National Center for PTSD

2002 Volume 11 (1) ISSN-105-7168

CLINICAL QUARTERLY

Menlo Park/Palo Alto * Boston * Honolulu * West Haven * White River Junction

EMERGENCY OUTREACH

NAVIGATIONAL AND BRIEF SCREENING GUIDELINES FOR WORKING IN LARGE GROUP SETTINGS FOLLOWING CATASTROPHIC EVENTS

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When a community-wide catastrophe occurs, emergency mental health services are often delivered in settings where large groups of survivors have congregated to receive information and apply for relief benefits. Community settings where outreach services are delivered include disaster relief service centers, shelters, family assistance centers, community centers, schools, hotel conference rooms, etc. To an untrained emergency mental health worker, such settings present the challenge of having to deliver unfamiliar services in unconventional surroundings in limited blocks of time to many individuals – the majority of whom may be ambivalent or resistant to receiving mental health services. Working effectively in these settings requires that emergency mental health responders modify conventional clinical skills and learn efficient and brief methods to engage and screen survivors. Often, only 10-30 minutes can be spent with any one individual when the ratio of survivors to mental health workers is high. To date, models and practice guidelines to help emergency mental health responders work effectively and efficiently in such settings are described in a limited number of training manuals (1-4).

In this brief article, one such model for delivering outreach emergency mental health services in large group settings is described. The model originally appeared in Disaster Mental Health Services: A Guidebook for Clinicians and Administrators (2). It is presented here with revision, taking into account the growing concern regarding the potential adverse effects of soliciting detailed trauma narration outside a context of on-going treatment and the increasing recognition that single-session interventions are unlikely to prevent long-term adjustment problems (5,6).

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The primary mission of outreach emergency mental health services is to identify, support, and refer individuals who may have difficulty recovering on their own. This objective is accomplished by: a) providing information and reassurance; b) practical help with problem solving; c) screening for risk associated with adverse mental health outcomes; and d) referring survivors who may benefit from more in-depth support to appropriate services. Delivering disaster mental health services is best understood in the context of *when*, *where*, and with *whom* interventions take place (see 2). For purposes of this article, *when* refers to the emergency phase or first three weeks following the onset of a catastrophe, *where* refers to a community setting, and *whom* refers to non-injured ambulatory adults 21-65 years of age.

SIX-STEP NAVIGATIONAL GUIDE TO WORKING IN LARGE GROUP SETTINGS

1. Contact setting manager

Upon arriving at an assigned site, it is not uncommon to encounter some form of "structured chaos." An important first step is to make contact with the site manager and provide a brief overview of emergency mental health services objectives. Ask the manager about any particular concerns or needs, and expectations or perceptions about mental health services. Let the manager know how long you will be there. Have fact sheets and handouts about stress reactions, self-care, and community resources ready to give to survivors.

Continued on page 3

Inside this issue

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2. Observe setting

Before engaging survivors, resist the urgency to jump right in. Take time to survey the environment. Evaluate the access to food and water, noise levels (can older adults easily hear conversation?), and seating arrangements (have seats been arranged to facilitate conversation and support among survivors?). Look to see if there are designated areas for children and quiet areas for people who need calm. Is there a bulletin board and a table for informational handouts? If there is a television in the setting, observe or inquire about how often the selected channels are covering traumatic aspects of the event. Use diplomacy to suggest changes in the environment that may reduce stress, facilitate support, and protect people from being exposed to further traumatic stimuli (e.g., suggest that television coverage of the event be limited to specific time slots and that children be protected from viewing catastrophic images).

3. Engage survivors

Offering mental health services and support to people who are not looking for such assistance or who may be ambivalent or resistant to receiving such help is challenging. To engage survivors, look for opportunities to be helpful (e.g., serving food, passing out supplies) and use informal conversation to establish rapport.

Sample icebreakers:

"Hi, my name is _____ .... I work with emergency mental health services.....
May I get you a soft drink or something else?" -or -

"How long have you been waiting to speak with a relief worker? -or -

"When did you arrive here? -or -

"Have you been able to talk with your family or friends?

Next, address an immediate concern, e.g.,

"What do you (or your family) need most right now?

"How are your kids doing?"

Once rapport is established, screening for risk can begin.

