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ABSTRACT
                Within the last decade, the role of the school psychologist
has been changing as a result of the impact of disasters and increasing
violence in schools and communities. This workshop was designed to help
school psychologists prepare for and intervene in disasters in their school
communities. The goals were: (1) to encourage school psychologists to broaden
their roles to include crisis intervention as an essential part of their
service deliveries; (2) to learn how intervention can give clues to
prevention; (3) to share information about disasters; and (4) to provide
participants the opportunity to prepare for disasters and assess their
feelings that may affect their service delivery. A chart details the four
phases of survivors' emotional reactions to disasters and several key
concepts of disaster mental health are explained. Also included is a personal
account of one mental health disaster volunteer's experiences and the lessons
learned. The importance of learning ways to take care of themselves is
stressed for the disaster mental health worker in order to prevent them from
becoming secondary victims of a disaster. (Contains 27 references.) (JDM)

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Risk Prevention for All Children/Adolescents:
Lessons Learned From Disaster Intervention

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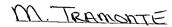Lowell Public Schools
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INTRODUCTION

Within the last decade, the role of the school psychologist has been <u>changing</u> as a result of the impact of disasters and increasing violence in our schools and communities. Some school districts have already experienced disasters: disasters that were weather-related, accident-related, illness-related, or bizarre and unusual (such as school shootings).

To help school psychologists prepare for and intervene in disasters in their school communities, this certified school psychologist has prepared this workshop with four objectives: (1) to encourage school psychologists to <u>broaden</u> their roles to include crisis intervention as an essential part of their service deliveries and to become trained and involved in disaster work;

(2) to learn how intervention can give clues to prevention that should be our primary concern;

(3) to share information about disasters in general and about this certified school psychologist's experiences as a Red Cross mental health disaster volunteer; and

(4) to provide participants with an opportunity to introspect about disasters and to assess their own feelings that may and can affect their service deliveries in dealing with several types of disasters.

Since this paper and workshop were prepared for participants with limited experience in the topic of disaster,

several complete quotations are purposely included to give the school psychologists the full measure of each of the expert's suggestions in his or her own words.

DEFINITION OF DISASTER

The Federal Emergency Management Agency (FEMA) defines a disaster as follows:

> A **major disaster** is defined as any natural catastrophe, or regardless of cause, any fire, flood, or explosion that causes damage of sufficient severity and magnitude to warrant assistance supplementing state, local, and disaster relief organization efforts to alleviate damage, loss, hardship, or suffering. Events associated with disaster are capable of causing traumatic stress when they cause or threaten death, serious injury, or the physical integrity of individuals. (FEMA, Pub. 229 (4), November 1995, p. 1).

Quarantelli (1985, pp.41-52) combines seven elements to answer the question, "What is a disaster?"

1. **Physical agents** (the fires, floods, tornadoes, etc.).

2. **Physical impact** (the visually observable destruction done by the physical agents).

3. **Assessment of physical impacts** (the damage has to exceed certain thresholds).

4. **Social disruption** (due to physical damage).

5. **Social constructions of reality** (perceptions of the seriousness of the impact)

6. **Political definitions** (official disaster declarations).

7. **Demands for action** (which exceeds normal response capabilities).

DISASTER TYPOLOGIES

According to Farberow and Gordon (1986), "Disasters vary in size, scope, extent of damage, loss of life, injury, and degree of disruption to the family and the community. They may be natural or manmade events, extend over a few moments or many months" (p. 3). Young (1994) categorizes disasters into a classification according to (a) **cause**: natural, industrial, or human (such as school shootings); and according to (b) **elements**: (earth, air, fire, water, and people).

The National Center for PTSD (2001) organizes disasters into (a) **natural** (earthquakes, floods, hurricanes, tornadoes, wildfires); (b) **technological** (chemical explosions, fires, toxic spills, transport accidents); and (c) **criminal** (arson, gang violence, riots, mass killings, terrorist acts). "Catastrophes, in general, progress through eight time stages: pre-disaster conditions, warning, threat, impact, inventory, rescue, remedy, and recovery" (Farberow and Gordon, 1986, p. 3). Although disasters and/or their timing usually occur unexpectedly, some can be anticipated. Planning for a disaster can prevent it from becoming overwhelming and causing undue loss.

