
C H A P T E R 4

Disaster Mental Health Training

Guidelines, Considerations, and Recommendations

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Disaster mental health (DMH) training necessarily takes into account the scope and complexity of disaster mental services delivery from the perspective of preparedness planning/training and training in the wake of a disaster. DMH service delivery and related training vary widely, according to when, where, by whom, and to whom DMH services are delivered. Comprehensive training should include instruction about navigational, engagement, screening/assessment, referral, and other intervention strategies that help the effort to respond to the needs of survivors of all ages (including emergency responders) who are seen either on- or off-site at various points in time (ranging from hours to months after the event). Moreover, in multicultural societies, ethnic diversity must be taken into account if mental health services are to be accepted and efficacious. Aggregate groups (e.g., families, communities, schools, and organizations) present unique system-level access, assessment, and intervention challenges that can be addressed in training. Preexisting community conditions, resources, and history (e.g., political, economic, and cultural), preexisting individual resources and history (e.g., mental health, medical, and economic), and the severity of the impact of the disaster on the community and helpers must also be taken into account to make training relevant.

GUIDELINES AND CONSIDERATIONS FOR DMH TRAINING

DMH training is shaped primarily by seven factors: (1) trainees' credentials, roles, and experience; (2) when the training is delivered; (3) topics and learning objectives; (4) the training process; (5) the time available for training; (6) background and teaching experience of the trainer; and (vii) available funding.

Trainees

Training may be delivered to a wide range of individuals, who by their credentials, job, or wish to volunteer are put in contact with survivors and disaster workers. Trainees should be sanctioned to operate within officially recognized structures. Trainees may include mental health professionals (e.g., social workers, psychologists, marriage and family therapists, psychiatric nurses, and psychiatrists), medical professionals (e.g., physicians, physician's assistants, nurses working in primary care, family practice, and pediatrics), clergy, fire department and police personnel, school personnel, and paraprofessionals (e.g., staff of helping organizations, community volunteers, and graduate students).

When Training Is Delivered

Of course, pre-disaster training is optimal as it can facilitate efforts to coordinate and integrate a system-level response as well as provide professional trainees with opportunities to learn about the significant differences between DMH services and conventional clinical services. Pre-disaster training and drills should be offered that, ideally, involve numerous community emergency services. Combining classroom teaching with participation in disaster simulations provides opportunities for operating within an incident command system, networking, operational testing, team building, and skill building. In lieu of more comprehensive training, a series of focused and specialized trainings can be provided to address a wide range of topics specific to DMH service delivery.

When training takes place in the aftermath of disaster, the content is shaped by the temporal phase of the disaster and the topics associated with relevant learning objectives. For example, topics specific to "just-in-time" training given in the immediate aftermath may include psychological first aid, common stress reactions, navigational and engagement strategies, grief work, and identification of high-risk individuals. Training given in the second to fourth week might include topics of acute stress disorder, early-

intervention modalities, working in the schools, outreach strategies, brief education delivery, and cross-cultural issues. Training in the later stages following disaster might include topics of posttraumatic stress disorder (PTSD) and other chronic reactions to trauma, comorbidities (e.g., depression and substance abuse), treatment protocols, vicarious traumatization, outreach strategies, and helper self-care.

Training Topics and Learning Objectives

Much of the disaster-related research over the past two decades has focused on the *impact* of disasters, with relatively little research on *interventions* (Norris et al., 2002). A recent report (Young, Ruzek, & Pivar, 2001) reviewed available training materials related to the systematic mental health response to disaster and community violence, describing the content of existing training materials, commenting on strengths and weaknesses of training in this arena, and making recommendations for more effective training methods. The reviewers found that although the training materials adequately cover a broad range of topics, they make too little reference to empirical evidence examining the effects of disaster and to procedures and tools for screening and assessment, devote little attention to problematic intervention issues, and provide insufficient guidance regarding planning for long-term follow-up services. Until specific DMH interventions are examined, the existing literature can be used to inform and guide training in disaster-related assessment with regard to individuals at risk for adverse mental health outcomes (e.g., Young, 2002), and as noted in the next section, the findings in other areas of research (e.g., early intervention) can be reasonably generalized and applied to DMH training.

We recommend multiple trainings to prepare mental health professionals and paraprofessionals to effectively respond to the varying needs of survivors and disaster-related personnel. Figures 4.1–4.5 present a comprehensive outline of training modules, designed and organized to take into account the training needs of mental health practitioners and administrators during preparedness and throughout the temporal phases after a disaster. Drawing from these fundamental modules, preparedness and postdisaster training coordinators can develop programs specific to practitioner and administrator needs.

Specific learning objectives are determined by who is being trained, the identified learning needs, and when the training is delivered. The trainer often must make this judgment, informed by his or her own professional experience. Table 4.1 presents a generic list of learning objectives.

MODULE I. DMH SERVICES: A CONCEPTUAL FRAMEWORK

- A. *Natural and Human-Caused Disasters*
- Typology and Traumatic Stressors
 - Associated Risks
 - Service Delivery Issues: Key Concepts
- B. *Effects of Disaster on Communities*
- A review of the literature
- C. *Effects of Disaster on Individuals*
- Conservation of Resources and Other Paradigms
 - Common Stress Reactions
 - Adults
 - Children
 - Emergency Responders and Other Helpers
 - Stressors Associated with Disaster Work
 - Service Delivery Issues
 - Risk Factors Associated with Adverse Mental Health Outcomes
 - Acute Stress Disorder
 - Posttraumatic Stress Disorder and Comorbidities
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FIGURE 4.1. DMH training curriculum: *Universal* module for practitioners and administrators.

