AUSTRALIAN CHILD & ADOLESCENT TRAUMA, LOSS & GRIEF NETWORK

ANU
THE AUSTRALIAN NATIONAL UNIVERSITY

GUIDE FOR HEALTH PROFESSIONALS WORKING IN PRIMARY CARE

SUPPORTING CHILDREN, YOUNG PEOPLE AND THEIR FAMILIES AFFECTED BY THE VICTORIAN BUSHFIRES

Booklet produced for the Victorian Bushfire Support and Training for Affected Schools Project

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THE AUTHORS

- Dr Elspeth Macdonald (Director), Sarah Olesen, Amanda Harris, Dr Virginia McAndrew, Elspeth Froude, Michelle Roberts, Ruth Wraith from the Australian Child and Adolescent Trauma, Loss and Grief Network.

- Professor Beverley Raphael, Chair of the National Mental Health Disaster Response Committee and Taskforce.

- Dr Penny Burns, Fellow in Disaster Medicine at the University of Western Sydney.

ACATLGN is a national collaboration to provide expertise, evidence-based resources and linkages to support children and their families through the trauma and grief associated with natural disasters and other adversities. It offers key resources to help school communities, families and others involved in the care of children and adolescents.

Introduction

These guidelines are designed to assist those working with children, young people and their families after the disaster of the Victorian Black Saturday bushfires (February 2009). The information in these guidelines will be relevant to a range of health professionals working in primary care settings.

Each of the health professionals will bring their own professional background, skills, experience and special attributes. It is intended that the material covered in this guide can be used to inform those working in various community-based settings. This may include: general practitioners, maternal and child health nurses, community-health staff, school health nurses, school-based psychologists and counsellors, community-based allied health professionals and others with specialised health or mental health training. The guidelines are informed by high quality evidence, the general consensus of experts in the field and clinical experience.

The **Guide for Supporting Children, Young People and their Families** is a living or dynamic document, which may be continually edited and updated. ACATLGN welcomes input about concerns and difficulties that those working with children, young people and families might face over the coming months. We also welcome any additional information you have that may be useful for other professionals. Please contact us to provide any feedback or suggestions:

http://www.earlytraumagrief.anu.edu.au/contactus/

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Links to this document are

http://www.earlytraumagrief.anu.edu.au/disasters_children/primary_care/
http://www.earlytraumagrief.anu.edu.au/health_general_practitioner/

Guide for supporting children, young people and their families affected by the Victorian Bushfires

Children of all ages can be profoundly affected by disasters such as the Victorian Black Saturday bushfires; through the trauma, grief, destruction of their sense of safety and security, and loss of home or school networks. Most important is the support and guidance for parents and assistance for their needs as well as the information to help them respond to their own children's issues. The needs of children and adolescents can also be systematically addressed through their school systems, communities and other groups.

A useful resource for dealing with children affected by disasters is LaGreca et al's comprehensive volume, 'Helping Children Cope with Disasters and Terrorism' (2002). Many excellent resources have been developed and are being used to support the response to this bushfire disaster. Network-based resources are available at:

www.earlytraumagrief.anu.edu.au

Primary health issues (general health and mental health, bereavement and loss, trauma syndromes, complex problems) are covered in the **General Practitioner Guide for Management of Mental Health and Related Consequences in the Victorian Bushfires**

http://www.earlytraumagrief.anu.edu.au/disasters_children/general_practitioner_disasters/

Specific programs are being developed in close partnership with school organisations and in partnership with the Australian Child and Adolescent Trauma Loss and Grief Network.

Children's reactions to the disaster will be influenced by:

- How directly they were affected by the fires

    o close direct experience leading to feelings of fear, terror and possibly panic

    o death of parents or family members

    o loss of significant others

    o damage/destruction of home, neighbourhood, school or community

    o loss of loved pets, toys etc.

- If they were separated from parents at the time, then the parents' reactions, both immediately and subsequently, will be important for the child, as will be how much parents, even in their own distress, can support and respond to the child afterwards. The broader family and social network are also important.

- Excessive TV viewing of traumatic images of the disaster.

- The child's stage of development. Young children may be particularly vulnerable.