THE FOUR PHASES OF DISASTER

There are four physical aspects (phases) of disaster that correspond to survivor emotional reactions (Weaver, 1999, p. 1). They are quoted as follows:

1. **Heroic Phase:** This phase occurs prior to or at the time of the disaster. Individuals in a community work together to save each other and their property. Everyone is concerned with survival.

2. **Honeymoon Phase:** This phase takes place within two weeks to two months after the disaster. Being promised help from government and communal agencies, the survivors feel optimistic about rebuilding their lives.

3. **Disillusionment Phase:** This phase lasts from about two months to one to two years after the disaster. Due to frustrations with bureaucracy's recovery delays, failures, and paperwork, the survivors turn to themselves to begin to rebuild their lives. Their frustration with organizations is identified as the "Second Disaster."

4. **Reconstruction Phase:** This phase may last for several years after the disaster. Individuals and the community work together to rebuild and reestablish normal functioning.

A CHART OF SURVIVOR EMOTIONAL REACTIONS TO THE FOUR PHASES

Cited from the American Red Cross Disaster Relief brochure (1995, p. 3), the following are the four phases along with the emotional reactions of survivors for each phase:

HEROIC PHASE	HONEYMOON PHASE	DISILLUSIONMENT PHASE	RECONSTRUCTION PHASE
Shock Fear Confusion Adrenalin rush Heroic acts People coming together	Attend to basic needs in chaotic environment Concerns about safety, food for today, place to sleep Unrealistic expectations about recovery Sharing of resources/ willingness to help others	Reality of impact on lives and community Realization of losses and work to be done Procedures to get assistance Community politics begin to emerge Grieving Psychosomatic complaints Abuse issues	Light at the end of the tunnel Begin to put the disaster behind Renewed feeling of empowerment Post-traumatic stress disorder Return to pre-disaster activities

DISASTER MENTAL HEALTH

The American Red Cross (1987) reports that disaster mental health (DMH) services function at three levels (population, environment, and individual) and can be classified into five types (education, problem solving, advocacy, referral, and intervention). Weaver (1999) describes disaster mental health as follows:

> Disaster mental health (DMH) is designed to
> help the victims (and the relief workers who
> rush to their aid) learn to cope effectively
> with the extreme stresses they will face in
> the aftermath of a disaster. The primary
> skills used for DMH intervention are advocacy,
> mediation, education, defusing, and debriefing (p. 1).

Weaver (1999, p. 1) further delineates the goal of DMH:

> The goal of DMH is to prevent the development
> of long-term, negative psychological

consequences of a disaster such as the
development of PTSD. Victims and relief
workers will be changed by their encounters
with disasters, but the majority of them will
not be damaged by those experiences.

The National Center for PTSD (2001) identifies the following as "the goals of on-site mental health care in the wake of disaster." They are quoted below:

PROTECT: Help preserve survivors' and workers' safety, privacy, health and self-esteem.

DIRECT: Get people where they belong, help them to organize, prioritize, and plan.

CONNECT: Help people communicate supportively with family, peers, and resources.

DETECT: Screen, triage, and provide crisis care to persons at-risk for severe problems.

SELECT: Refer people to health, spiritual, mental health, or social financial services.

VALIDATE: Use formal and informal educational opportunities to affirm the normalcy and value of each person's reactions, concerns, ways of coping, and goals for future.

The following quotes are Weaver's (1995, pp. 67-87) list and descriptions of seven helping processes used by DMH workers:

1. **Emotional First Aid** – This consists of 11 suggestions:

    a. Remain calm – Be an appropriate role model.

    b. Introduce yourself and your agency/services role.

    c. Get needed demographic information immediately.

d. Use active listening skills and allow plenty of time
    for ventilation.

e. Give process details that help lessen fear of the
    unknown.

f. Be truthful about what you have to offer and be careful
    not to overstate it.

g. Verify attentiveness. You may need to repeat things
    several times for survivors in shock.

h. Usually, it is best not to stop any tears.

i. Sometimes, giving a hug may help.

j. Shun 'Superman/Wonderwoman' urges and involve others.

k. Learn to recognize and remember your own limitations.