Processes of Training

In addition to the content of training materials, it is important to consider the *process* of training. Much of the material in the existing training manuals is dedicated to explaining their topics or content (Young et al., 2001). The complexity of the skills involved in delivering DMH services suggests that the best training must go beyond simply describing the array of disaster reactions, coping behaviors, and various methods of intervention. Two recent studies of involving mental health practitioners who provided services to individuals affected by either the Oklahoma City or the World Trade Center bombings (Norris, Watson, Hamblen, & Pfefferbaum, 2005) found that the majority of these practitioners preferred to observe the demonstration of helping interventions. Allowing trainees to rehearse interventions and receive feedback should also be helpful in regard to their gaining mastery of essential helping skills. Videotapes can be used to enable trainees to see and hear disaster-related stories, survivor/responder reactions and coping efforts, and examples of helping behaviors. Using improvised vignettes, helping skills can be demonstrated with opportunities to practice them with performance feedback.

MODULE II. PRACTITIONER GUIDELINES

A. Overview: Disaster Mental Health Services

- Objectives: Micro/Macro
- Methods
 - Outreach, Engagement Strategies, Building Rapport and Casefinding
 - Assessment
 - Brief Survivor Education
 - Referral
 - Follow-Up
- Interventions
 - Early Intervention Modalities
 - Group and Individual Treatment Modalities, Etc.
- Temporal Phases
 - Preparedness
 - Emergency
 - Early Post-Impact
 - Recovery
 - Restabilization
 - Matching methods/ interventions to temporal phase
- Service Delivery Settings
 - Nontraditional Community Settings
 - Relief Centers
 - Family Assistance Centers
 - Shelters
 - Commercial
 - Residential, Etc.
- Consumers
 - Survivors

B. DMH Practitioner Preparedness

- DMH Training Guidelines
 - Training Content (content of other modules)
 - Training Processes
 - Recruitment, Selection of Team Members, Operational Procedures, Team Readiness Maintenance
- Networking, Systems, Memorandums of Understanding
- Training Paraprofessionals

*Sections "C" and "D" share some similar topics as each is designed to be used separately with Section A and Module I. In cases of comprehensive training, that is, training about emergency and crisis counseling program services, eliminate redundant topics.

C. DMH Emergency Services*

- Practice Objectives
 - Micro (specific to)
 - Temporal Phase (emergency, early post-impact)
 - Consumers (identification of survivors, helpers, and special-needs groups at risk for continuing problems)
 - Service Delivery Settings (relief centers, family assistance centers, shelters, etc.)
- Macro (specific to)
 - Communities (public health)
- Micro Practice Methods
 - On-Scene Support
 - Psychological First Aid
 - Key Processes in Recovery: Basic principles of care and helping skills
 - Stress Reactions: What survivors should expect
 - Social Support
 - Outreach and Casefinding Methods
 - One-Contact Protocols
 - Two-Contact Protocols
 - Three-or-more-Contact Protocols
 - Working Large-Group Settings
 - Working Commercial and Residential Settings
 - Assessment (common stress reactions; acute stress reactions; risk factors for adverse outcomes; long-term effects of disaster; screening methods and tools)
 - Referral Protocols (securing linkage)
 - Bereavement Support
 - Age-Specific Interventions
 - Pharmacotherapy
 - Individual and Group Education: Content-understanding trauma reactions, self-care strategies, active problem solving, maladaptive coping

D. DMH Crisis Counseling Services and Programs*

- Practice Objectives
 - Micro (specific to)
 - Temporal Phase (transition from early post-impact to recovery and restabilization)
 - Consumers (identification of survivors, helpers, and special-needs groups at risk for continuing problems)
 - Service Delivery Settings (community, school, workplace, etc.)
- Macro (specific to)
 - Communities
- Professional Practice Methods
 - Outreach and Casefinding Services
 - One-Contact Protocols
 - Two-Contact Protocols
 - Three-or-more-Contact Protocols
 - Working Large-Group Settings
 - Working Commercial and Residential Settings
 - Assessment
 - Referral Protocols (securing linkage)
 - Screening tools
 - Early Intervention Modalities
 - Brief Interventions to Reduce Alcohol Consumption
 - Assessing alcohol consumption
 - Brief advice about moderate drinking
 - Increasing motivation to reduce consumption
 - Group and Individual Treatment Modalities: Cognitive Therapy Methods
 - Trauma-Focused Treatment
 - Problem-Solving-Oriented Treatment
- Paraprofessional Practice Methods
 - Outreach and Casefinding
 - Service General Helping Behaviors
 - Assessment and Referral Protocols
- Consumer-Directed Services
- Special Service Delivery Issues

FIGURE 4.2. DMH training curriculum: *Practitioner* modules.

MODULE III. ADMINISTRATIVE GUIDELINES

A. Overview: Multivariate and Contextual Integration

- Objectives: Micro/Macro
- Methods: Community-wide assessment strategies and tools, interagency planning, program development
- Temporal Phases: Preparedness, Emergency, Early Post-Impact; Recovery, Restabilization
- Settings: Nontraditional
- Consumers: Survivors, Helpers, Special Populations
- Resources: Internal/External
- Services: Integration of Multiple Variables