4. Screen survivors for risk factors associated with adverse mental health outcomes

Risk assessment is achieved using informal, but structured conversation, with topics corresponding to post-disaster, within-disaster, and pre-disaster risk factors (Table 1). Because survivors have imminent practical concerns, assessment is best begun with conversational topics related to *present concerns* (i.e., post-disaster factors) followed by questions about the within-disaster experience and pre-disaster factors.

Risk factors may overlap, interact, and combine to create increased risk e.g., severity of exposure (within-disaster risk factor) may result in lower perceived social support (post-disaster risk factor).

Table 1. Risk factors associated with adverse mental health outcomes[1]

Post-disaster factors

- Resource deterioration (7-9)
- Social support deterioration (9,10)
- Social support increase (11-13)
- Marital distress (14)
- Loss of home/property and financial loss (15-17)
- Decline in perceived social support (18-20)
- Alienation and mistrust (21-22)
- Peritraumatic reactions (23-25)
- Avoidance coping (17, 26-27)

Within-disaster factors

- Bereavement (28-30)
- Injury (14, 16, 31)
- Severity of exposure (32-34)
- Panic (35-37)
- Horror (26)
- Life threat (10, 14, 16)
- Relocation or displacement (14, 38-39)

Pre-disaster factors

- Female gender (40-42)
- Age in the years of 40-60 (43, 44)
- Ethnic minority group membership (33, 45-46)
- Poverty or low socioeconomic status (47-49)
- Presence of exposed children in the home (18, 50-51)
- Psychiatric history (17, 47, 52)

On the following two pages, examples of questions related to post-disaster, within-disaster, and pre-disaster risk factors are presented to guide emergency outreach assessment. There will not be enough time to do a comprehensive assessment, that is, to ask every question. The selection of questions is based on clinical judgment and information reported by the survivor.

1. Because of space limitations, a maximum of three studies is listed for each risk factor. For a comprehensive literature review, see Norris, F. H. (2001). 50,000 disaster victims speak: An empirical review of the empirical literature 1981-2001.White River Junction, VT: National Center for PTSD.

Assessing **post-disaster** risk factors

Resource loss
"How badly damaged was your home?"
"Are you able to continue working?"
"Do you have enough savings to get through this?"
"Do you have other property that was badly damaged?"

Coping and support
"What concerns you the most about what happened to you or someone else you are concerned about?"
"What do you ordinarily do to manage stress?"
"Do you believe you can cope with this experience?"
"What might help you cope with this experience?"
"How is it for you to talk about your experiences?"
"Is there anyone in particular you turn to for support?"
"Are there people around you who support you?"
"With whom do you live?"

Stress Reactions[2]
"Have you been having repeated disturbing memories or thoughts?"
"Do you have trouble falling asleep?"
"Have you been having repeated disturbing dreams?"
"Do you find yourself feeling or acting like you are suddenly reliving the experience?"
"Do you become very upset or experience heart pounding, or trouble breathing when experiencing reminders of what happened?"
"Do you avoid thinking or talking about a stressful experience related to what happened?"
"Do you avoid situations that remind you of the experience?"
"Do you have trouble remembering important parts of the experience?"
"Have you lost interest in activities you use to enjoy?"
"Do you feel distant or cut off from people?"
"Do you feel emotionally numb and unable to have close feelings for people who are close to you?"
"Do you feel like your future has been cutoff?"
"Have you been feeling irritable or having angry outbursts?"
"Have you been having difficulty concentrating?"
"Are you watchful and on-guard"?
"Do you feel jumpy or easily startled?"

Caveat: Asking survivors to talk about their within-disaster experience may result in their becoming overwhelmed by distressing recollections and feelings. Though such reactions might be informative to the clinician with regard to risk assessment, in these settings it is important to keep distressing reactions from becoming too intense. This can be accomplished by not probing for detail and, when necessary, redirecting the survivor's attention (Table 2).

2. Adapted from the PCL-C for DSM-IV (1994), Weathers, Litz, Huska, & Keane, NC-PTSD

Assessing **within-disaster** risk factors

Exposure and Separation from Family
"Where were you when _____ happened?"
"Where was your family when _____happened?"
"What did you do when _____ happened?"
"Were you afraid for your life?"

Do not probe for sensory detail (e.g., sights, sounds, smells).

Bereavement
"Do you know anyone who was killed or injured?"
(for guidelines to talk with bereaved, see 4).

Displacement
"Were you able to return home?"
"Are you able to continue living in your home?"