- Ongoing disruptions, including not being able to return to school, accommodation insecurity, ongoing life and family disruptions (McFarlane 1987, McDermott & Palmer 2002, McDermott et al 2005).

Children's reactions

Children's reactions will differ, depending on their age, experience and ongoing circumstances. *Children may have ongoing fears* regarding safety, security and separation from parents. These fears may present as follows:

- young children - regression, clinging, sleep difficulties

- older children - bravado, withdrawal, emotional problems, behavioural problems, sleep difficulties

- adolescents - acting out, caregiving, arousal, depression, drug use, sleep difficulties.

Children may experience grief at the losses that have occurred and show sadness, withdrawn behaviours, seek comfort from other family members, cling to attachment objects, ask questions repetitively.

- young children - may not understand the finality of death, may feel abandoned

- older children - may 'attach' to others, seek security, experience guilt

- adolescents - may show a range of grieving emotions or denial, anger, guilt, pseudomaturity.

Children may develop trauma syndromes eg PTSD:

- high arousal, sleep difficulties, irritability, lack of concentration

- numbing, avoidance, withdrawal

- re-experiencing, including some repetitive play

- developmental regression.

Children may develop traumatic grief

This is a mixture of trauma and grief and is common in such circumstances.

Children are vulnerable to multiple stressors: Chemtob et al (2008) have highlighted the particular vulnerabilities of children when there are multiple stressors. This is particularly problematic in the current disaster. He has also demonstrated impacts for pre-school children in such circumstances.

Children may be quiet, good and compliant early after the disaster, until they regain some sense of a secure world, and only later show the impact (even six months or more afterwards).

Common symptom patterns include:

- increased fearfulness about any threat

- clinging, and possibly regressed behaviours, fearing separation

- sleep difficulties

- general bodily complaints eg. stomach pains, headaches

- difficulties concentrating at school

- withdrawn, sad, and even depressed response

- aggressive, acting out, even conduct problems.

Disasters may impact on development through the severity of the children's experience, their reactions, and the degree to which they are able to be supported adequately. However it's important to remember children's resilience and to recognise and assist this.

Helping children involves also helping parents, or other caregivers close to the child, by: (i) supporting them with their own needs about their experiences given the disaster and their own trauma and grief; and (ii) providing them with advice about children's needs and how to support them. For instance, children need reassurance:

- that they are loved

- that they will be safe and secure

- that they can share, or speak about, any of their feelings

- that they can ask questions that will be answered simply and honestly

- that they will be comforted and looked after now and in the future.

Helping children involves supporting their resilience by recognising and promoting their:

- positive, hopeful and optimistic responses

- connectedness to others and their social skills

- capacity for recognising and expressing their own feelings

- capacity to focus and problem solve as appropriate to their developmental levels

- sense of self.

For more information see: http://www.embracethefuture.org.au/resiliency/index.htm

Recognising changes in behaviour

Changes in childrens' behaviour can be influenced by the child's:
- disaster-related exposure to threat, loss, dislocation/disruption events

- post-disaster environment such as life adversities, other stressors, and loss of resources as a consequence of the disaster

- cognitive and physical development, gender.

Persistent changes in the following may indicate the need for further assessment:

- 'clingy' behavior with parents or other caregivers

- refusing to return to sleep alone, go to school

- specific fears related to the bushfire (such as fears about being permanently separated from parents)

- disturbed sleep - such as nightmares, screaming during sleep and bedwetting

- loss of concentration and irritability

- being startled easily or jumpy

- behaviour problems, such as misbehaving in school or at home in ways that are not typical for the child

- regression in developmental achievements

- somatic (body) complaints (stomach aches, headaches, dizziness) for which a physical cause cannot be found

- withdrawing from family and friends, sadness, listlessness, decreased activity

- preoccupation with the events of the bushfire (play, re-enactments).

