms of meditation decrease heart rate and blood pressure, increase breathing volume, but decreasing the number of breaths per minute, increase peripheral blood flow and improve immune function, decrease skeletal muscle tension, epinephrine level, gastric acidity, and motility, anxiety and decrease depression, traumatic stress, alcohol and drug consumption (Gatchel & Maddrey, 1998; Bonadonna, 2003; Gross et al, 2004; Freeman, 2004; and Anselmo, 2005).

d. Aromatherapy

Aromatherapy is an offshoot of herbal medicine “in which aromatic plant extracts are inhaled or applied to the skin as a means of treating illness and promoting beneficial changes in mood and outlook. Though aromatherapy and herbal medicine use many of the same plants, in aromatherapy the plants are distilled into oils of exceptional potency” (Allison, 1999, p. 86). The benefit of these oils comes from their influence on the limbic system that coordinates mind and body activity. This system is very sensitive to odors and encodes them into associations and memories, which when awakened, alter basic physical functions such as heart rate, blood pressure, breathing, and hormone level. When these oils are rubbed into the skin or inhaled, they set off a reaction leading to rapid and significant alterations in memory, heart rate, and other bodily mechanisms. Some boost energy, some promote relaxation, and others have pharmaceutical effects. However, no treatment should ever involve more than a few drops of oil.

There are numerous uses of aromatherapy including: overcome anxiety, anger, tension, stress, insomnia, exhaustion, depression, stress, countering depression, nervous tension, fearfulness, useful in the enhancement of mood,

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increase in vitality, and relaxation. Some of the ones helpful for the relief of emotional states include:

- i. Anxiety, nervous tension: Benzoin, bergamot, chamomile, camphor, cypress, geranium, meadow sweet, orange blossom
- ii. Depression, melancholy: basil, geranium, jasmine, newroli, patchouli, rose, bergamot, lavender
- iii. Confusion, indecision: basil, cypress, peppermint
- iv. Fear. Paranoia: basil, clary, juniper, jasmine
- v. Grief: hyssop, marjoram, rose

e. Journal Writing

Keeping a log or journal is a very healing technique to use for individuals experiencing life-threatening illness and during the grieving process. It allows the person to express innermost feelings and thoughts without fear of criticism. It is often helpful for those who are uncomfortable or unable to articulate how they feel or what they are going through. The healing emanates from the actual writing and expression, and not from an analysis of the content of the journal. The writing may be totally private or shared with others. Many clients do not think of this technique and the health care provider may suggest it.

There are numerous topics for journal writing or the client can just write thoughts and feelings as they occur. The individual may find comfort in writing when difficult times occur, for example, unanticipated news about diagnosis or prognosis, dealing with crises, or writing to God, a loved one, or one's disease. Often the journal becomes one's own record of grieving. It often serves as a chronicle of personal growth, insights, and wisdom gleaned from the experience of loss, fear, anxiety and bereavement.

f. Touch

There are many forms of touch considered to be holistic/integrative modalities (Dossey, Keegan, and Guzzetta, 2005; Aspen, 2003; Allison, 1999a; Micozzi, 2001; Fontaine, 2000; Walker and Walker, 2003).

These include but are not limited to:

- i. Acupressure—the application of pressure, using fingers, thumbs, palms, or elbows to specific sites along the body's energy meridians to stimulate, disperse, and regulate the body's healing energy for the purpose of relieving tension and reestablishing the flow of energy along the meridian lines.
- ii. Body therapy—a general term used for approaches (e.g., Alexander technique, chiropractic, Rolfing, shiatsu, Feldenkrais, etc.) that use

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hands-on techniques to manipulate and balance the musculoskeletal system to facilitate healing, increase energy, relieve pain, and promote relaxation and well-being.