Assessing **pre-disaster** factors

In the context of outreach services, it is advisable to discuss risk factors related to pre-existing stress and psychopathology as universal risks (common to anyone) rather than to directly ask about chronic stress or psychiatric history. For example,

> "We know from research and from talking with many survivors, that people who have major health or financial concerns prior to a disaster, or who have had to cope with depression, anxiety, schizophrenia, or deal with substance abuse often are more vulnerable after an event like this. The same is true for people who have been previously traumatized. If this is the case for you, you may need to take extra care, and, you may want to talk more at length with a mental health professional about it."

If rapport is established, use clinical judgment in considering whether to ask these kinds of questions:

> "What kind of stress were you having to deal with before all this happened?"
> "Have you ever been through anything traumatic before?"

Table 2. Helping a survivor cope with distressing intrusive thoughts

Begin by acknowledging the person's distress. Gently suggest an activity to redirect the focus of attention to disrupt the flow of intrusive thoughts (e.g., mindful walking, washing face and hands, deep breathing, eating); or consider finding something for the person to hold or to touch, (e.g., a pen, a book, clothing, chair) and ask her or him to describe what each object feels like.

If the person appears to be re-experiencing trauma, orient him or her to environment, date, time.

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5. Provide support, reassurance, and information

During the course of conversation, support is given via reflective listening (warmth, empathy, genuineness), information, problem solving suggestions, and reassurance to help reduce self-criticism or worry, particularly about common stress reactions. Be prepared to reframe cognitive distortions related to guilt, helplessness, trust, etc. (see, Table 3). Discuss the warning signs that indicate persistent problems in adults (Table 4), and if needed, in children and the elderly. Underscore the importance of social support, and the negative effects associated with phobic avoidance of reminders of the event. Inform survivors of the risks associated with chronic stress, previous psychiatric problems, and previous traumatic experiences. Review effective stress management strategies (see, Educational talking points, Table 5). If necessary, begin a referral process. At times, advocacy on behalf of a survivor is appropriate. Close "conversation" with a summary of your impressions (i.e., your judgment of how the person is coping, underscoring what he or she is doing well, and which specific behaviors might place them at risk). Make recommendations about self-care, additional resources, and circumstances that would suggest the importance of getting additional help.

Table 3. Examples of distorted cognitions and brief cognitive reframes

Distorted cognitions	Brief cognitive reframes
"I was coward. Because of me several people died."	"You felt afraid and perhaps ashamed, but you might consider that your actions kept you from injury and factors far beyond your control resulted in the deaths that occurred."
"I should have calmed down by now."	"I can understand why you might feel inpatient. It takes time to go through something like this. Many other survivors are at the same place you are at this point."
"I was helpless then; I just don't have it in me to help myself or cope with this."	"You felt helpless; now you feel uncertain about your abilities -- *and* your actions helped saved your life; it appears you continue to help yourself do what you need to do and are letting others help you as needed."
"People can't be trusted. I can't trust anyone anymore."	"I can understand you feel let down. Most likely, there will be people you can trust and some that you can't."

Table 4. Warning signs: Advising survivors about when to seek help

- Abuse of alcohol/drugs
- Inability to provide essential self-care (eating, hygiene)
- Inability to work
- Phobic avoidance of reminders
- Persistent inordinate grief
- Frequent episodes of intense inappropriate anger
- Intrusive thoughts
- Overwhelming resource loss
- Severe sleep disruption or frequent nightmares
- Severe unremitting anxiety
- Symptoms of clinical depression
- Symptoms of psychosis
- Significant impaired problem solving ability
- Significant social isolation
- Spiritual/existentialdespair
- Suicidal ideation

Note: If any of these problems are identified during assessment, make appropriate referral.

Table 5. Educational talking points

Well-known traumatic stressors

Life threatening exposure, (duration, intensity, frequency), loss of loved ones, resource loss (property, financial, social support, etc.)

Common stress reactions and their course

Emotional: Anger, anhedonia, emotional numbing, fear, grief, guilt, shame

Cognitive: Confusion, difficult concentration, disorientation, indecisiveness, intrusive thoughts, memory loss, self-blame and negative appraisal, shattered beliefs and assumptions, shortened attention span

Physical: body aches, change in appetite, change in libido, diarrhea, difficult sleep, fatigue, hyper-ventilation, nausea, racing heartbeat, startle, tension, tremor

Interpersonal: Feelings of rejection, increased conflict, increase distrust, increase use of "controlling" behaviors, withdrawal from social support and social activity

Risk factors associated with adverse mental health outcomes

See pre-disaster, within-disaster, and post-disaster variables associated with adaptation to trauma, Table 1.