2. **DMH Crisis Intervention** - There are three objectives.

a. To relieve feelings of survivor (or helper) anxiety,
    depression, and guilt.

b. To prevent further disorganization or decompensation.

c. To screen for those persons with more serious problems
    and/or issues that may require additional services (and
    possibly need ongoing mental health treatment).
    With DMH interventions, a three-part formula is
    employed: Get People Talking; Get People Busy Doing
    Something Constructive; and Begin Problem Solving.

3. **The Miraculous Healing Powers of Sleep** - Sleep, or lack of
    it, can be the DMH worker's best friend or worst enemy.

Survivors and DMH workers need to sleep in order to deal with the disaster and its aftermath.

4. **Defusing** – This is the process of talking it out – allowing victims and workers the opportunity to ventilate about their disaster-related memories, stresses, losses, and methods of coping.

5. **Debriefing** – This is a formal meeting, generally held 24 to 72 hours after an unusually stressful incident, strictly for the purpose of dealing with the residuals of the event.

6. **Critical Incident Stress Debriefing (CISD)** – The CISD model, also known as the Mitchell model, involves an individual group interview between the emergency respondents who witnessed a critical incident and a facilitator (or sometimes several facilitators). There are four types of debriefing: On-Scene (or Near-Scene); Initial Defusing; Formal CISD; and Follow-Up CISD. The paradigm consists of seven phases: Introduction; Fact; Thought Reaction; Emotional Reaction; Reframing; Teaching; and Re-Entry.

7. **Screening** – The DMH worker needs to screen survivors and workers in crisis to determine those who need short-term interventions and those who need to be referred to other helping agencies.

   In addition to the seven just listed, the following three can be added: support, education, and liaison with other mental health community agencies.

THE IMPORTANCE OF THE FAMILY IN THE HEALING PROCESS

The emotional symptoms of a child survivor can only be understood in the context of his/her family as the child affects the family members and the family members affect the child. When a disaster threatens to or does separate children from their families, a strong and traumatic sense of separation anxiety occurs. **After violence or a disaster occurs, the family is the first-line resource for helping.** Consequently, in this paper, strategies to assist parents to help their children are included in order to guide school psychologists in their family interventions. Early intervention is critical.

SOME KEY CONCEPTS OF DISASTER MENTAL HEALTH

Disaster mental health services differ from mental health programs in non-disaster times. The U.S. Department of Health and Human Services (1994, p. 1) identifies fourteen differences that are cited here:

1. **No one who sees a disaster is untouched by it.** This not only includes those survivors of disasters but also those who witnessed it or heard about or saw it. It also involves mental health workers who help.

2. **There are two types of disaster trauma**. One is **individual trauma** that manifests itself in the stress and grief reactions which individual survivors experience; the other is **collective trauma** which can sever the social ties of survivors with each other and with the locale.

3. **Most people pull together and function during and after a disaster, but their effectiveness is diminished.** In the early 'heroic' and 'honeymoon' phases of the disaster, survivors are upbeat. However, as the realization of the loss becomes more real, the grief reactions intensify and impair functioning.

4. **Disaster stress and grief reactions are a normal response to an abnormal situation.** Survivors need to be informed of the normalcy of their reactions. However, in some cases, the grief responses can be pathological (warranting therapy or counseling) if the grief is an intensification, a prolongation, or an inhibition of normal grief.

5. **Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.** The problems of living are basic to existence such as locating missing loved ones; finding temporary housing, clothing, and food; getting medical care; replacement of eyeglasses or medication; and applying for financial assistance.

6. **Disaster relief procedures have been called, 'The Second Disaster.'** This is described as the process of obtaining temporary housing, replacing belongings, getting permits to rebuild, applying for government assistance, seeking insurance reimbursement, and acquiring help from private or voluntary agencies is often fraught with rules, red tape, hassles, delays, and disappointment. Families are forced

to deal with organizations that seem or are impersonal, inefficient, and inept.

7. **Most people do not see themselves as needing mental health services following disaster and will not seek out such services.** Many people equate 'mental health' services with being 'crazy.' With the pragmatic pressures of putting the concrete aspects of their lives back together, the survivors do not see psychological intervention as a top priority.

8. **Survivors may reject disaster assistance of all types.** People may be too busy with cleaning up and other concrete demands to seek out services and programs that might help them. The bottom-line impact of losses is often not evident for many months or, occasionally, for years

9. **Disaster mental health assistance is often more 'practical' than 'psychological' in nature.** At first, mental health services is practical and concrete and responds to the basic needs of the survivors. Mental health workers perform any practical function that is needed to meet the basic needs of survivors.

