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Interventions Following Mass Violence and Disasters: Strategies for Mental Health Practice,
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P A R T I

INTRODUCTION

Overview

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To set this volume in context, it is useful to consider the historical background. The current field of disaster mental health originated in military psychiatry. Frontline treatment (or forward psychiatry), first developed during World War I, has been extensively used, especially by Israel, Norway, Sweden, Australia, and the United States. As developed during World War II by the U.S. military psychiatrist Thomas W. Salmon, frontline treatment emphasizes the importance of administering psychological interventions as close to the front as possible. This process has been modified over time (Artiss, 1963; Kardiner & Spiegel, 1947; Neria & Solomon, 1999; Solomon & Benbenishty, 1986) but has retained the following three major principles:

1. *Proximity*—providing intervention as close to the active (combat) zone as possible.
2. *Immediacy*—providing intervention as soon as possible after an acute combat stress reaction.
3. *Expectancy*—emphasizing that acute stress reaction is a normal response to an overwhelming event, and that rapid recovery and resumption of normal duties are expected.

Many publications on frontline treatment attest to its effectiveness in returning soldiers to duty and in minimizing later morbidity, although little

solid empirical evidence supports these claims. The best recent data were obtained in a quasi-experimental study concerning Israeli Defense Force (IDF) personnel during the 1982 War in Lebanon. IDF troops with combat stress reactions (CSRs) either received frontline treatment in a forward-echelon medical unit, close to the battlefield, or were evacuated to rear-echelon units in Israel. Among those who received frontline treatment, 60% returned to active duty and 40% developed posttraumatic stress disorder (PTSD) at 1-year follow-up. In contrast, among those who received rear-echelon treatment, only 22% returned to active duty while 71% met diagnostic criteria for PTSD at 1-year follow-up (Milgram, 1986; Neria & Solomon, 1999; Solomon, Shklar, & Mikulincer, 1987). A recent 20-year follow-up study (Solomon, & Mikulincer, 2004) shows that soldiers who received frontline treatment have lower rates of posttraumatic and other psychiatric symptoms, experience less loneliness, and report better interpersonal functioning compared to similarly traumatized soldiers treated in rear-echelon facilities. Thus, frontline treatment seemed effective for ameliorating the immediate distress of CSR and for preventing later PTSD.

Frontline treatment is a flexible, individualized approach whereby the soldier remains in uniform, stays active with useful (but simple) chores, has the structure and order of a safe environment, has the opportunity to talk at his or her own pace if and when ready, is provided nurturance and peer support by comrades when possible, and is not forced to participate in psychological treatment. In contrast, psychological debriefing (see below) is often mandatory, follows a rigid format, is time limited, is not individualized, and might not be provided by colleagues.

Important early articles and books on frontline treatment from the United States and the United Kingdom include Ahrenfeldt (1958), Salmon (1919), Kardiner (1941), Kardiner and Speigel (1947), Glass (1954), and Artiss (1963).

DISASTER MENTAL HEALTH

Whereas frontline treatment has been focused on combat and the military, disaster mental health focuses on unpredictable events that happen to a civilian population.

Defusing

Defusing is designed as a brief (10–30 minutes) conversational intervention that can occur informally (e.g., during a meal or while standing in line for services). Defusings are designed to give survivors support, reassurance, and information. They may be used when an individual appears preoccu-

pied with thoughts about a stressful event and indicates willingness to discuss them. A typical defusing progresses through four phases: fact finding, inquiring about thoughts, inquiring about feelings, and support and reassurance (Young, Ford, Ruzek, Friedman, & Gusman, 1998).

A report on 510 Swedish peacekeepers deployed to Bosnia showed that peer support followed by defusing led by the platoon commander had a positive effect on both the immediate and the postservice mental health of participants in contrast to other interventions or to no intervention. Defusing had significantly better outcomes than psychological debriefing (Larsson, Per-Olof, & Lundin, 2000). Frontline treatment or its key components have supported earlier conclusions by military psychiatrists that this approach effectively reduces acute combat stress reactions and prevents PTSD (Kardiner & Speigel, 1947; Neria & Solomon, 1999; Solomon & Benbenishty, 1986).