- iii. Reflexology—the application of pressure to specific reflex areas on the feet/hands corresponding to other parts of the body to locate and correct problems in the body.
- iv. Massage—the practice of kneading or otherwise manipulating a person’s muscles and other soft tissue with the intent of inducing physical and psychological relaxation, improvement of circulation, relief of pain and sore muscles, and improving that individual’s well being. Procedural massage is done to diagnose, monitor, or treat the illness itself, focusing on the end result of curing the illness or preventing further complications. Massage has been one of the most important interventions for pain reduction, comfort, tension release, prevention of atrophy of muscles and stiffness of joints and inducing sleep.
- v. Therapeutic touch—(TT) developed by Dolores Krieger and Dora Kunz. This is a specific modality of centering intention while the practitioner moves the hands through the client’s energy field for the purpose of assessment and treatment. It is based on the philosophy that universal life energy flows through and around us, and any interruption in this free flow of energy leads to illness. The goal is to balance and repattern the body’s energy so that it flows most efficiently to promote health and prevent disease. The TT practitioner scans the client’s energy flow, replenishing it where necessary, releasing congestion, removing obstructions, and restoring order and balance in the ill system. This approach is also an effective complementary care approach for facilitation of the body’s natural restorative processes thereby accelerating healing, promoting relaxation, reducing pain and anxiety, and treating chronic conditions and stress (Krieger, 1997, 2002; Denison, 2004; Newshan, 2004).
- vi. Reiki—based on Buddhist teachings using hands-on touch to support and intensify energy in the physical, emotional, intellectual, and spiritual areas. “Universal and individual energy are aligned and balanced through the application of gentle hands-on touch to energy pathways of the body”(Abrams, 1999, p. 133). Those who use Reiki attribute it to reducing stress and stress-related illnesses including acute and chronic conditions, helping in debilitating disease because it

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bolsters the immune system by increasing energy, and contributing to a general sense of overall well being in the client.

The philosophy of Reiki contends that a person is vitalized by a vital energy that comes from the universal life force. One becomes ill when the energy flow is interrupted or stopped. Everyone has access to this life force. Opening pathways for energy flow is the prime objective of Reiki.

g. Herbology

Herbology is also known as *phytotherapy* or *phytomedicine*. Herbal remedies have been used in various cultures for centuries and are increasingly popular in the United States as health products and medicines. In fact, herbal use is the fastest growing category of alternative/complementary therapy in the US. McCaleb et. al (2000) define herbs as plants or plant parts (bark, fruit, stem, root, or seed) that are used in fresh, dried, or extracted form for promoting, maintaining, or restoring health. Bach Flower remedies are also included in the area of herbology. Herbs are prepared in many forms: tinctures, extracts, capsules, tablets, lozenges, teas, juices, vapor treatments, poultices, compresses, salves, liniments, and bath products (Springhouse, 2001; Bascom, 2002).

- i. Adaptogenic herbs— increase the body’s resistance to illness.
- ii. Nervine herbs to 1) strengthen and restore; 2) ease anxiety and tension; and 3) stimulate nerve activity
- iii. Stimulating herbs to stimulate physiologic and metabolic activities
- iv. Tonic herbs which enliven and invigorate by promoting the “vital force”, the key to health and longevity.
- v. Pain relieving herbs

Although herbs are natural substances and overall risk seems to be low, they cannot be used indiscriminately. Herbs are medicinal and may have serious side effects and interactions with prescription drugs.

Many clients may hesitate to inform their health care provider that they are using herbs. It is therefore important for the health provider to assess the elderly clients’ use of herbs and advise them accordingly.

Warn elderly clients and those with known adverse drug reactions, allergies, chronic skin rashes, or pre-existing liver disease that they have an increased risk of adverse from herbal medicines

Some herbs that may be useful during traumatic periods include:

- Ginko biloba: difficulty in concentration and memory, confusion, lack of energy, depression

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- Kava Kava: relief of anxiety and insomnia (do not use with Parkinson's disease)
- St. John's Wort: mild to moderate depression (do not use with seizure disorders and migraines)
- Valerian: Improves sleep, relieves insomnia, acts as a sedative
- Gorse: despair and hopelessness
- Agrimony, rock rose, red chestnut: anxiety and insomnia

h. Homeopathy

Homeopathy comes from the Greek word "homeo" which means similar and "pathos" which means disease or suffering. (Borion, 2004). It is based on the Law of Similars, or Like Cures Like where stimulating the natural healing properties in the body cures a disease or alleviates a symptom (Freeman, 2004). In other words, when a substance identical to the symptoms of the disease is introduced into the body in very small/minute doses, it stimulates the person's healing energy.