Self-care and stress management strategies

Positive coping: Exercise, eating well, receiving and giving social support, relaxation techniques, etc.

Negative coping: Substance abuse, workaholism, social withdrawal, phobic avoidance of reminders of event

Benefits of self-awareness of emotional experience, mindfulness, and selected self-disclosure

Parenting/support guidelines: How to monitor children & other vulnerable family members reactions; how to support children and other family members

Characteristics of recovery: Anticipatory guidance about general course of individual & community recovery

Information about available resources

When and where to seek additional help

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6. Termination at the site

When the allotted time ends, inform the setting manager about your leaving and summarize your activities. If necessary, present your rationale for recommendations about changing specific features in the environment. Before leaving, inquire about how the site manager is coping with his or her managerial responsibilities and personal reactions to the catastrophe. Offer your support. If possible, give estimation of when other mental health professionals will return.

Summary

Working effectively in community settings where large groups of survivors are congregated following a catastrophe is extremely challenging, especially for the untrained emergency responder. Navigational and brief screening guidelines are needed to help emergency mental health professionals quickly identify, support, and refer survivors who may have difficulty recovering on their own. A six-step model outlining methods for engaging, identifying, and supporting survivors at risk for adverse mental health outcomes is described along with essential educational talking points related to survivor self-care and when survivors should seek additional help.

References

1. First Response To Victims of Crime (2000). U.S. Dept. of Justice Office of Justice Programs.
2. Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.F., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. St. Louis, MO: Dept of Veterans Affairs Employee Education System, National Media Center.
3. Pueler, J. & Wee, D. (1994). "Outreach services following disaster" in D. Myers (Ed.), Disaster Response and Recovery: A handbook for mental health professionals. Dept. of Human and Health Services, Publication No. (SMA) 94-3010.
4. Weaver. J.D. (1995). Disasters: Mental health interventions. Professional Resource Press: Sarasota, FL.
5. Bryant, R.A., & Harvey, A.G. (2000). Acute stress disorder. A handbook of theory, assessment, and treatment. Washington, DC: AmericanPsychological Association.
6. Shalev, A.Y. (2000). Stress management and debriefing: Historical concepts and present patterns. In B. Raphael & J.P. Wilson (Eds.), Psychological debriefing (pp. 17-31). Cambridge: Cambridge University Press.
7. Arata, C.M., Picou, J.S., Johnson, G.D., & McNally, T.S. (2000). Coping with technological disaster: An application of the conservation of resources model to Exxon Valdez oil spill. Journal of Traumatic Stress, 11, 23-39.
8. Freedy, J.R., Shaw, D., Jarrell, M., & Masters, C. (1992). Towards an understanding of the psychological impact of natural disasters: An application of the conservation resources stress model. Journal of Traumatic Stress, 5, 441-454.
9. Smith, B., & Freedy, J. R. (2000). Psychosocial resource loss as a mediator of the effects of flood exposure on psychological distress and physical symptoms. Journal of Traumatic Stress, 13, 349-357.
10. Bland, S.H. et. al. (1997). Social network disturbances and psychological distress following Earthquake evacuation. Journal of Nervous and Mental Disease, 185, 188-194.
11. Bartone, P.T., Ursano, R.J., Wright, K.M., & Ingraham, L.H. (1989). The impact of a military air disaster on the health of assistance workers: A prospective study. Journal of Nervous and Mental Disease, 177, 317-328.
12. Bromet, E.J., Parkinson, D.K., Schulberg, H.C., & Gondek, P.C. (1982). Mental health of residents near the Three Mile Island reactor: A comparative study of selected groups. Journal of Preventive Psychiatry, 1, 225-276.
13. Dougall, A.L., Hyman, K.B., Hayward, M.C., McFeeley, S., & Baum, A. (2001). Optimism and traumatic stress: The importance of social support and coping. Journal of Applied Social Psychology, 31, 223-245.
14. Norris, F.H., & Uhl, G.A. (1993). Chronic stress as a mediator of acute stress: The case of Hurricane Hugo. Journal of Applied Social Psychology, 23, 1263-1284.
15. Bland, S.H., O'Leary, E.S., Farinaro, E., & Trevisan, M. (1996). Long-term psychological effects of natural disasters. Psychosomatic Medicine, 58, 18-24.
16. Briere, J. & Elliot, D. (2000). Prevalence, characteristics, and long-term sequelae of natural disaster exposure in the general population. Journal of Traumatic Stress, 13, 661-679.
17. North, C.S., Nixon, S.J., Shariat, S., Mallonee, S., McMillen, J.C., Spitznagel, E.L., & Smith, E.M. (1999). Psychiatric disorders among survivors of the Oklahoma City bombing. Journal of the American Medical Association, 282, 755-762.
18. Solomon, S.D., Bravo, M., Rubio-Stipec, M., & Canino, G. (1993). Effect of family role on response to disaster. Journal of Traumatic Stress, 6, 255-269.
19. Kaniasty, K., Norris, F.H., & Murrell, S.A. (1990). Perceived and received social support following natural disaster. Journal of Applied Social Psychology, 20, 85-114.
20. Kaniasty, K., & Norris, F.H. (1993). A test of the support deterioration model in the context of natural disaster. Journal of Personality and Social Psychology, 64, 395-408.
21. Baum, A., Gatchel, R., & Schaeffer, M. (1983). Emotional, behavioral and physiological effects at Three Mile Island. Journal of Consulting and Clinical Psychology, 51, 565-572.
22. Dohrenwend, B.P. (1983). Psychological implications of nuclear accidents: The case of Three Mile Island. Bulletin of the New York Academy of Medicine, 59, 1060-1076.
23. Fullerton, C.S., Ursano, R.J., Tzu-Cheg, K., & Bharitya, V. R. (1999). Disaster-related bereavement: Acute symptoms and subsequent depression. Aviation, Space, and Environmental Medicine, 70, 902-909.
24. Koopman, C., Classen, C., & Spiegel, D. (1996). Dissociative responses in the immediate aftermath of the Oakland/Berkeley firestorm. Journal of Traumatic Stress, 9, 521-540.
25. Weisaeth, L. (1989). The stressors and the post-traumatic stress syndrome after an industrial disaster. Acta Pscyiatrica Scandinavica [Supplement], 80, 25-37.
26. Clearly, P.D. & Houts, P.S. (1984). The psychological impact of the Three Mile Island incident. Journal of Human Stress, 10, 28-34.