Psychological Debriefing

Psychological debriefing (PD) was initially an application of frontline psychiatry—proximity, immediacy, expectancy—principles to civilian disaster situations. Critical incident stress debriefing (CISD), one type of PD (Mitchell, 1983; Raphael, 1986), is a one-time approach whereby groups of 10–20 trauma-exposed individuals participate in 2- to 3-hour procedures. PD is a group-oriented onsite intervention that occurs shortly after the traumatic event. Although there are variations, a typical debriefing includes seven general components: introduction; review of facts; recounting thoughts and impressions; sharing emotional reactions; normalization of feelings/reactions; future planning/coping/psychoeducation; and disengagement (Bisson, McFarlane, & Rose, 2000; Bryant & Litz, Chapter 9, this volume; Dyregov, 1997).

There is little empirical evidence supporting the efficacy of PD or showing that it prevents PTSD. Some research suggests that PD may even exacerbate posttraumatic distress under certain conditions (by exacerbating intrusive recollections or producing secondary traumatization) thereby increasing the incidence of PTSD (Bisson et al., 2000; Neria & Solomon, 1999).

At the National Institute of Mental Health consensus conference the following recommendation was approved:

Early intervention in the form of a single one-on-one recital of events and expression of emotions evoked by a traumatic event (as advocated in some forms of psychological debriefing) does not consistently reduce risks of later developing PTSD or related adjustment difficulties. Some survivors (e.g., those with high arousal) may be put at heightened risk for

adverse outcomes as a result of such early interventions. (National Institute of Mental Health, 2002, p. 8)

PUBLISHED LITERATURE

Another way to assess the growth of disaster mental health and PTSD fields is to review the relevant literature. The most authoritative source is the National Center for PTSD's (www.ncptsd.va.gov) PILOTS database (Published Literature on Traumatic Stress), the largest and most comprehensive database (currently over 28,000 citations) on stress, trauma, acute post-traumatic distress, PTSD, and related topics.

Before 1980, the English language literature on PTSD included 207 published articles; most (175) were devoted to combat stress reactions/war neurosis or military-related PTSD. Seminal publications by then included studies of World War I veterans (Kardiner, 1941; Rivers, 1918) and World War II veterans (Archibald & Tuddenham, 1966; Artiss, 1963; Bourne, 1970; Futterman & Pumpion-Mindlin, 1951; Glass, 1954, 1955; Grinker & Spiegel, 1945; Salmon, 1919). There was also an outpouring of major articles concerning war neurosis/PTSD, depression, alcoholism, and substance abuse among American veterans of the Vietnam War (Borus, 1973, 1974; DeFazio, 1975; Figley, 1978; Haley, 1974; Helzer, Robins, & Davis, 1976; Howard, 1976; Lifton, 1973; Nace, Meyers, O'Brien, Ream, & Mintz, 1977; O'Neill & Fontaine, 1973; Shatan, 1973, 1978; Wilson, 1978).

The most important publication in 1980 was the American Psychiatric Association's (1980) DSM-III, which first proposed PTSD as an official psychiatric diagnosis and operationalized its diagnostic criteria. It is noteworthy that despite three subsequent revisions of the American Psychiatric Association's canon of diagnoses—DSM-III-R (1987), DSM-IV (1994), and DSM-IV-TR (2000)—the criteria for PTSD have held up quite well.

The trauma, acute stress, and PTSD literature has grown remarkably since 1980. Among the 28,000 publications in the current PILOTS database, over 800 are devoted entirely to the recognition and treatment of acute stress reactions and acute stress disorder.

A major new direction for the literature was the addition of a new diagnosis, acute stress disorder (ASD), in DSM-IV (American Psychiatric Association, 1994). ASD filled an important diagnostic niche between exposure to a traumatic event and potential onset of PTSD symptoms 1 month later. ASD also spurred important research on acute posttraumatic psychological reactions and clinical interventions. We address this in depth in subsequent chapters.