10. **Disaster mental health services must be uniquely tailored to the communities they serve.** The demographics and characteristics of the affected community; the type of community (urban, suburban, or rural); the ethnic and cultural variability; and the integration of the mental

health services with the existing community agencies must be considered.

11. **Mental health staff need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.** The traditional 'office-based' approach to therapy is of little use in disaster work. Workers should avoid the term 'mental health' and instead identify their services as **'assistance,' 'support,' or 'talking.'** Instead of waiting for survivors to come to the mental health worker, an outreach program should be initiated. Mental health workers need to go to where the survivors are and assist them in any way possible.

12. **Survivors respond to active interest and concern.** When approach with warmth and genuine concern, survivors usually are eager to talk about their experience. Mental health workers should approach the survivors and not feel that they are intruding or invading their privacy.

13. **Interventions must be appropriate to the phase of disaster.** There are four phases, and the mental health worker needs to recognize the emotional reactions to each of the phases. In the 'heroic' and 'honeymoon' phases, the survivors may feel optimistic rather than bereaved. In the 'disillusionment' phase, the survivors are cognitively trying to piece the disaster together and to understand

what happened. They become frustrated with the bureaucratic delays and failures. In the 'reconstruction' phase, the individual and the community work together to rebuild. In talking with a survivor, the mental health worker does not have to talk about the crisis but can also communicate about ordinary events.

14. **Support systems are crucial to recovery.** The most important support group for individuals is the family. Workers should attempt to keep the family together (in shelters and temporary housing, for example).

SOME LESSONS LEARNED FROM MY RED CROSS EXPERIENCES

This mental health disaster volunteer, a member of the American Red Cross Disaster Services Human Resources System, was called to service to assist at the national 1999 May Oklahoma tornado, 1999 November EgyptAir, and 2000 May New Mexico wildfire disasters and at several local Massachusetts fire and workplace shooting disasters. Some of the lessons learned from those disasters and from this professional's school psychologist's experiences in a large multicultural community will be shared at this workshop. In addition, some of Weaver (1995) and the Red Cross' (1991) lessons learned that were similar to this Red Cross volunteer's experience are also incorporated.

<u>LESSONS LEARNED</u>

<u>TEAM MEMBER</u>:

* DMH workers work with all ARC workers and do any job and perform any function that contributes to the Red Cross mission and to the team's success. They pitch in where and when needed.

<u>DISASTERS</u>:

* DMH workers need to be able to function in unstructured, ambiguous, and changing environments.

* DMH workers need to know that they will work in disorganized and devastated environments that include evidence of destruction and the tears and pain of survivors.

* DMH workers need to attend orientation and daily -up-dated meetings that share methods of interrelating with survivors, family members, friends, and neighbors, that provide ongoing information in a changing environment, and that give basic information about the specific disaster and people.

<u>TERMINOLOGY</u>:

* DMH workers need to avoid introducing themselves as mental health workers, psychologists, social workers, or counselors. These professional labels are a turn off to some. Instead, one suggestion is to introduce oneself as "involved with the healing process."

- DMH workers need to avoid the passive word "victim" and in its place use the active term "survivor" which implies some control over oneself and the world.

RED CROSS SETTINGS:

- DMH workers need to feel comfortable in providing services in different and nontraditional community-based settings.

- DMH workers may work in disaster assistance service centers, shelters, family service centers, emergency aid stations, morgues, family reception sites, and/or in Red Cross field headquarters where they provide mental health services and assist DMH supervisors. In addition, they may be assigned to a hot line, may function as liaison with the community mental health agencies, and/or may be on call, especially at night.

- DMH workers may visit the damaged areas and do outreach: They make condolence visits to families; do home visits; reach out to schools, residential care facilities, and community agencies; and consult as well as provide educational information about trauma and disasters.

DIVERSITY:

- DMH workers need to be sensitive to cultural, ethnic, social, and socioeconomic diversity and to become familiar and comfortable with the survivors' various backgrounds.

- DMH workers need to provide services that are culturally and sensitively appropriate.

- DMH workers need to be aware as to how survivors perceive and interpret a trauma from a religious/spiritual or superstitious perspective.