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27. Maes, M., Delmeire, L., Schotte, C., Janca, A., Creten, T., Mylle, J., Struyf, A., Pison, G., & Rousseeuw, P. (1998). Epidemiological and phenomenological aspects of post-traumatic stress disorder: DSM-II-R diagnosis and diagnostic criteria not validated. Psychiatry Research, 81, 179-193.

28. Green, B.L., Grace, M.C., & Gleser, G., (1985). Identifying survivors at risk: Long-term impairment following the Beverly Hills Supper Club fire. Journal of Consulting and Clinical Psychology, 53, 672-678.

29. Green, B.L., Grace, M.C., Vary, M.G., Kramer, T.L., Gleser, G.C., & Leonard, A.C. (1994). Children of disaster in the second decade: A 17 year follow-up of Buffalo Creek survivors. Journal of the American Academy of Child and Adolescent Psychiatry, 33, 71-79.

30. Murphy, S.A. (1984). Stress levels and health status of victims of a natural disaster. Research in Nursing and Health, 7, 205-215.

31. Shariat, S., Mallonee, S., Kruger, E., Farmer, K., & North, E. (1999). A prospective study of long-term health outcomes among Oklahoma City bombing survivors. Journal of the Oklahoma State Medical Association, 92, 178-186.

32. Bravo, M., Rubio-Stipec, M., Canino, G.J., Woodbury, M.A., & Ribera, J.C. (1990). The psychological sequelae of disaster stress prospectively and retrospectively evaluated. American Journal of Community Psychology, 18, 661-680.

33. Palinkas, L.A., Petterson, J.S., Russell, J., & Downs, M.A. (1993). Community patterns of psychiatric disorders after the Exxon Valdez oil spill. American Journal of Psychiatry, 150, 1517-1523.

34. Pynoos, R., Goenjian, A., Tashjian, M., Karakashian, M., Manjikian, R., Manoukian, G., et al. (1993). Post-traumatic stress reactions in children after the 1988 Armenian earthquake. British Journal of Psychiatry, 163, 239-247.