CONSENSUS CONFERENCE

In the Preface we discussed the 2001 Consensus Conference. Its major recommendations focused on key operating principles of early intervention, guidance to evidence-based practice, optimal timing of early interventions, screening for survivors, follow-up guidelines, expertise and training, research and evaluation, and ethical issues. Crucial gaps in knowledge were also identified. The full report is available elsewhere (National Institute of Mental Health, 2002; www.nimh.nih.gov/research/massviolence.pdf).

ACTIVITIES SINCE THE CONSENSUS CONFERENCE

Two major developments among those of the past 3 years that moved the disaster mental health field forward at an accelerating pace are most significant: first, our collective experience with the aftermath of September 11, and second, the current military mental health experience at the frontlines or with returnees from Iraq and Afghanistan.

A major player in learning and disseminating information has been the Center for Mental Health Services (CMHS), a division of the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA). This provides funding and assistance for mental health services and outreach following any national disaster through its crisis counseling program. Clinical experience and evaluation data obtained from the CMHS-supported post-9/11 crisis counseling program in New York, Project Liberty, has been a major addition to our understanding about the longitudinal course of acute posttraumatic distress and community-level approaches to alleviate it.

Numerous national surveys conducted within days of the September 11 attacks, some of which remain ongoing (Galea et al., 2002; Schuster et al., 2001; Silver, Holman, McIntosh, Poulin, & Gil-Rivas, 2002), have provided valuable information on the psychological impact of such events, on resilience and recovery among most affected survivors, and on vulnerability and psychiatric morbidity among a significant minority of victims. The bioterrorism program at the Uniformed Services University of the Health Sciences has made great strides in furthering our current understanding and in promoting policy and practice to help prepare for future episodes. The National Institute of Mental Health has published the aforesaid book on the consensus conference, promoted further research, and, in partnership with CMHS, convened several high-level roundtable discussions by national and international experts on methodologies for screening populations at risk and providing effective early interventions in the immediate

aftermath of catastrophes. The Centers for Disease Control and Prevention in conjunction with the National Center for Child Traumatic Stress and National Center for PTSD took important steps to develop a public mental health strategy to alleviate the mental health consequences of future mass casualties. The Anxiety Disorders Association of America convened a conference in June 2002 to address key conceptual models and scientific findings pertinent to the phenomenology, psychology, psychobiology, and evidence-based early interventions for adults and children exposed to catastrophes (see Friedman, Foa, & Charney, 2003; Friedman, Hamblen, Foa, & Charney, 2004). Finally, CMHS has supported the National Center for PTSD's ongoing effort to develop evidence-based practice guidelines for early intervention. An important aspect of that initiative has been the development of case histories on Oklahoma City's mental health response following the terrorist bombing of the Murrah Federal Building and Project Liberty's efforts following the World Trade Center attacks (Norris, Watson, Hamblen, & Pfefferbaum, 2005; see also Norris et al., Chapter 18, this volume).

CURRENT STATUS OF THE FIELD

A Population Perspective

Although 95% of individuals exposed to some traumatic event reported some posttraumatic psychological distress, only 29% experienced reactions deemed serious from a clinical perspective. Most reactions were transient with symptom dissipation within a month for 42% and within a year for an additional 23%; only 30% experienced chronic symptoms lasting longer than a year (Norris, Murphy, Baker, & Perilla, 2003). Furthermore, a recent review of 160 studies on disaster survivors suggests that two-thirds will not develop clinically significant chronic psychiatric disorders that persists for months or years (Norris, Friedman, & Watson, 2002; Norris, Friedman, Watson, et al., 2002).

When considering the impact of terrorism, the prevalence of psychological distress appears to be considerably higher than for natural disasters. A random-digit dialing national survey of Americans completed within 3–5 days of September 11 indicated that 44% reported one or more substantial symptoms of severe distress, while 90% reported moderate distress (Schuster et al., 2001). Similar findings come from a Web-based survey of a national probability sample conducted 2 months after the World Trade Center attacks, indicating that 17% of the U.S. population outside New York reported symptoms of September 11-related posttraumatic stress (Silver et al., 2002). It is noteworthy that rates of posttraumatic distress in

both studies are considerably higher than the prevalence of PTSD and depression, 7.5 and 9.7% respectively, among New Yorkers within weeks of the World Trade Center attacks (Galea et al., 2002).