Adapted from

American Academy of Child and Adolescent Psychiatry (2005). **Helping children after a disaster.** Accessed at:
http://aacap.org/page.ww?name=Helping+Children+After+a+Disaster&section=Facts+for+Families

American Academy of Pediatrics. **Psychosocial issues for children and families in disasters: A guide for the primary care physician.** Accessed at:
http://mentalhealth.samhsa.gov/publications/allpubs/SMA95-3022/default.asp

Trauma and grief experiences

Bushfire-related losses occur in extra-ordinary circumstances where children and young people may have experienced:

- a death in the family, such as the death of a parent, sibling, other close family member, or the death or loss of someone else important to the child where there is a strong attachment or relationship

- extreme personal terror if they were in the fire themselves. Even if they were not present at the time of the fires, children and adolescents sometimes experience images surrounding the circumstances of the death of someone close to them

- fear that they themselves, a family member or someone close to them might die or be injured in the bushfire

- knowing someone personally, who was not a family member or someone close to them, who died as a result of the bushfire

- separation from their parents, other family members or those they normally live with

- the destruction of their sense of safety and security, changes in their parents' wellbeing, loss of home, pets and cherished possessions, loss of school, loss of peer and community networks.

These traumatic experiences that are potentially life-threatening or threaten the child's physical safety, can result in feelings of horror, fear and/or helplessness (Cohen, Kelleher, & Mannarino, 2008).

When death occurs in traumatic circumstances, such as in a bushfire or other disasters, the experience for survivors is likely to be associated with psychological trauma. A child's reaction in such circumstances may be a complex mixture of grief and trauma responses, and is more painful and difficult for children (and adults) to deal with.

> "It is important to differentiate between after-effects, caused by the traumatic nature of the death, and grief reactions. When a death occurs suddenly, the child's reactions are partly caused by the nature of the death and the way they are told about it, and partly by the loss itself." (Dyregov, A., 2008, Grief in Children: A handbook for Adults 2nd ed. p. 44)

Children's responses to deaths

A comprehensive guide is provided by the American Academy of Pediatrics: *Psychosocial issues for children and families in disasters: A guide for the primary care physician.*

Accessed at: http://mentalhealth.samhsa.gov/publications/allpubs/SMA95-3022/default.asp

Table five in this guide provides details of the developmental considerations, effect of disasters, results of disasters, views of disasters in the comprehension of death in children and adolescents.

It's useful to bear in mind that the age ranges are approximate and that responses to loss are influenced by a range of factors including temperament, modelling of parents and peers and cultural and religious traditions.

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Children's responses to potentially traumatic events

A single-page of information was developed by the **National Institute of Mental Health**, **USA**, for community workers supporting children exposed to disaster. It includes information on possible responses to disaster and how to provide assistance to children and adolescents affected by disaster.

Accessed at: http://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-violence-and-disasters-what-community-members-can-do/how-children-react-to-trauma.shtml

Childhood Traumatic Grief responses

Childhood Traumatic Grief (CTG) is also known as Traumatic Bereavement and Traumatic Loss in children. CTG is a form of non-typical bereavement sometimes seen in children who experience a traumatic loss. A traumatic loss is the death of someone close to the child under traumatic circumstances (Cohen, Mannarino, Greenberg, Padlo, & Shipley, 2002); for example, due to domestic violence, natural disaster, or suicide. Death '*from natural causes can also result in traumatic grief if the child's subjective experience of the death is traumatic'* (Cohen et al., 2002) p. 308). For example, the child may be told about the traumatic nature of the death and imagine what this looked like.

- When traumatic grief occurs, bereaved children experience trauma symptoms that impede their ability to grieve in a normal way. This means that they cannot come to terms with, and adapt to, the death of their loved one. Trauma symptoms in children include having intrusive and upsetting thoughts and memories about the death. These are usually triggered by reminders of the death, such as places, people, memories, and objects that are linked to the deceased person. These thoughts lead to physical symptoms of anxiety (e.g., shaking, headaches, dizziness) that are distressing for the child. The symptoms of normal grief and Traumatic Grief may look different depending on the child's developmental age (For further information about these stages see Cohen et al., 2002).

- Children often avoid reminders of the death or deceased person to prevent having these feelings (e.g., if the death often comes to the child during dreaming, the child may avoid/refuse bedtime). Avoidance also includes 'numbing' one's self to the outside world, which may lead to further feelings of loneliness. Trauma symptoms, and the avoidance reflected by some of these symptoms, can prevent the bereaved child from successfully grieving their loss and adapting to life without the loved one. For example, they may be unable to reminisce about happy times with the person because all memories may trigger negative and traumatic reminders and feelings (Pynoos & Nader, 1990).