Homeopathic remedies are prepared from natural substances – plant, animal and mineral. The use of micro doses, that is highly diluted doses, assures the minimization of toxicity and side effects. Homeopathic medicines are available in various dosage forms: pellets (tiny beads), tablets, liquids, suppositories, and ointments. Homeopathic remedies are safe, economical, simple to administer, mild in their action and have very few serious or prolonged adverse effects (Micozzi, 2001). Aconite is particularly helpful during excessive trauma and acute fear and can be used very successfully during disaster situations as was found during and post 9/11. Additionally, "Rescue Remedy" a flower remedy is used for any acute shock or upset following a trauma, either physical or mental or injury. Coffea is useful for racing mind; Phosphorus for nightmares, and Ignatia for fear that you will never wake again.

i. Acupuncture

Acupuncture is a modality that assists the body to promote natural healing and improve functioning. It is one of the most commonly used CAM modalities, and is used to treat numerous conditions by balancing the flow of vital energy throughout the body. Illness is seen as a process of energetic disharmony, which acupuncture helps to reestablish by inserting special needles into acupoints just under the skin, to assist correction and rebalancing the flow of energy. (Kuhn, 1999).

By stimulating the acupuncture points, the nervous system releases chemicals and hormones that change the experience of pain or that influence the body's regulating system. The energy and biochemical balance produced by

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acupuncture stimulates natural healing abilities and promotes physical and emotional health and well being.

Of use in trauma situations, Acupuncture can be used to treat insomnia, addictions, environmentally induced illness, migraines, pain and GI disturbances. It should not be used in cases of psychosis.

j. Prayer

Clients with undergoing extreme stress and having encountered a disaster often question “why” or “why not me” and may need support in their desire to connect with something larger and outside of themselves. Focusing on them as spiritual beings allows them to explore the meaning and purpose of their experience and can bring comfort often alleviating pain.

O’Brien (2003) notes that “Prayer is as unique as the individual who prays. Whether one’s prayer is of petition, adoration, reparation, or thanksgiving, both the form and the content may vary greatly” (p.105). Prayer is a simple act of turning our attention to the sacred. Depending on one’s beliefs, this can be God of whatever religion or culture, a higher power, or the ultimate reality. Prayer can be active or passive, involve words or be wordless. It can involve asking something for oneself or another, expressing repentance for wrongdoing and asking for forgiveness, giving praise and honor, summoning the presence of the almighty, or offering gratitude (Ameling, 2000). Many forms of prayer are meditative in nature e.g. centering prayer, mantra, prayer beads, and have the benefits of meditation previously discussed in the section on *Meditation*.

Clients also can benefit from prayerful listening to sacred music or sounds, writing or art, or expressing their intent toward the sacred through some body movement or posture (Taylor, 2003).

k. Support Groups

Support groups are composed of those people who have had a similar problem and are reaching out to others for comfort and ease in dealing with their experience. There is often a sense of security and community in sharing with others who have had similar adversities. Often comfort comes from not having to face misfortune or catastrophe alone. There are many therapeutic benefits of groups: Hope that change is possible and one does not have to be a victim of the past; Caring demonstrated by the listening, compassion, support and attentiveness of others; Acceptance of one’s feelings, thoughts and values by others; Empathy involving a true understanding of another’s struggle such as loneliness, fear, upset, guilt, and through this identification with others, being able to see and understand oneself more with greater

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clarity; Catharsis and being able to express repressed and threatening feelings; Power in recognizing untapped personal reserves and strengths that can be used in dealing with one's issue or crisis; Helping others which can give a sense of altruism and satisfaction; Humor and seeing one's problems from a different perspective; and Group Cohesion which allows a climate of togetherness.

Support groups often are valuable during and after traumatic events as victims of disaster frequently feel that they are the only ones having such feelings about the event – either total personal devastation or relief that they were not harmed or killed. Many people find these feelings and thoughts difficult to express fearing rebuke by others. Additionally, individuals who have experienced a trauma may not be able to discuss it frankly with their families. And often family members are unsure what to say for fear of upsetting the traumatized individual or themselves. It is frequently easier for the individual to discuss it in a group where there are others who have had the same or similar experience and who are not relatives. It also can be helpful for family members to attend a support group with the individual or attend a separate group.

I. Nutrition

Hippocrates once declared: "Let food be your medicine." Lifestyle and nutrition play a fundamental role in healthy aging. Cognitive impairment, depression, lethargy, anemia and poor response to medical, surgical and psychological interventions may be caused by nutritional deficiencies. During traumatic crises, people often have eating/appetite problems. It is particularly important during times of stress to eat well-balanced meals to enhance the ability to cope with excessive stress. Suggestions include: eating regularly no matter how one feels; drinking one quart of water everyday; eating a healthy breakfast with protein; eating live food (fresh fruits and vegetables); limiting stressor foods which can actually increase overall stress (sugar, caffeine, carbonated drinks, high carbohydrates). Under extreme stress, some people overdo it with alcohol or drugs to alleviate feelings or reactions, but these can actually make them worse.