Early Detection and Intervention

Although most people exposed to a terrorist attack exhibit psychological distress, we currently cannot distinguish vulnerable from resilient individuals immediately after a terrorist attack, mass casualty, or natural disaster. Whereas some survivors experience transient acute posttraumatic reactions that may be briefly incapacitating, others develop the initial stage of a severe, chronic, and potentially incapacitating psychiatric disorder. A number of prognostic candidates have been proposed as early indicators of future chronicity such as functional impairment (Norris et al., 2003), elevated heart rate (Shalev, Peri, Canetti, & Schreiber, 1996), and negative cognitions (Ehlers & Clark, 2003). Unfortunately, none of these has been tested sufficiently. In addition, the new DSM-IV diagnosis of ASD has had only limited usefulness as a screening criterion for the general population as the majority who develop PTSD will not have met ASD criteria beforehand (Bryant, 2003). Our current inability to develop reliable methods for differentiating resilient from vulnerable individuals immediately after a traumatic event is obviously a major concern for public mental health planners who, understandably, do not want to pathologize normal and transient posttraumatic distress and who do not want to use scarce and expensive clinical resources for individuals who will recover spontaneously or with minimal assistance.

As noted elsewhere (Friedman, 2005) early detection is important because different interventions may be indicated for people situated at different loci along the vulnerability to resilience spectrum. For example, very vulnerable survivors might be most susceptible to the potentially deleterious effects of psychological debriefing shortly after a terrorist attack (Rose & Bisson, 1998). They might do better if treatment is delayed at least several weeks, after which they should be offered a brief course of cognitive-behavioral treatment (Bryant, 2003). In contrast, the most resilient survivors might benefit most from not receiving any formal intervention during the acute posttraumatic phase so that natural recovery processes can run their course (Ehlers & Clark, 2003). They might benefit most from psycho-educational opportunities or family/peer group support.

To summarize, many differences apparently exist between individuals regarding posttraumatic vulnerability versus resilience, the likelihood of transient versus chronic posttraumatic reactions, and the best pretraumatic preparation and posttraumatic interventions.

EVIDENCE-BASED EARLY INTERVENTIONS

Data from both adults and children suggest that attending to basic needs (safety, security food, shelter, acute medical problems, etc.), psychological first aid, clinical assessment, screening, and surveillance may be the best intervention in the early phase of recovery (Friedman, 2005). Treatment at this time could be indirect, for example, focusing on sleep problems, providing educational information about normal reactions to traumatic stress, encouraging survivors to seek support from significant others, and helping parents with their anxiety so as not to frighten children. Focused cognitive-behavioral interventions may be best initiated at least several weeks and possibly several months after the trauma for those individuals still experiencing significant symptoms.

A more extensive discussion of evidence-based early intervention is beyond the scope of this overview. A thorough discussion of practical concerns and the current status of clinical evidence in this regard can be found in later chapters.

WHAT WE KNOW, WHAT WE DON'T KNOW, AND WHAT WE SHOULD DO¹

We complete our summary with an adapted excerpt from an editorial titled "Toward Evidence-Based Early Intervention for Acutely Traumatized Adults and Children" (Friedman et al., 2003) that introduced a special issue of *Biological Psychiatry*.

Reproduced here are passages concerning phenomenology and early intervention (pp. 766–767).

Phenomenology

1. *We know* that the general response to trauma is one of immediate and significant distress; that most people recover spontaneously but a sizable minority progress to chronic incapacitating disorders such as PTSD or depression; that it is difficult to predict who will recover and who will develop trauma-related chronic disorders; that ASD has limited use as a screening criterion because most who develop PTSD never meet diagnostic criteria for PTSD; and that little current information pertains to children.

¹Material in this section is adapted from Friedman et al. (2003). Copyright 2003, with permission from the Society of Biological Psychiatry.

2. *We don't know* the full range of psychological reactions in the acute phase regarding symptom profiles and functional impairment; how to weigh age, gender, and cultural differences; what measurable acute post-traumatic phenomenological, diagnostic, psychological, and biological factors will let us distinguish resilient survivors from those vulnerable to develop PTSD and other psychiatric problems; and the best methods and instruments to evaluate posttraumatic distress and monitor affected individuals over time.