B. DMH Planning

- Administrative Objectives
 - Micro Specific to
 - Temporal Phase
 - Consumers (survivors, helpers, high-risk and special-needs groups)
 - Service Delivery Settings
 - Macro Specific to
 - Communities
 - Media utilization (e.g., information dissemination)
 - Events
 - Administrative Methods: Guidelines for Developing DMH Plans
 - Involving Community and Cultural Stakeholders (e.g., service providers, businesses, faith communities, primary care professionals and other stakeholder groups) in Planning and Infrastructure Development Activities
 - DMH Plans: General Contents
 - Authority and Mission statement
 - Linkage of Agency Level Planning to Federal, State, Regional, County, and Community-Based Organizations
 - Staffing Roles, Responsibilities, and Training
 - Involving Key Stakeholders
 - Disaster Management Strategies
 - Community-wide Assessment Strategies and Tools
 - Risk Communication Guidelines
 - Procedures for Delivering and Providing Care to Survivors
 - Procedures for Delivering and Providing Care to Local and State Emergency Response Personnel During and Following Disaster Operations
 - Educational Materials for Survivors and Emergency Responders
 - Budgeting for Emergency Management Services
 - Quality Assurance and Program Evaluation

C. DMH Emergency Services

- Administrative Objectives
 - Micro Specific to
 - Temporal Phase (emergency, early post-impact)
 - Consumers (survivors, helpers, high risk and special-needs groups)
 - Service Delivery Settings
 - Macro Specific to
 - Communities
- Administrative Methods
 - Technical Assistance and Grant Applications
 - Community-wide Assessment Strategies and Tools
 - Risk Communication Guidelines
 - Procedures for Delivering and Providing Care to Survivors
 - Procedures for Delivering and Providing Care to Local and State Emergency Response Personnel During and Following Disaster Operations
 - Procedures for Obtaining and Distributing Educational Materials for Survivors and Emergency Responders via Media

D. DMH Crisis Counseling Services and Programs

- Administrative Objectives
 - Micro Specific to
 - Temporal Phase (transition from early-post impact to recovery)
 - Consumers (survivors, helpers, high risk and special-needs groups)
 - Service Delivery Settings
 - Macro Specific to
 - Communities
 - Media campaigns
 - Event planning
- Administrative Methods
 - Program Formation, Implementation, and Maintenance
 - Linkage of Services and Programs to Federal, State, Regional, County, and Community-Based Organizations
 - Staffing Roles, Responsibilities, and Training
 - Contracting for Service Locations
 - Involving Key Stakeholders
 - Fiscal Mechanisms
 - Staff Health Care
 - Quality Assurance and Program Evaluation
 - Closing Programs

FIGURE 4.3. DMH training curriculum: *Administrative* modules.

MODULE IV. SPECIAL POPULATIONS

- A. *High-Risk, Ethnic, and Special-Needs Groups: Service Considerations*
- Injured
 - Bereaved
 - Children
 - Ethnic Minorities and Cross-Cultural Competency
 - Older Adults
 - Chronically Mentally Ill
 - Displaced Individuals
 - Emergency Workers
 - Mental Health Workers: Self-Care before, during, and after an Assignment
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FIGURE 4.4. DMH training curriculum: Special-populations module for practitioners.

Time Allotted for Training

The amount of time allotted for training is determined by many variables, however, most trainings fall into 4-, 8-, 12-, or 16-hour programs. Longer programs can use the extended time to create opportunities for planning, team building, networking among participants, role playing, exercises, and demonstrations of helping behaviors.

Trainers

Generally speaking, most trainers are licensed mental health clinicians or administrators who have disaster experience that includes responding to a range of disasters (natural, human-caused, mass casualties) and communities (urban, rural, ethnic diversity). Exceptions to this rule are speakers who can address specific topics (e.g., resources, administrative methods, cultural

**MODULE V. RESPONSE STRUCTURES, PROCESSES,
AND ORGANIZATIONS**

- A. *The Big Picture: Response Structures, Processes, and Organizations*
- Federal Response Plan
 - National Disaster Medical System
 - Federal Resources
 - State Resources
 - Community Resources
 - Nonprofits
 - Professional Organizations
 - New Developments and Future Directions
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FIGURE 4.5. DMH training curriculum: Response structures, processes, and organizations module for practitioners and administrators.

**TABLE 4.1. Generic Practitioner Learning Objectives of DMH
Emergency Response Training**

Upon completion of training, participants will be able to:

- Identify the conceptual framework of emergency/DMH services.
 - Identify DMH response structures, processes, and organizations.
 - Identify fundamental components to an emergency mental health response plan.
 - Identify common survivor stress reactions.
 - Identify predisaster, within-disaster, and postdisaster risk factors associated with adverse mental health outcomes.
 - Identify at-risk groups and individuals in the wake of disaster.
 - Target phase-specific interventions to match needs of specific at-risk groups and individuals.
 - Identify guidelines for delivering psychological first aid.
 - Identify strategies of engagement and building rapport with non-treatment-seeking and treatment-seeking survivors.
 - Identify guidelines for working in large-group settings.
 - Identify guidelines for brief one-on-one supportive counseling (one contact; two contacts; three or more).
 - Identify guidelines for delivering brief education packages.
 - Identify guidelines for delivering stress management skills.
 - Identify guidelines for securing referral linkages.
 - Identify intervention considerations specific to disaster workers, children, minority groups, and older adults.
 - Identify guidelines for emergency mental health provider stress management and self-care.
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characteristics of the community, spirituality, bereavement, and treatment modalities). The characteristics of an effective instructor have been delineated in the *American Red Cross Instructor Candidate Training Participant's Manual* (American Red Cross, 1990). These characteristics include possessing good communication skills, in-depth knowledge of the subject, a positive attitude, appropriate attire, patience and flexibility in responding to trainee's learning needs, and skills to manage class and motivate trainees. In addition, having a conceptual and practiced understanding of the learning process is essential. From classroom setup to conducting a course, skills such as good "climate setting," bridging ideas from one section of training to another, facilitating discussion, guiding student practice, clarifying, using interactive learning, and knowing current media presentation technology are important instructor qualities for achieving learning objectives.