Diets rich in phytochemicals and antioxidants (Kuhn, 1999) are valuable during times of stress. Phytochemicals are plentiful in fruits; vegetables especially broccoli, cauliflower, cabbage, brussel sprouts, onions, garlic, soybeans and kale; whole grains; legumes; and seeds. Phytochemicals are essential to sustain life but are most essential for optimal health and the prevention of disease. They increase resistance to disease and boost immunity. Whole foods contain the phytochemicals, pills do not.

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Antioxidants are a group of vitamins (A, beta-carotene, C, and E; minerals (selenium and zinc); enzymes and the hormone melatonin. Antioxidants are obtained from many food sources (fruits and vegetables, fish, lean meats, whole grains and rice and nuts). They protect the body, increase immunity, and improve response to stress as well as improving mental wellbeing.

m. Exercise

There are many benefits of exercise during periods of stress and crisis. Some of these include an improved mental attitude toward yourself and life in general, greater capacity to cope with stress, more regular and restful sleep patterns, healthier eating, increased ability to avoid or lessen mild depression, and a better connection among body, mind and spirit (Aspen, 2003). Walking, biking, dancing, swimming and easy jogging are all activities that the elderly can participate in.

Several alternative therapies use bodywork and movement to influence physiologic and psychological functioning. These include: The Alexander Technique, The Feldenkrais Method, Rolfing Movement Integration, Pilates Method, and the Trager Approach.

Two techniques very common for mind-body fitness are Yoga and Tai Chi. These modalities open the body to the vital life force to achieve balance.

- i. Yoga is a series of physical postures which can be performed seated, standing, of lying prone or supine. Although there are many branches of Yoga, there are some forms of Yoga which are gentle and most useful for older persons. They use comfortable postures/poses, deep relaxation and breathing practices to coordinate breath and movement. The attempt is to bring about a steady and comfortable equilibrium of mind and body. Yoga has been shown to treat additions, reduce anxiety, and enhance well being in the elderly.
- ii. Tai Chi derived from qigong (Qi or Chi meaning energy and gong meaning work or exercise) is a form of contemplation with movement. One is taught to be mindful of movements and postures and the breathing. As breathing becomes quieter and deeper, postures, movements, the mind and the whole person become calmer (Aspen, 2003). As the individual learns to control some bodily functions, the mind becomes quieted. It promotes serenity, inner peacefulness and focus. Tai Chi is practiced at a slow, strain free pace and has been successfully used with the elderly population.

B. Spirituality

1. Changes in Spirit

a. Implications for Disasters

- * Spirituality is “an awareness that there are levels of reality not immediately apparent and that there is a quest for integration in the face of forces of fragmentation and depersonalization” (Downey, 1997, p. 16).
- *The spirit of the person seeks to transcend suffering through virtues of love, hope, faith, acceptance, courage, and as sense of meaning in the encounter with death and in the midst of fear and despair (Arnold, 1989).
- *Spirituality engenders serenity and transcendence, thereby buffering stress (Doka, 1993).
- *Spirituality further melds the individual’s past, present and future (Hicks, 1999), which can be helpful in times of disaster when individuals draw on past experiences and strengths to cope with the present and hope for the future.
- *In times of crisis or disaster, older adults may experience spiritual suffering as they ask “Why did this happen (to me)?” “Why is God allowing me (us) to suffer?” “Will I be able to finish my life’s work?” and “What will happen after I die?” and answers to these questions may promote healing which can be experienced as acceptance and peace (Puchalski, 2002).

b. Definition of Terms

- i. Spirituality is a more broad concept than religiosity as it refers to the energy in the deepest core of the individual and is an integrating life force that allows individuals to transcend their physical being and gives an ultimate meaning and purpose to life (Conrad, 1995). Spirituality can be understood as the dynamic principles developed throughout the life span that guide a person’s view of the world and influence their perception regarding a higher power or relationship

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with God, as well as sense of hope, trust, faith, love, and moral conviction (Hicks, 1999).