- *Differences between Childhood* **Posttraumatic Stress Disorder** *(PTSD) and CTG*: The trauma symptoms seen in childhood PTSD and CTG are very similar. However, in CTG these symptoms specifically impact upon the child's ability to grieve their loss and interfere with their adaptation to life without loved ones. PTSD does not necessarily (though can) have this effect; i.e., a child may have PTSD but still be able to grieve. Children with CTG can also develop symptoms from reminders of the lost loved one. **Posttraumatic Stress Disorder (PTSD)** (DSM IV) is diagnosed when a constellation of symptoms of marked psychological distress in response to a trauma, persist for more than a month and cause significant distress or impairment in functioning. This would include

persistent re-experiencing symptoms, persistent avoidance of reminders of the trauma with numbing of responses, and physiological arousal.

Two useful reviews

American Academy of Pediatrics. **Psychosocial issues for children and families in disasters: A guide for the primary care physician.**
Accessed at: http://mentalhealth.samhsa.gov/publications/allpubs/SMA95-3022/default.asp

Wooding, S., & Raphael, B. (2004). **Psychological impact of disasters and terrorism on children and adolescents: Experiences from Australia.** *Prehospital and Disaster Medicine, 19*(1), 10-20.
Accessed at: http://pdm.medicine.wisc.edu/TOC191.htm

What the health professional working in primary care can do

Health professionals working in primary care can be in a position to monitor children and adolescents' health and wellbeing, including mental health symptoms. This should be specifically done, as well as supporting parents and family members for their own needs and those of their children. Support in ongoing ways over time is important.

An international consensus process has identified the following five overarching principles as important for ongoing care post-disaster (Hobfall et al 2007):

- Promoting a sense of safety, security

- Promoting calming

- Promoting a sense of effectiveness (people being able to take actions themselves will help with their recovery)

- Promoting connectedness – links to family, peers, network of support

- Promoting hopefulness.

These positive strategies can take place alongside assessment and care dealing with distress and suffering.

Health professionals working in primary care can:

- Provide advice, information and support to manage fears

- Monitor symptoms and behaviours over time and:

    o discuss with parents and advise

    o with high levels of increasing distress / behavioural change persisting beyond the first month – discuss with parents, reassure, seek expert advice and refer if necessary

o   refer for assessment by a skilled mental health professional who can provide specific assessment and care.

Engaging children and their families in mental health treatment may be a 'process' rather than simply the single action of referring them to another provider. In order for the child and/or family to receive appropriate treatment, it may be necessary for the primary care health worker to provide ongoing monitoring and encouragement (Cohen et al., 2008).

The opportunity to gather mental health information about children after a disaster may be gained from their parents when reviewing them or from their parents for other reasons e.g. when presenting at the general practitioner with physical complaints.

The needs of children after disasters are well addressed by Pynoos et al (2007) who emphasise a public mental health approach. They have outlined stages of post-disaster intervention.

- ***Psychological first aid*** (National Child Traumatic Stress Network and National Center for PTSD). Brief supportive interventions for children and families in the early weeks including emotional support, social support, practical assistance, information gathering and provision, and linking with collaborative services.

  Many of the important concepts are highlighted by Pynoos, Steinberg, and Brymer (2007) and Vernberg et al (2008).

Psychological First Aid

These objectives include:

Making contact

Ensuring immediate safety and comfort

Helping with stabilization

Gathering information

Providing practical assistance

Promoting use and provision of social support

Providing information on coping

Linking with collaborative services

From Pynoos, Steinberg, & Brymer 2007, p. 56 ; Vernberg et al 2008

A PDF version of the *Psychological First Aid: Field Operations Guide* can be accessed at:
http://www.nctsnet.org/nccts/nav.do?pid=typ_terr_resources_pfa

For more information:
http://www.earlytraumagrief.anu.edu.au/disasters_children/psychological_first_aid/

- *Skills for psychological recovery* (FEMA and CMHS in the USA). These skills are relevant for adults and children and help to build on resilience.

