

# Rutgers Psychological First Aid

## Psychological First Aid Components Provided

Date: \_\_\_\_\_ Provider: \_\_\_\_\_ Location: \_\_\_\_\_

Provider: Place a checkmark next to each component of Psychological First Aid that you provided in this session.

### **Contact and Engagement**

- Initiated contact in an appropriate manner
- Asked about immediate needs

### **Safety and Comfort**

- Took steps to insure immediate physical safety
- Attended to physical comfort
- Attended to a child separated from parents
- Assisted with concern over missing loved one
- Assisted with acute grief reactions
- Attended to spiritual issues regarding death
- Provided information about funeral issues
- Helped survivors regarding death notification
- Helped with confirmation of death to child
- Gave information about the disaster/risks
- Encouraged social engagement
- Protected from additional trauma
- Assisted after death of loved one
- Helped with talking to children about death
- Attended to traumatic grief
- Helped survivors after body identification

### **Stabilization**

- Helped with stabilization
- Gathered information for medication referral for stabilization
- Used grounding technique

### **Information Gathering**

- Nature and severity of disaster experiences
- Concerns about ongoing threat
- Physical/mental health illness and medication(s)
- Extreme guilt or shame
- Availability of social support
- History of prior trauma and loss
- Death of a family member or friend
- Concerns about safety of loved one(s)
- Disaster-related losses
- Thoughts of harming self or others
- Prior alcohol or drug use
- Concerns over developmental impact
- Other: \_\_\_\_\_

**Practical Assistance**

- Helped to identify most immediate need(s)
- Helped to develop an action plan
- Helped to clarify need(s)
- Helped with action to address the need

**Connection with Social Supports**

- Facilitated access to primary support persons
- Modeled supportive behavior
- Helped problem-solve obtaining/giving social support
- Discussed support seeking and giving
- Engaged youth in activities

**Information of Coping**

- Gave basic information about stress reactions
- Taught simple relaxation technique(s)
- Assisted with developmental concerns
- Addressed negative emotions (shame/guilt)
- Addressed substance abuse problems
- Gave basic information on coping
- Helped with family coping issues
- Assisted with anger management
- Helped with sleep problems

**Linkage with Collaborative Services**

- Provided link to additional services service(s): \_\_\_\_\_
- Promoted continuity of care \_\_\_\_\_
- Provided handout(s) \_\_\_\_\_

Adapted from: “Brymer M, Jacobs A, Layne C, Pynoos R, Ruzek J, Steinberg A, Vernberg E, Watson P, (National Child Traumatic Stress Network and National Center for PTSD), Psychological First Aid: Field Operations Guide, 2<sup>nd</sup> Edition. July, 2006.”

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## Student Needs

Date: \_\_\_\_\_ Provider: \_\_\_\_\_ Survivor Name: \_\_\_\_\_ Location \_\_\_\_\_

Provider: Use this form to document what the survivor needs most at this time. This form can be used to communicate with referral agencies to help promote continuity of care.

**1. Place a checkmark next to the corresponding difficulties the survivor is experiencing.**

| BEHAVIORAL   | EMOTIONAL   | PHYSICAL  | COGNITIVE  |
|--|---|---|--|
| <input type="checkbox"/> Extreme disorientation                            | <input type="checkbox"/> Acute stress reactions                 | <input type="checkbox"/> Headaches                      | <input type="checkbox"/> Inability to accept/cope with death of loved one(s) |
| <input type="checkbox"/> Excessive drug, alcohol, or prescription drug use | <input type="checkbox"/> Acute grief reactions                  | <input type="checkbox"/> Stomachaches                   | <input type="checkbox"/> Distressing dreams or nightmares                    |
| <input type="checkbox"/> Isolation/withdrawal                              | <input type="checkbox"/> Sadness, tearful                       | <input type="checkbox"/> Sleep difficulties             | <input type="checkbox"/> Intrusive thoughts or images                        |
| <input type="checkbox"/> High risk behavior                                | <input type="checkbox"/> Irritability, anger                    | <input type="checkbox"/> Difficulty eating              | <input type="checkbox"/> Difficulty concentrating                            |
| <input type="checkbox"/> Regressive behavior                               | <input type="checkbox"/> Feeling anxious, fearful               | <input type="checkbox"/> Worsening of health conditions | <input type="checkbox"/> Difficulty remembering                              |
| <input type="checkbox"/> Separation anxiety                                | <input type="checkbox"/> Despair, hopeless                      | <input type="checkbox"/> Fatigue/exhaustion             | <input type="checkbox"/> Difficulty making decisions                         |
| <input type="checkbox"/> Violent behavior                                  | <input type="checkbox"/> Feelings of guilt or shame             | <input type="checkbox"/> Chronic agitation              | <input type="checkbox"/> Difficulty making decisions                         |
| <input type="checkbox"/> Maladaptive coping                                | <input type="checkbox"/> Feeling emotionally numb, disconnected | <input type="checkbox"/> Other: _____                   | <input type="checkbox"/> Preoccupation with death/destruction                |
| <input type="checkbox"/> Other: _____                                      | <input type="checkbox"/> Other: _____                           |   | <input type="checkbox"/> Other: _____  |

**2. Place a checkmark next to any other specific concerns**

- Past or preexisting trauma/psychological problems/substance abuse problems
- Injured as a result of the disaster
- At risk of losing life during the disaster
- Loved one(s) missing or dead
- Financial concerns
- Displaced from home
- Living arrangements
- School/Work
- Assisted with rescue/recovery
- Has physical/emotional disability
- Medication stabilization
- Concerns about child/adolescent
- Spiritual concerns
- Other: \_\_\_\_\_

**3. Please make note of any other information that might be helpful in making a referral.**

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**4. Referral**     CAPS     DOS     VPVA     Health Services     Crisis Numbers

- Within project (specify) \_\_\_\_\_
- Other disaster agencies
- Professional mental health services
- Medical treatment
- Substance abuse treatment
- Other community services
- Clergy
- Other: \_\_\_\_\_

**5. Was the referral accepted by the individual?**

Yes     No

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