- ii. Religiosity is one way of expressing spirituality and refers to beliefs, and practices of different faiths and an acceptance of their traditions, such as Catholicism, Judaism, Protestantism, and Islam, as examples. Religion, for many, forms a basis for meaning and purpose in life and provides a moral code of behavior (Sherman, 2004).

c. **Benefits of Spirituality and Religiosity for Older Adults**

- i. Religious attendance provided a protective effect for community-dwelling elders against mortality, even after controlling for most potential confounders of social support, health status, and physical functioning (Oman & Reed, 1998).
- ii. For community-residing and institutionalized older adults, personal meaning, and involvement in religious activities were significant predictors of well-being (Fry, 2000).
- iii. Based on a sample of older adults in specialized housing unit, religious beliefs and practices served as a coping mechanism to deal with life's problems and as a source of support (Mull, Cox, & Sullivan, 1987).
- iv. In a sample of men and women ages 66 to 92 years, qualitative findings indicated that most of the older adults believed in a higher power, which supported them constantly and was perceived as a helping, guiding, and healing (Mackenzie, Rajogopal, Meibohm, & Lavizzo-Mourey, 2000).
- v. A systematic review of 724 studies indicated a significant relationship between religious involvement and better mental health, greater social

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support, and less substance abuse as well as depression, lower blood pressure and fewer cardiac events (Koenig, Cohen, & Blazer, 1992; Keonig, 2002).

d. Role of Hope in Spiritual Well-Being

i. Cousins (1979) reminds us that death is not the ultimate tragedy of life

but rather separation from our connections with others and separated from a desire to experience things that make life worth living, separated from hope. This separation may be experienced as a result of disaster.

ii. Spirituality or religiosity may be a source of hope, particularly in

during times of adversity as “spirituality offers hope for living on in the world through a connection with others, traditions and rituals and through establishing legacies” (Sherman, 2004, p. 20).

iii. Definitions

*Hope is not a belief that something is going well, but rather that whatever happens will make sense, no matter how it turns out (Mitchell, 1997).

*Hope may be defined as a positive expectation for meaning attached to an event, recognizing that individuals shape their hopes by finding new meanings for living (Parker-Oliver, 2002).

*Hope is a process of enduring suffering through trust in a higher power, and making meaning in one’s life (Duggleby, 2000).

*Professionals may assist older adults to find hope as they search for meaning in their life circumstances.

*Hope can be promoted by recognizing and encouraging a sense of determination and courage in the face of adversity” (Sherman, 2004, p. 20). Hope can be encouraged through short-term attainable goals, and making meaning of life’s experiences.

*Hope can be provided by listening attentively, which conveys a sense of value and worth and as a result the older adult gains hope that

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he/she will not be isolated or abandoned in their time of distress (Duggleby, 2000).

e. Spiritual Assessment as It Relates to Crisis and Disasters

* Conversations about spiritual needs often begin with the use of open-ended questions such as "Do you have any thoughts about why this is happening to you?" or "Can you tell me more about that" (Lo et al., 2002) as older adults begin to discuss their feelings regarding crisis and disaster.

* Spiritual assessment may include such questions as (Puchalski, 2001; Hermann, 2000):

- Are you suffering in physical, emotional, social, or spiritual ways?
- What is the meaning of the experience to you?
- Do you see a purpose in your suffering?
- Are you able to transcend your suffering?
- Are you in despair or do you feel hopeful?
- What kind of things do you hope for?
- Do your personal beliefs help you to cope?
- What gives your life meaning and purpose?
- Who do you turn to for help?

* Spiritual history or assessment (Highfield, 2000) involves questions related to:

- S:** Spiritual belief system (religious affiliation).
- P:** Personal spirituality or beliefs and practices of affiliation that the older adult accepts.
- I:** Integration with a spiritual community (role of the religious/spiritual group and the individual's role in that group).
- R:** Ritualized practices and restrictions.
- I:** Implications for medical care
- T:** Terminal events planning (impact of beliefs on advance directives).

f. Principles of Spiritual Care (Doka & Morgan, 1993):

- Each person has a spiritual dimension.
- Tragedy, illness, and death can be opportunities for spiritual growth.
- Spiritual care may be different for each individual depending on his or her religious or cultural background.
- Spirituality is supported through formal and informal ways, such as religious practices, secular symbols, rituals, art forms, prayer and meditation.
- Care should be offered in settings that accommodate the needs of religious or spiritual practices and rituals and promote spiritual work.