35. Chung, M.C., Werrett, J., Farmer, S., Easthope, Y., & Chung, C. (2000). Responses to raumatic stress among community residents exposed to a train collision. Stress Medicine, 16, 17-25.

36. McFarlane, A.C. (1989). The aetiology of post-traumatic morbidity: predisposing, precipitating and perpetuating factors. British Journal of Psychiatry, 154, 221-228.

37. Udwin, O., Boyle, S., Yule, W., Bolkton, D., & O'Ryan, D. (2000). Risk factors for long-term psychological effects of a disaster experienced in adolescence: Predictors of PTSD. Journal of Child Psychology and Psychiatry, 41, 969-979.

38. Najarian, B., Goenjian, A., Pelcovitz, D., Mandel, F., & Najarian, B. (2001). The effect of relocation after a natural disaster. Journal of Traumatic Stress, 14, 511-526.

39. Riad, J., & Norris, F.H. (1996). The influence of relocation on the environmental, social, and psychological stress experienced by disaster victims. Environment and Behavior, 28, 163-182.

40. Caldera, T. Palma, L., Penayo, U., & Kulgren, G. (2001). Psychological impact of the Hurricane Mitch in Nicaragua in a one year perspective. Social Psychiatry and Psychiatric Epidemiology, 36, 108-114.

41. Goenjian, A., Pynoos, R., Steinberg, A., Najarian, L., Asarnow, J., Karayan, I., Ghurabi, M., & Fairbanks, L. (1995). Psychiatric comorbidity in children after the 1988 earthquake in Armenia. Journal of the American Academy of Child and Adolescent Psychiatry, 34, 1174-1184.

42. Norris, F.H, Kaniasty, K., Conrad, M.L., Inman, G.L., & Murphy, A.D. (in press). Placing age differences in cultural context. A comparison of the effects of age on PTSD after disasters in the U.S., Mexico, and Poland. Journal of Clinical Geropsychiatry.

43. Gleser, G.C., Green, B.L., & Winget, C.N. (1981). Prolonged psychological effects of disaster: A study of Buffalo Creek. New York: Academic Press.

44. Thompson, M., Norris, F.H., & Hanacek, B. (1993). Age differences in the psychological consequences of Hurricane Hugo. Psychology and Aging, 8, 606-616.

45. Garrison, C.Z., Bryant, E.S., Addy, C.L., Spurrier, P.G., Freedy, J.R., & Kilpatrick, D.G. (1995). Post-traumatic stress disorder in adolescents after Hurricane Andrew. Journal of the American Academy of Child and Adolescent Psychiatry, 34, 1193-1201.

46. Perilla, J., Norris, F.H., Lavisso, E. (in press). Ethnicity, culture, and disaster response: Identifying and explaining ethnic differences in PTSD six months after Hurricane Andrew. Journal of Social and Clinical Psychology.

47. Dew, M.A. & Bromet, E.J. (1993). Predictors of temporal patterns of psychiatric distress during 10 years following the nuclear accident at Three Mile Island. Social Psychiatry and Psychiatric Epidemiology, 28, 49-55.

48. Hanson, R.F., Kilpatrick, D.G., Freedy, J.R., & Saunders, B.E. (1995). Los Angeles County after the 1992 civil disturbances: Degree of exposure and impact on mental health. Journal of Consulting and Clinical Psychology, 63, 987-996.

49. Phifer, J.F. (1990). Psychological distress and somatic symptoms after natural disaster: Differential vulnerability among older adults: Psychology and Aging, 5, 412-420.

50. Bromet, E.J. et al. (2000). Children's well-being 11 years after the Chernobyl catastrophe. Archives of General Psychiatry, 57, 563-571.

51. Havenaar, J.M., Rumyantzeva, G.M., van denBrink, W., Poelijoe, N., van den Bout, J., van Englelend, H. & Koeter, M. (1997). Long-term mental health effects of the Chernobyl disaster: An epidemiologic survey in two former Soviet regions. American Journal of Psychiatry, 154, 1605-1607.

52. Lonigan, C., Shannon, M., Taylor, C., Finch, A., & Sallee, F. (1994). Children exposed to disaster: II: Risk factors for the development of post-traumatic symptomology. Journal of the American Academy of Child and Adolescent Psychiatry, 33, 94-105.

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