Funding

Funding for DMH training may come from many sources, depending on whether the program is sponsored by the government, nonprofit, or pri-

vate sectors. Funding from the federal government is overseen primarily by the Department of Homeland Security, Federal Emergency Management Agency (FEMA), the Substance Abuse and Mental Health Services Administration, and the Center for Mental Health Services (CMHS), through various grant mechanisms. Nonprofit funding and private-sector funding may involve pharmaceutical company or local institutional support.

POSTTRAUMA EARLY-INTERVENTION RESEARCH: IMPLICATIONS FOR TRAINING

As indicated in this book, research on early posttrauma interventions is increasing rapidly. Although this field of research is relatively new and does not yet offer up strong directives regarding postdisaster practice, such intervention research can inform our design of DMH training.

An encouraging development in this regard is the increasing attention to new cognitive-behavioral treatment “packages” directed at individuals diagnosed with acute stress disorder. The pertinent outcome studies have all been targeted at assault and accident survivors, and the extent to which findings will generalize to disaster-affected populations is not yet clear. However, similarities in acute stress response across traumatized populations, correspondence of the package components to empirically validated treatments for chronic PTSD, and theory-based construction of these methods suggest that these treatment packages will be applicable for severely affected disaster-exposed groups 2–3 months after the event.

Less encouraging is the controversy regarding the utility of “psychological debriefing,” a face-valid small-group method that has been widely used following disasters. Recent studies of the efficacy of debriefing methods call into question its usefulness in preventing psychopathology (Bisson, McFarlane, & Rose, 2000; Litz, Gray, Bryant, & Adler, 2002); however, the quality of these studies has been viewed as poor (ISTSS) and to date, researchers have not been able to examine how debriefing is commonly used following disasters.

Survivor Education

While little is known about the impact of postdisaster education, there is reason to believe that when delivered alone, some forms of education have limited effectiveness in preventing the development of PTSD in those most at risk following motor vehicle accident and assault (Bryant & Harvey,

2000; Bryant, Harvey, Dang, Sackville, & Basten, 1998; Bryant, Sackville, Dang, Moulds, & Guthrie, 1999). Given the evident need for individual and group survivor education services following disasters, it is important that DMH workers be trained in education targeted at those factors that are both thought to affect recovery (on the bases of empirical findings and current theory) and that may be influenced via brief provision of information (Ruzek, 2002; Young & Gerrity, 1994)

Skills Training

Little is known about the effectiveness of our ability to increase adaptive coping in DMH service environments and whether such changed coping is associated with better outcomes. Nonetheless, research has suggested that several kinds of coping may be associated with reduced post-trauma problems (e.g., social support, anxiety management, and problem solving), and much postdisaster care involves education about coping. Methods used in skills training, such as modeling, behavior rehearsal, self-monitoring, repetitive practice in the real-world environment, and multisession instruction can be expected to enhance the impact of disaster-related education.

Brief Psychological Interventions to Reduce Traumatic Stress Reactions

The success of brief (i.e., 4–5 session) cognitive-behavioral treatment (CBT), comprised of education, breathing training/relaxation, imaginal and *in vivo* exposure, and cognitive restructuring, delivered within weeks of the traumatic event, with both acute stress disorder (Bryant et al., 1998, 1999) and chronic PTSD (Foa & Rothbaum, 1997; Resick, Nishith, Weaver, Astin, & Feuer, 2002) suggests that it may be appropriate to deliver aspects of these interventions to severely impaired disaster survivors.

The most powerful elements of effective CBT interventions are thought to involve exposure therapy and cognitive restructuring. Exposure therapy holds significant promise as an early intervention, but because of its potential to exacerbate short-term distress and the fact that most practitioners have not received training in its application, research must be conducted to determine whether and under what conditions it can be recommended for use with disaster survivors. Cognitive restructuring is an intervention that may be less emotionally provocative. Because disaster counselors often encounter negative cognitions, they should receive education about the role of cognition in development of PTSD (Ehlers & Clark, 2000) and training in more systematic approaches to modification of dis-

troubling disaster-related beliefs (e.g., misinterpretations of acute stress reactions, guilt and shame, and negative beliefs about the future).

Brief Alcohol Interventions

Research on brief alcohol interventions has shown that such services can lower alcohol consumption (e.g., Heather, 1995). Particularly relevant is a demonstration that a single session of counseling can reduce drinking in patients recently treated in hospital trauma centers (Gentilello et al., 1999). Although this body of research has not been brought to bear on DMH practice, it is reasonable to hope such interventions will reduce the likelihood of problem drinking postdisaster. Given their robustness even as brief interventions, alcohol-abuse interventions should be incorporated into training.

Identification of Survivors at Risk for Longer-Term Problems

One of the key functions of DMH workers is referring “at-risk survivors” for mental health treatment. Ideally, training would also include a module on screening. Research has much to say about pre-, within-, and post-disaster risk factors affecting development of PTSD and other negative sequelae in the contexts of disaster (e.g., Galea et al., xxxx; Norris et al., 2002) and traumatic stress (see Orner, Kent, Pfefferbaum, Raphael, & Watson, Chapter 7; Bryant & Litz, Chapter 9; Young, Chapter 8; and Raphael & Wooding, Chapter 10; this volume).

However, identification of the most vulnerable people during the immediate posttraumatic period is very difficult at this time. Experts in the field are currently grappling with the multiple issues that make screening in the early phases after mass trauma difficult.