g. Spiritual Caregiving

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- Spiritual care is more than religious care in that spiritual care discovers, reverences, and tends the spirit---that is the energy or place of meaning and values of another human being” (Driscoll, 2001, p. 334).
- In giving spiritual care, professionals enter the world of others, to respond to fears, concerns, and feelings with compassion and to bear witness to their physical, emotional, social, or spiritual suffering.
- Professionals can support the older adults intrinsic dignity that comes from being a human being with inherent value and worth by reviewing past life experiences and helping the older adult focus on their life accomplishments, the value of their relationships with others, and their ability to forgive and be forgiven. Support can be given to help them complete life tasks or to make peace with themselves, others, or God.
- The existing religious or spiritual practices of the older adult should be supported or encouraged, including the use of prayer.
- If a person is not religious, spiritual conversations can center around hope, love, courage, and forgiveness (Koenig, 2002).
- The presence of professionals can be comforting as well as their caring and listening, rather than giving advice (Koenig, 2002).
- Referral to a clergy member or chaplain as they take time to listen, discern the significance of the spoken word, intuit what is the importance of what is spoken and affirm the value of shared silence (Purdy, 2002).
- Spiritual support may involve listening to rhetorical questions in which the older adult wants an honest hearing of the question rather than an answer or wish to explore such concerns as whether God exists, the meaning of mortality, the integrity of doubt, the need to forgive or the loneliness of suffering (Purdy, 2002).
- Humor can be a source of spiritual uplifting as it can be a coping method for spiritual growth and healing momentarily removing one from an isolated state to join in surprise at ludicrous human situations (Johnson, 2002).
- Spiritual caregiving may involve encouraging older adults to socialize with family, friends, and children or to encourage them to help others, even if it only in the form of active listening.
- Spiritual care can entail preserving an older person’s meaning in life and sense of usefulness by passing on their personal legacies or life stories, reminiscing about the past, encouraging them to watch spiritual or religious television programs or enjoy their favorite sacred or secular music (Hermann, 2000).

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- Professionals can help older adults find a moment of pleasure in the present moment or enjoy some aspect of nature even in the face of adversity, such as disaster.

C. Rituals

1. The Role of Ritual

- a. Philosophy and rationale related to rituals for disasters
 - i. Human beings are ‘hard-wired’ to do rituals; there is a neurobiological basis.
 - ii. Rituals address the range of psychological, social and political factors/aspects that may be associated with immediate post impact and long-term stages of disaster recovery.
 - iii. Rituals have both spiritual and societal purposes and can address individual and collective needs.
- b. What is ritual?
 - i. Definition of ritual: ritual provides a framework, a container, and way to symbolically “mark” events. Rituals have specific stated intentions and separate ritual time and space from the everyday.
 - ii. The arts and crafts of rituals are the senses and symbols. Ritual is a sensory and a symbolic experience. It is necessary to choose appropriate symbols for the ritualized event, and stimulate the senses through sensory props.
 - iii. The method acknowledges and honors cultural and religious practices and beliefs of participants. This is used as a starting point for discussing and planning rituals.
 - iv. Reminiscence, life review and stories are compatible with rituals. They can help to build selfhood, community and recapture meaningfulness.
- c. What are the benefits of rituals for disasters?
 - i. Relief of anxiety and comfort: for healing, safety, and hope
 - ii. Integration and healing: for the individual, families and communities to honor what have been lost and develop coping strategies
 - iii. Order and clarity: for betwixt and between times;
 - iv. Continuity and community: for times of change is a framework for understanding and contextualizing the disaster

2. Types of disaster rituals (post disaster, commemorations, memorials)

- a. Commemorative rituals/first anniversaries
- b. Rituals of loss and expression of grief
- c. Rituals of hope and resolution

3. Building a ritual “toolkit” and using the elements of ritual

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- a. The toolkit provides a way to respond to and develop rituals in a variety of settings and situations. Start with the senses and symbols.
- b. Senses and symbols: include a shawl or colored cloth, bowl of water, candle or flashlight, shells, flowers & vase, and sweet candies. Add to the kit other items such as: camera, colored paper & pens, yarn, colored stones and feathers.
- c. Music: collect healing music, cultural music, music from different areas, chimes, bells, and other instruments and musical genres.
- d. Use the elements of ritual: beginning, middle, end, and stated intention, opening, activity, and closing. Be creative.
- e. Don't forget the power of the circle as a formation for doing ritual.

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