- DMH workers need to be aware of the importance of nonverbal communication in international disasters where several languages are involved.

INTERVENTION:

- DMH workers need to be aware that to be assigned to a particular role takes time and that they may have to wait for specific and clearly defined duties to perform.

- DMH workers need to protect the confidentiality of the survivors and others they help.

- DMH workers need to employ "the psychology of presence," a powerful interpersonal bond. One's presence or being with someone can and does at times mean more than all of the skills and academic degrees we attain. What is most important to individuals who experienced a traumatic event is that they know that you are there and that you care. There are times when we just have to be there, to be present, to be available, and to be ready to help in any way when and as needed, not only with psychological intervention, but

especially with the fulfillment of basic human, survival, and practical needs.

- DMH workers need to explore the community to find people needing assistance, instead of taking a "wait, see, and intervene" attitude.

- DMH workers need to persevere on their intervention mission even though they do not see any immediate results.

- DMH workers need to have experience in psychiatric triage, first aid, CPR, crisis intervention, defusings, debriefings, crisis reduction counseling, and brief treatment.

- DMH workers can implement successfully part of the NOVA group crisis model with individuals

- DMH professionals should mill (mingle with) the people on site, bring them food and drink, and informally chat with them to determine how they are coping.

- DMH workers need to be available to offer interventions to survivors, family members, friends, neighbors, Red Cross workers, or to any other disaster relief worker. When they observe others are stressed out, they approach them, are supportive, and let them vent.

- DMH workers need to impart information obtained from Red Cross headquarters, to pass out literature, and to distribute survival and recovery items to survivors. Stuffed animals and

dolls are also distributed. They have been found to be very therapeutic.

- DMH workers act as liaison with local mental health resources, accumulate information about local mental health personnel and services, and work closely with them to refer survivors and/or family members whose symptoms and risk factors have been assessed.

- DMH workers need to refer others to spiritual services where appropriate.

- DMH workers need to think on their feet and make immediate field decisions. If they are unsure of what to do, they should use their cell phones to call Red Cross headquarters for advice.

- DMH workers defuse ARC stressed workers on site as needed and debrief ARC workers to process their experiences and to "tell their story" before they travel home.

A FEW IDENTIFIED STRESSES OF THE DMH WORKER:

- DMH workers stand on their feet a lot, experience extraordinary stressful situations, function in an area that may be somewhat unsafe, and may work in an environment that the Red Cross has designated as a hardship assignment.

- DMH workers become physically and emotionally exhausted, and, as a result, frustration and anger may surface.

- DMH workers may experience "survivor guilt" when they see the extreme losses of others and compare them to the minor losses in their own lives.

TAKING CARE OF SELF:

- DMH workers need to prevent themselves from becoming secondary victims.

- DMH workers need to take rest and lunch breaks each day, eat nutritiously, sleep restfully, as well as participate in some form of exercise such as walking.

- DMH workers need to drink a lot of water.

- DMH workers need to reduce the amount of caffeine, alcohol, chocolate, sugar, and nicotine that they take in.

- DMH workers should discuss their experiences with other DMH workers and supervisors.

- DMH workers need to work with at least one other worker for emotional support.

- DMH workers may find it useful to keep a journal of their experiences and feelings.

- DMH workers need to keep in contact with family and friends.

- DMH workers should be aware that some survivors will project and displace their anger at them and/or at another ARC worker or other worker and that they should not take it personally.

- **DMH workers need to participate in a debriefing before returning home and after they return home.**

REFERENCES

American Red Cross (1995). Disaster relief orientation: Resources for your assignment. Washington, DC: ARC.

American Red Cross (1991). Disaster mental health services. Washington, DC: ARC.

American Red Cross (May, 1987). The disaster services human resources system member's handbook. Washington, DC: ARC.

Canter, A. S., & Carroll, S. A. (Eds.). (1999). Crisis prevention and response: A collection of NASP resources. Bethesda, MD: The National Association of School Psychologists (NASP).

Dwyer, K., Osher, D., and Warger, C. (1998). Early warning, timely response: A guide to safe schools. Washington, DC: U.S. Department of Education.

Everly, G. S. (1995, July). The role of the critical incident stress debriefing (CISD) process in disaster counseling. Journal of Mental Health Counseling (Special Issue-Disasters and Crises: A Mental Health Counseling Perspective), 17(3), 278-290.