Referral: Reducing Obstacles to Use of Mental Health Services

Though it is often reported by DMH practitioners that most survivors do not seek postdisaster-related mental health services, to date, there is no published research examining survivors’ attitudes toward the use of such services. Many factors, such as having to attend to basic needs and imminent problems, avoidance, fear of stigmatization, misunderstanding of the nature of counseling, and cultural norms about coping, may all limit motivation to pursue a referral. Discussing these attitudes and employing motivational interviewing techniques (Rollnick, Heather, & Bell, 1992) may

enable outreach workers and other DMH counselors to increase rates of referral acceptance.

DMH TRAINING IN SCHOOLS

In times of disasters, schools are the primary, *de facto* provider of mental health services in the community. Even without a disaster, the school is often a source of social support through parent and teacher activities and associations, which are familiar, customary, and accepted conduits of information and assistance. Utilization studies have shown that up to 80% of children who receive some form of mental health intervention or treatment access those services from a school counselor, school psychologist, school social worker, or a community mental health professional assigned to a school-based program (Burns et al., 1995).

Few mental health programs have been rigorously designed, implemented, and evaluated in the real-world setting of schools (Hoagwood & Erwin, 1997), and even fewer are designed, implemented, and evaluated specifically for ethnic minority children (Kataoka, Zhang, & Wells, 2002) or for large-scale incidents of disaster or terrorism (Norris et al., 2002). However, there is a literature that is relevant to school interventions. For example, several studies (Almqvist & Brandell-Forsberg, 1997; Malmquist, 1986; Rigamer, 1986; Sack, Angell, Kinzie, & Rath, 1986) suggest the value of psychoeducation for parents and teachers based on their findings that parents and teachers tend to minimize children's trauma-related reactions. Such findings point to the importance of teaching school mental health staff about why and how to deliver psychoeducational programs for parents and teachers.

Training and Access to Schools

In general, board members, superintendents, and educators in management vary greatly in their understanding of DMH training for schools, and likewise, community mental health professionals vary greatly in their understanding of how schools operate. Consequently, schools and community mental health agencies can benefit from establishing predisaster working relationships and trainings-in-common to help each learn about their respective personnel and operations. Without predisaster planning, coordination, and training, well-intentioned mental health professionals can compound the chaotic environment after a disaster.

For example, after one tragic school shooting that received national media attention, 250 "counselors" from a variety of city and county, pri-

vate and public agencies flooded the high school campus of 1,900 students to offer help. The principal wanted to know the counselors' credentials. Were they licensed? Were they experienced with children or adults? Because state education law required background checks of adults, including volunteers, working with students in a school, some of the questions were answered. During the process of screening, many of the volunteers disclosed that they had never worked at a school or provided crisis counseling services to adolescents. Some became highly emotional about the death and injury of the students and needed support themselves. Some volunteers had no degrees but worked as gang or drug peer counselors. School administrators were grateful for the overwhelmingly positive response of the volunteers but did not fully realize the implications of having to screen, train, feed, house, and organize a volunteer group which was larger than the total number of employees in the school. Developing partnerships with appropriate, child-serving mental health agencies before a crisis allows all parties to plan ahead for these contingencies.

DMH training for schools must be geared toward implementing school-based mental health services that enhance classroom management and demonstrate benefits to children's health, mental health, and learning. The challenge is to establish school/DMH partnerships to ensure that mental health interventions result in the least disruption to the work of the classroom and the routines of the schoolday.

Once training is approved, the first step is delivering multidisciplinary staff training to develop sufficient skills and resources to implement specialized DMH services. Preparing school and district staffs to respond requires increasing their level of information and awareness and building skills necessary to develop disaster-related roles and responsibilities. Work to ameliorate the negative effects of disasters on children begins with the adults in the school family. Teachers, principals, school nurses, counselors, and others at the school must be encouraged to take the time to address their own disaster experiences and any related trauma effects.

Training for Individuals in Positions of School Leadership

Community and school-based mental health professionals may be in the best position to mentor school leadership through the unfamiliar landscape of creating postdisaster school-based recovery programs that enhance classroom management and demonstrate benefits to children's health, mental health, and learning. All school personnel operate within a hierarchical system of governance from school sites to the "central office" or executive staff of the school district. At the highest levels of leadership in schools, the Board of Education and the Superintendent of Schools represent the ulti-

mate authority to approve the provision of all training, programs, and services in the schools of the district.

Training for Teachers

After disasters, the classroom teacher is not only the instructional leader of the classroom but also the caregiving adult well acquainted with the cognitive, social, and emotional status of students. Teachers require training about the disaster-related behaviors that are common among school-age children (e.g., impaired concentration and learning; regression; and altered behavior such as aggression, recklessness, reduced inhibitions, somatic complaints, and school attendance refusal).

Teacher training should also include opportunities to practice new methods of intervening with disaster-related anxiety, withdrawal, anger, or uncooperative student behavior. Mental health professionals can “coach” teachers on how to speak with students about disaster-related fears and experiences in a manner appropriate to age and developmental level. For example, teachers can help students identify traumatic reminders or encourage them to alert the teacher when intrusive thoughts and/or anxious feelings overwhelm their ability to cope in the classroom (Pynoos & Nader, 1988).

Training for “Nonteaching” School Personnel

In all school districts, there is an array of nonteaching staff members of all ages, often reflecting the community surrounding the school. They are paraprofessionals who may speak a second language, in addition to English, or share the same ethnicity, culture, religion, or place of birth of the students. As such, after a disaster, they are an important linguistic, cultural, and emotional bridge to students and their families. The office manager, secretary or clerical staff, custodians, cafeteria staff, and bus drivers should all receive training with appropriate levels of content and demonstrations of supportive actions and interactions with students and adults.