Skills for Psychological Recovery

(FEMA and CMHS in the USA)

These skills are relevant for adults and children and help to build on resilience.

- Assistance with problem-solving and coping to deal with ongoing post disaster stresses

- Strengthening capacity to manage ongoing trauma and loss reminders

- Focused assistance with particularly troubling aspects of the disaster experience

- Helping to restore family functioning and normal routines

- Assisting children and families in managing ongoing grief reactions and emerging depressive responses

- Promoting linkage with mental health, health and social services

- Promoting child, youth and family developmental progression, taking into account the new "normalities"

- Enhancing information for ongoing safety personally and for health

- Promoting constructive activities for personal and social resilience

From Pynoos, Steinberg, & Brymer 2007

- *Enhanced services*. The primary therapeutic foci are traumatic experiences; trauma and loss reminders; trauma–related bereavement; post-disaster adversities; and assisting developmental progression.

- *Specific treatments*: treatment strategies utilising the evidence are outlined below for children and adolescents who have developed significant disorders and for whom there may be an exacerbation of pre-existing problems and co-morbidity of trauma or grief syndromes with other mental health problems.

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Three tiers are proposed in order to meet children's varying needs and differ according to the objectives, the settings in which interventions are provided, the expected level of expertise of personnel, the program content, and the modalities of delivery of interventions (Pynoos et al., 2007).

Primary care health workers are likely to provide interventions at Tiers 1 and 2 of the three tiers or levels of care:

- o **Tier 1 – broad interventions** to promote adaptive adjustment, normal developmental progression, and prevent the onset of problems

- o **Tier 2 – specialised interventions** to reduce psychological distress, promote normal developmental progression and adaptive adjustment for children and adolescents who have been moderately to severely affected, and to prevent as far as possible severe and persisting mental health problems

- o **Tier 3 – highly specialised interventions** by expert mental health professionals to reduce severe psychological distress, high-risk behaviours and to treat severe mental health problems and their associated functional impairments.

In deciding the intervention it is critical to consider the:

- child's **developmental age** (infants; toddlers & preschoolers; primary school aged; secondary school aged)

- **degree** to which the child was affected by the disaster exposures – e.g., the level of threat, loss, disruption/dislocation, secondary/other adversities

- **stage of recovery** – for example, the period before the disaster, when the disaster occurs, immediately after the disaster, days to weeks after the disaster, months or years after the disaster

- degree to which the family, other carers, the school and other providers can be involved in the child's care.

Evidence of what works

- Cognitive behaviour therapy programs focused on children's fearful trauma-related symptoms, particularly child PTSD can be provided and will assist (Pynoos et al 2007, McDermott et al 2005).

- Traumatic grief has been effectively managed after disasters with specific initiatives such as eight or more sessions of trauma and grief-focused interventions in schools (Pynoos et al 2007), or others delivered through specific programs provided in clinical or other settings (Cohen et al 2006). These programs are important because they have been applied directly to disaster-affected populations and build on earlier trials.

- Programs integrated into school settings, for instance with a bushfire related workbook for children to fill in with linked risk-assessment and intervention option (McDermott et al 2005, McDermott & Palmer 2002).

- Group and individual intervention with 10 session manualised treatment for grief and trauma have been evaluated positively for a disaster-affected population, four months after Hurricane Katrina (Salloum & Overstreet 2008).

- School based programs have been shown to be effective in a number of studies, particularly building on the work of Chemtob et al (2002).

- Summary of evidence for the management of PTSD in adults and children in primary and secondary care (National Guideline Clearinghouse)
  Accessed at: http://www.guideline.gov/summary/summary.aspx?doc_id=6850
  [taken from National Collaborating Centre for Mental Health. Posttraumatic stress disorder: the management of PTSD in adults and children in primary and secondary care. London (UK): National Institute for Clinical Excellence (NICE); 2005.]

Resource Websites

Australian Child and Adolescent Trauma, Loss and Grief Network
http://www.earlytraumagrief.anu.edu.au

Early Childhood Australia
http://www.earlychildhoodaustralia.org.au

National Center for Child Traumatic Stress Network
http://www.nctsnet.org

National Center for PTSD (USA)
http://www.ncptsd.va.gov

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