3. *We can close the gaps in knowledge* by developing models that fully characterize acute phase reactions and predict chronicity; by conducting epidemiological research on the general population and longitudinal studies on specific vulnerable/resilient groups; by developing standard and reliable instrumentation and procedures for such research; and by promoting separate initiatives for children.

Early Intervention

1. *We know* that randomized clinical trials with cognitive-behavioral interventions successfully accelerated recovery and/or reduced PTSD incidence; that randomized trials on individual psychological debriefing indicate that such early intervention is either ineffective or may actually delay recovery; that acute pharmacotherapeutic interventions have been tested sparingly; and that no empirical studies exist on acute psychosocial interventions for children.

2. *We don't know* how knowledge of psychological and biological mechanisms can be translated to effective treatments; what treatments will help trauma survivors at what times; what acute psychotherapeutic and/or pharmacological interventions to recommend at present; and what societal interventions, such as education, preventive actions, community interventions, and risk communication strategies, should currently be recommended.

3. *We can close the gap* by investigating a wide spectrum of individual, group, and community interventions. Research on individual interventions should consider efficacy, effectiveness, timing, treatment setting, dosage, target population, cultural factors, and developmental level. Research on group interventions should rigorously test group debriefings, self-help initiatives, and other psychosocial approaches. Research on societal and community level interventions should systematically evaluate pretraumatic preparation as well as posttraumatic community/societal interventions, and a range of outcomes at both the individual and community level: adaptive functioning, mental/physical health, knowledge/attitudes concerning trauma, effective coping, and health-seeking behavior.

CONCLUSIONS

We have begun to make headway in filling some important gaps. Our growing understanding has enabled us to ask better questions, design more pertinent research, develop new tools for early intervention, and address major educational challenges such as training for professionals and education for the general population. We see this volume as the next step following the post–September 11 conferences and roundtables described in the beginning of this chapter. We hope it will spawn future policy, practice, and research to advance the field with vision, sophistication, humility, creativity, and a strong sense of urgency.

REFERENCES

- Ahrenfeldt, R. H. (1958). *Psychiatry in the British Army in the Second World War*. New York: Columbia University Press.
- Archibald, H. C., & Tuddenham, R. D. (1965). Persistent stress reaction after combat: A 20-year follow-up. *Archives of General Psychiatry*, *12*, 475–481.
- Artiss, K. L. (1963). Human behavior under stress: From combat to social psychiatry. *Military Medicine*, *128*, 1011–1019.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Bisson, J. I., McFarlane, A. C., & Rose, S. (2000). Psychological debriefing. In E. B. Foa, T. M. Keane, & M. J. Friedman (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (pp. 39–59). New York: Guilford Press.
- Borus, J. F. (1973). Reentry: I. Adjustment issues facing Vietnam veterans. *Archives of General Psychiatry*, *28*, 501–506.
- Borus, J. F. (1974). Incidence of maladjustment in Vietnam returnees. *Archives of General Psychiatry*, *30*, 554–557.
- Bourne, P. G. (1970). *Men, stress and Vietnam*. Boston: Little, Brown.
- Bryant, R. A. (2003). Early predictors of posttraumatic stress disorder. *Biological Psychiatry*, *53*, 789–795.
- DeFazio, V. J. (1975). The Vietnam era veteran: Psychological problems. *Journal of Contemporary Psychotherapy*, *7*, 9–15.
- Dyregrov, A. (1997). The process in psychological debriefings. *Journal of Traumatic Stress*, *10*, 589–605.