Training for School Nurses

Beyond their extensive education and health-related skills, school nurses can benefit from training that provides them with additional skills to assess medical problems that may be caused by disaster-related stress and educate students, parents, and staff about disaster-related stress and coping skills. As key members of the school crisis team, nurses can enhance their work in triage and psychological first aid with DMH training.

Training for School Mental Health Staff

The school counselor, the school psychologist, and the school social worker represent the “in-house” mental health professionals of the school. Obviously, each should be included in community mental health training for response and recovery work with children. It is not uncommon across school-based disciplines that professional training and experiences widely vary.

An additional step is to combine the training of school mental health professionals with community mental health professionals (before and after a disaster). Joint training can provide opportunities to strengthen partnerships and develop an integrated, coordinated DMH response in the school and community. Most “school crisis training” typically focuses on the immediate response phase, emphasizing checklists, psychological first aid, psychoeducation, and community referral. Training with community mental health professionals gives school-based practitioners the opportunity to gain a more comprehensive view of DMH needs over time, including assessments and interventions appropriate to the intermediate and long-term mental health needs of students and staff.

DMH TRAINING TO PROMOTE SELF-HELP/MUTUAL AID FOLLOWING A DISASTER

Self-help/mutual aid (SH/MA) interventions in response to disasters refer to a set of approaches for increasing personal coping through informal sources, and specifically peers (i.e., those who share firsthand knowledge associated with a particular circumstance or event), in some structured way. Postdisaster SH/MA interventions could include peer-led community wide meetings that allow members to share stories and provide support and promotion of self-help groups for persons experiencing posttraumatic distress or grieving the loss of a loved one, as well as versions of these approaches offered over the Internet. The promotion of SH/MA interventions before a disaster occurs could include establishing the groundwork for community meetings to take place in the event of future national, state, or local events that affect local communities.

Training

DMH practitioners generally have little experience in helping establish SH/MA interventions. Furthermore, overinvolvement, control, and direction by mental health professionals might coopt the SH/MA ethos (Constantino & Nelson, 1995). Table 4.2 presents an outline of training, designed and organized to be consistent with the SH/MA ethos and methods.

TABLE 4.2. DMH Practitioner Training: How to Help Establish Disaster-Related Self-Help Groups

- Rationale and theoretical foundation of self-help groups
 - Specific issues about self-help groups in response to disasters
 - Self-help groups: Mental health professional roles
 - Promoting the formation of self-help groups
 - Allocation of resources for training of self-help group leaders
 - Encouraging participation in self-help groups as a coping strategy
 - Media campaigns (newspapers, radio, television)
 - Referrals
 - Encouraging the development of a broad range of groups (parenting, displaced families, bereavement, cultural groups, etc.)
 - Partnering with community groups (e.g., ethnic, disability and elderly groups) to encourage them to develop groups
 - Assistance to group leaders in identifying meeting places
 - Advisory/consultant role
 - Group types (e.g., long-term support vs. single or short-term groups)
 - Leadership skills
 - Starting and ending groups
 - Listening skills
 - Effective group leadership skills
 - Dealing with difficult situations (e.g., hostility and extreme emotional distress)
 - Confidentiality
 - Special issues
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An innovative example of SH/MA disaster preparedness is the Disaster Community Support Network of Philadelphia (DCSN), a program established by the Mental Health Association of Southeastern Pennsylvania (MHA SP). A document describing the DCSN in greater detail can be found online at www.mhasp.org/help/dcsn.pdf.

Theory and Research on SH/MA

The potential benefits associated with SH/MA interventions in which peers provide support and assistance to one another are based on a wide range of theories presented in Table 4.3 (Salzer & Mental Health Association of Southeastern Pennsylvania Best Practices Team, in press).

REAL-WORLD ISSUES: DMH TRAINING IN NEW YORK STATE FOLLOWING 9/11

Determining and meeting the training needs of large numbers of crisis counselors most of whom were not experienced in the delivery of DMH services, who were working with different populations in different stages of

TABLE 4.3. Theories Underlying Benefits of Peer-Delivered Services

Social comparison theory

- People seek out interactions with others who have similar experiences.
- Upward comparisons increase self-improvement (e.g., develop skills) and self-enhancement (e.g., increase sense of hope and decrease fears) efforts.
- Downward comparisons are ego enhancing and maintain positive affect by providing examples of how bad things could be.

Social learning theory

- Behavior change is more likely when modeling is provided by peers than nonpeers.
- Peers model coping and health-enhancing behaviors.
- Peers enhance self-efficacy that one can change behavior.

Social support theories

- Consumer-directed services increase support networks, receipt of supportive behaviors, and perceptions of support.
- There are five types of support: (1) emotional (someone to confide in, provides esteem, reassurance, attachment and intimacy); (2) instrumental (services, money, transportation); (3) informational (advice/guidance, help with problem solving and evaluation of behavior and alternative actions); (4) companionship (belonging, socializing, feeling connected to others); and (5) validation (feedback, social comparison).

Experiential knowledge

- Experience leads to an understanding and knowledge base that is different from that acquired through research and observation (i.e., professional knowledge).
- Experiential knowledge leads to different intervention approaches.