Everly, G. S., & Mitchell, J. T. (1999). Critical incident stress management (2nd ed.). Ellicott City, MD: Chevron.

Farberow, N. L., & Gordon, N. S. (1986). Manual for child

 health workers in major disasters. Rockville, MD: National

 Institute of Mental Health (NIMH).

Feinberg, T. (1999). The midwest floods of 1993: Observations

 of a natural disaster. In Andrea S. Canter & Servio A.

 Carroll (Eds.), Crisis prevention and response: A collection

 of NASP resources. Bethesda, MD: The National Association of

 School Psychologists.

Jamieson, J. E. (1999). Applying spiritual values and resources

 in the management of traumatic stress. Trauma response, 6(1),

 14.

Myers, D. (1994). Disaster response and recovery: A handbook

 for mental health professionals. Washington, DC: U.S.

 National Institute of Mental Health.

National Institute of mental Health. Helping children and

 adolescents cope with violence and disasters.

 http://www.nimh.nih.gov/publicat/violence.htm

National Center for PTSD (2001). Helping survivors in the wake

 of disaster: At the disaster site or in shelters/relief

 centers.

 http://www.ncptsd.org/facts/disasters/fs_helping_survivors.html

Poland, S., & McCormick (1999). Coping with crisis: Lessons

 learned. Longmont, Colorado: Sopris West.

Quarantelli, E. L. (1985). What is disaster? The need for

clarification in definition and conceptualization in research. In B. J. Sowder (Ed.), Disasters and mental health: Selected contemporary perspectives (DHHS Publication No. ADM 85-1421, pp. 41-73). Rockville, MD: CMHS (formerly NIMH).

Schmookler, E. L. (1996). Trauma treatment manual. http://users.lanminds.com/~eds/manual.html.

Tramonte, M. R. (2000). Helping children, adolescents, and families cope during/after a disaster. A paper presented at the National Association of School Psychologists' Convention on March 29th in New Orleans, Louisiana.

Tramonte, M. R. (1999). School psychology in the new millennium: Constructing and implementing a blueprint for intervening in crises involving disasters and/or violence. A paper presented at the National Association of School Psychologists' Convention on April 8th in Las Vegas, Nevada.

Tramonte, M. R. (1998). Intervening in school-related violent deaths in a multicultural setting: Linking support systems for students and families. A paper presented at the National Association of School Psychologists' Convention on April 17th in Orlando, Florida.

Waddell, D., & Thomas, A. (1999a). Disasters: Developing a crisis response plan. In Andrea S. Canter & Servio A. Carroll (Eds.), Crisis prevention & response: A collection of NASP resources (pp. 127-129). Bethesda, MD: The National Association of School Psychologists (NASP).

Waddell, D., & Thomas, A. (1999b). Disaster: Helping children
cope: A handout for parents. In Andrea S. Canter & Servio A.
Carroll (Eds.), Crisis prevention & response: A collection of
NASP resources (pp. 119-121). Bethesda, MD: The National
Association of School Psychologists (NASP).

Waddell, D., & Thomas, A. (1999c). Disaster: Helping children
cope: A handout for teachers. In Andrea S. Canter & Servio A.
Carroll (Eds.), Crisis prevention & response: A collection of
NASP resources (pp. 123-126). Bethesda, MD: The National
Association of School Psychologists (NASP).

Weaver, J. D. (1999). How to Assist in the Aftermath of
Disasters and Other Life Crises. In L. VandeCreek, & T. L.
Jackson (Eds.), Innovations in clinical practice: A source
book (Vol. 17. Sarasota, FL: Professional Resource Press, pp.
397-411.

Weaver, J. D. (1999). Disaster mental health: Detailed
Information.
http://ourworld.compuserve.com/homepages/johnbdweaver/dmhi.htm

Weaver, J. D. (1995). Disasters: Mental health interventions.
Sarasota, FL: Professional Resource Press.

Young, M. A. (1998). The community crisis response team
training manual (2nd ed.). Washington, DC: Office for Victims
Assistance (NOVA).

Young, M. A. (1994). The community crisis response team
training manual. Washington, DC: Office for Victims of crime

(OVC) and the National Organization for Victims Assistance

(NOVA).

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