Helper-therapy principle

- Helping others is beneficial: (1) increased sense of interpersonal competence as a result of making an impact on another's life; (2) development of a sense of equality in giving and taking between himself or herself and others; (3) helper gains new personally relevant knowledge while helping; and (4) helper receives social approval from the person they help and others.
-

disaster recovery in a densely populated area, was a significant and never-ending challenge following 9/11. Of primary importance in training crisis counselors is imparting the philosophical underpinnings of the crisis counseling program (CCP). Briefly, the CCP is designed to address short-term mental health needs of communities affected by disasters through public education, outreach, and crisis counseling. In contrast to traditional clinical practice, such programs assume that (1) disaster victims are normal people responding normally to very abnormal situations, and services should be directed at normalizing individuals' experiences and distress; (2) crisis counselors can help reduce distress, restore preevent functioning, prevent

chronic dysfunction and distress, facilitate community recovery, and provide comfort and support through empowerment and skills building, education, resource referral, support, outreach, and community capacity building; (3) services may be provided appropriately by trained paraprofessionals; (4) people prefer natural sources of assistance, and services should be provided in schools, churches, and places of work; and (5) people who need help the most may not necessarily seek it, and services must assume a proactive posture to reach out to vulnerable groups. Because of their emphasis on normalizing responses, CCP have traditionally avoided diagnosis and psychological assessment.

The considerations regarding whom to recruit and train as part of the DMH response were, in large part, forced by the huge scope of the disaster. The immediate need for thousands of crisis counselors and hundreds of supervisors and managers from almost 200 provider agencies shaped many decisions. To uphold a reasonable level of quality management while attending to a sense of urgency in the Immediate Services Program, the New York City Department of Mental Health (as it was known at the time) required that provider agencies be licensed by New York State Office of Mental Health. Working directly with only licensed mental health provider agencies largely determined the staff who would be working in the program and eliminated the huge and time-consuming process of credentialing staff and/or verifying the quality, credibility, and sustainability of service providers largely unknown to the state or the city departments of health.

The FEMA CCP model recommends caution in diagnosing in the immediate aftermath of the disaster unless an individual is in severe psychotic or functional distress that impairs daily activities (Center For Mental Health Services, 2001). The mental health community wanted a highly prescriptive model of crisis counseling service delivery, symptom checklists, and PTSD scales. Outside a limited number of disaster experts, a significant paradigm shift was required for almost all involved. Many community members expressed disappointment that several models of crisis intervention and trauma treatment that they utilized were not supported by the project due to the controversy surrounding their efficacy. The significant differences between conventional clinical practice and a DMH conceptualization of service delivery remained a training issue throughout the disaster.

Moreover, the notion of using paraprofessionals, such as psychiatric interns, emergency room residents, psychology students, caseworkers, and indigenous community members vital to disseminating services in closed communities (Everly Jr., 2002; North & Hong, 2000), was aggressively shunned by the mental health professional community, whose members felt that mental health professionals would be better equipped to make more subtle clinical judgments about the need for targeted education, coping skills training, and referral to more intensive services. This reinforced the

recommendation of the state mental health authority and the consulting CMHS staff that training was needed in the basic crisis counseling model during the initial phase and that supervision also needed to occur frequently at this stage (Holloway & Neufeldt, 1995; Najavits, 2000). The FEMA CCP model also emphasizes that crisis counselors provide a supportive presence in the community, where survivors normally gather, not in mental health counseling offices. This, too, was contrary to how most mental health clinicians conceptualized and traditionally delivered mental health services.

In an attempt to lessen the anticipated resistance of the mental health professional community to this “nontraditional” model of care, FEMA CCP model trainings were scheduled almost immediately and were offered often to large audiences. At the trainings, the differences between the FEMA model and the existing mental health structure were highlighted. The New York City disaster response unit mandated the FEMA overview training for all crisis counselors.

A significant training need was related to outreach, which was an unfamiliar mode of service delivery to most of the licensed mental health agencies and their staff of licensed clinicians. Some agencies began by attempting outreach services to community members unknown to them. Other, more community-rooted agencies looked to hire larger numbers of paraprofessionals and indigenous workers from within their communities to deliver services. This plan resulted in the need to train nonlicensed interns, bachelor’s-level workers, and students from mental health fields such as psychology or nursing. Other paraprofessionals in need of training included clergy, caseworkers, community leaders, and peer counselors. Indigenous workers such as laborers, clerks, caregivers, and shopkeepers were seen as important for providing crisis counseling in ethnic communities where culture and language barriers existed (Aguilera & Planchon, 1995; Diaz-Lazaro & Cohen, 2001).

Trainers

The New York community was privileged to have many experts in disaster and trauma volunteer to participate in the necessary trainings. Due to large numbers of self-identified experts, cross-scheduled trainings, and the need to ensure a consistent, appropriate approach that followed the CCP model, it was determined that all training activities funded by the FEMA grant would need to be approved centrally, at the state level, rather than at the local provider level. This determination also prompted New York’s Bureau of Training and Workforce Development to organize a training task force of representatives from the organizations participating in any mental health training activities in the overall disaster relief response.

As the disaster response project moved into the regular services program phase, the state and city staff intensified training in outreach strategies, identifying hidden populations, expanding the understanding of cultural competence, and using marketing strategies and geomapping to assist in targeted outreach planning.

Challenges Associated with Training in the Aftermath of 9/11

After 9/11, disaster workers had to overcome many obstacles:

- Translating what was heard in terms of training needs into the next set of training workshops with expert, tailored materials within short time frames;
- Attending both to high-risk groups that may benefit from referral for treatment and to the general public, who are less likely to need (or accept) long-term, formal mental health treatment;
- Effectively tailoring each segment of the program by working with community groups and providers to develop the specific training needs that address their populations, organizational structure, and cultural norms.

TOWARD IMPROVING DMH TRAINING

In this concluding section, we offer a number of recommendations toward improving DMH training as it applies to content and procedures; identifying how new technologies can advance the efficacy, availability, and efficiency of training; and developing future research.

Content and Procedures

Because a significant amount of training and services takes place under the auspices of FEMA/CMHS, our recommendations begin with how the FEMA model of crisis counseling is taught.

1. The potential for resistance to the model (by those with minimal experience in crisis counseling experience as well as by highly trained psychotherapists) suggests that in-depth review of the conceptual framework is needed. In addition, role-plays enabling trainees to practice necessary helping skills (e.g., strategies of engagement, rapport building, administering psychological first aid, delivering brief survivor education, skills training, and reducing and managing stress reactions) can help to overcome precon-

ceptions that trainees might hold about the conceptual framework of the FEMA model.

2. The FEMA/CMHS model does little to train counselors to meet the mental health service needs of the severely affected (i.e., survivors who may benefit from treatment). Whereas, the current model emphasizes psychoeducational-oriented interventions, we propose that FEMA/CMHS training be broadened to include evidence-based interventions for disaster-related PTSD, depression, and substance abuse. Specifically, it may be useful to incorporate some parts of CBT intervention packages into training, after adapting them for disasters (i.e., for delivery by nonspecialists, or in briefer formats, for use with individuals who are at high risk for problems following disaster).

3. The state Offices of Emergency Management may be the most suited lead organizations for coordinating local community efforts toward recruiting indigenous workers to join with the paraprofessionals and professionals participating in disaster relief training. With the state's coordination of the potential workforce, the development of a database of these available resources may yield the largest numbers of prepared individuals for deployment over long periods in the advent of large-scale disasters.

4. Including DMH training as a component of the academic curriculum across mental health disciplines in academic institutions can boost the number of trained paraprofessionals (and future professionals). Curricula can include the key concepts of disaster recovery, the strategic use of indigenous and paraprofessionals helpers as well as professional staff, and the importance of interdisciplinary coordination. Schools of medicine, psychology, social work, nursing, and counseling can also be a significant and immediate source of paraprofessional staff to rely on after disaster.

5. Standing DMH response teams may periodically need to take new courses and visit settings (e.g., hospital trauma centers) where acutely traumatized individuals are seen and offered services in order to minimize skill decay (Hagman & Rose, 1983) and to learn about advancements in the field.

6. It may be helpful to develop training "tracks" for specific helper audiences that require special skills or who encounter disaster survivors in settings different from the emergency response setting. DMH team leaders may benefit from specific training in the skills need to organize and lead their disaster team. Psychiatrists and other physicians who may be called on to medicate survivors of traumatic disaster may benefit from training in up-to-date pharmacotherapeutic management of acute stress responses. "Indigenous" primary care physicians/nurses who receive training in screening, brief intervention, and referral may significantly improve their ability to be of service to survivors. Local mental health clinicians may benefit from learning about newer treatment approaches.

7. One desirable outcome of training coordination between the state, localities, and voluntary agencies assigned to the immediate disaster response is a statewide certification in disaster response, encompassing those concepts most common across localities in any type of disaster.

8. It is highly recommended to invite DMH training experts from nonaffected areas.

9. Future work is needed to develop and disseminate a wide-range of SH/MA intervention modes.

10. Specification and standardization of training procedures can ensure quality control and set the stage for more careful evaluation of the impact of training. Greater detailed instruction in how to conduct a course (including instructor scripts to introduce sections and promote discussion, and procedural guidelines regarding use of slides, videotapes, role-plays, and skills demonstration) is needed.

New Technologies

Despite new preparedness initiatives, one aspect of DMH training improvement relates to the need to train DMH workers quickly in the aftermath of a disaster. A potential new technology for “just-in-time” training is the use of personal digital assistants (PDA) and tablet-size computers. Pocket-size computers can now hold detailed training content, algorithms for procedural decisions, and video (visual) demonstrations of helping behaviors. A recent study (Wisher, Sabol, & Ozkaptan, 1996) showed that job aids predicted improvement and increased performance by nearly 25% on seven critical tasks. Another major option for “just-in-time training” is use of web-facilitated training. In addition, web-based training may ultimately be the most optimal form of training in the event that a community is quarantined and there is limited access to those in need of training. Another strength of web-based curricula is that it could potentially be used for many different applications: preparations/credentialing, periodic upgrade of skills, just in-time training, or on-the-ground guidance.

Research

For the content of DMH training to become more evidence-based, a DMH research–training interface must continue to develop. Empirical investigations of interventions, intervention timing, intervention–survivor matching, intervention with individuals versus groups, intervention by professionals versus paraprofessionals, consumer-directed services, optimum administrative service-delivery networks, types of training procedures, the efficacy of specific training modules, and other topics will, in effect, help training content and procedures to become more extensive and precise. It will be impor-

tant to design a system for periodically updating DMH practice guidelines and associated training content based on emerging empirical findings and theoretical developments.

Just as it is important to move toward evidence-based DMH services, it is important to use evaluation to guide the evolution of DMH training procedures. However, there are significant challenges to determining the efficacy of disaster-related training because of the inherent “distance” between training and clinical outcomes. Even so, valuable information could be gained from studies comparing the efficacy of various teaching procedures (lecture, role-play, “teachbacks,” knowledge-based tests, trainer demonstrations, self-guided software programs, etc.) and the efficacy of specific training modules for a controlled application.

CONCLUSION

In this chapter we have delineated the content and procedures for DMH training for clinicians, administrators, school personnel, and paraprofessionals. Factors related to training such as trainees’ credentials, roles, and experience; when the training is delivered; topics and learning objectives; the training process; the time available for training; background and teaching experience of the trainer; and available funding were discussed. The implications of posttrauma early-intervention research for DMH training was presented, along with considerations for training school personnel and mental health professionals to help in the development of disaster-related self-help groups. In addition, the real world challenges of assessing and meeting the learning needs of mental health professionals and paraprofessionals in the aftermath of 9/11 was described. Finally, we presented recommendations about improving DMH training with regard to content, procedures, research, and new technologies.

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