- Ehlers, A., & Clark, D. M. (2003). Early psychological interventions for adult survivors of trauma: A review. *Biological Psychiatry* 53, 817–826.
- Figley, C. R. (1978). Symptoms of delayed combat stress among a college sample of Vietnam veterans. *Military Medicine*, 143, 107–110.
- Friedman, M. J. (2005). Toward a public mental health approach for survivors of terrorism. *Journal of Aggression, Maltreatment, and Trauma*, 10, 527–539.
- Friedman, M. J., Foa, E. B., & Charney, D. S. (2003). Toward evidence-based early interventions for acutely traumatized adults and children. *Biological Psychiatry*, 53, 765–768.
- Friedman, M. J., Hamblen, J. L., Foa, E. B., & Charney, D. S. (2004). Fighting the psychological war on terrorism. *Psychiatry*, 67, 123–136.
- Futterman, S., & Pumpian-Mindlin, E. (1951). Traumatic war neuroses five years later. *American Journal of Psychiatry*, 108, 401–408.
- Galea, S., Ahern, J., Resnick, H. S., Kilpatrick, D. G., Bucuvalas, M. J., Gold, J., et al. (2002). Psychological sequelae of the September 11 terrorist attacks in New York City. *New England Journal of Medicine*, 346, 982–987.
- Glass, A. J. (1954). Psychotherapy in the combat zone. *American Journal of Psychiatry*, 110, 725–731.
- Glass, A. J. (1955). Principles of combat psychiatry. *Military Medicine*, 117, 27–33.
- Grinker, R., & Spiegel, J. (1945). *Men under stress*. Philadelphia: Blakiston.
- Haley, S. A. (1974). When the patient reports atrocities: Specific treatment considerations of the Vietnam veteran. *Archives of General Psychiatry*, 30, 191–196.
- Helzer, J. E., Robins, L. N., & Davis, D. H. (1976). Depressive disorders in Vietnam veterans. *Journal of Nervous and Mental Disease*, 163, 526–529.
- Howard, S. (1976). The Vietnam warrior his experience and implications for psychotherapy. *American Journal of Psychotherapy*, 30, 121–135.
- Kardiner, A. (1941). *The traumatic neuroses of war*. Washington, DC: Hoeber.
- Kardiner, A., & Spiegel, H. (1947). *War stress and neurotic illness*. New York: Hoeber.
- Larsson, G., Per-Olof, M., & Lundin, T. (2000). Systematic assessment of mental health following various types of posttraumatic support. *Military Psychology*, 12, 121–135.
- Lifton, R. J. (1973). *Home from the war: Vietnam veterans: Neither victims nor executioners*. New York: Simon & Schuster.
- Milgram, N. (1986). *Stress and coping in time of war: Generalizations from the Israeli experience*. New York: Brunner/Mazel.
- Mitchell, J. T. (1983). When disaster strikes: The Critical Incident Stress Debriefing. *Journal of Medical Emergency Services*, 8, 36–39.
- Nace, E. P., Meyers, A., O'Brien, C. P., Ream, N., Mintz, J. (1977). Depression in veterans two years after Viet Nam. *American Journal of Psychiatry*, 134, 167–170.
- National Institute of Mental Health Report. (2002). *Mental health and mass violence—Evidence-based early psychological intervention for victims/survivors of mass violence: A Workshop to Reach Consensus on Best Practices*. Washington, DC: U.S. Department of Defense; U.S. Department of Health and Human Services, the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, Center for Mental Health Ser-

- vices; U.S. Department of Justice, Office for Victims of Crime; U.S. Department of Veterans Affairs, National Center for PTSD; and the American Red Cross.
- Neria, Y., & Solomon, Z. (1999). Prevention of posttraumatic reactions: Debriefing and frontline treatment. In P. A. Saigh & J. D. Bremner (Eds.), *Posttraumatic stress disorder: A comprehensive text* (pp. 309–326). Boston: Allyn & Bacon.
- Norris, F., Friedman, M., & Watson, P. (2002). 60,000 disaster victims speak: Part II. Summary and implications of the disaster mental health research. *Psychiatry*, *65*, 240–260.
- Norris, F., Friedman, M., Watson, P., Byrne, C., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981–2001. *Psychiatry*, *65*, 207–239.
- Norris, F. H., Murphy, A. D., Baker, C. K., & Perilla, J. L. (2003). Severity, timing and duration of reactions to trauma in the population: An example from Mexico. *Biological Psychiatry*, *53*, 769–778.
- Norris, F., Watson, P., Hamblen, J., & Pfefferbaum, B. (2005). Provider perspectives on disaster mental health services in Oklahoma City. *Journal of Aggression, Maltreatment, and Trauma*, *10*, 649–661.
- O’Neill, D. J., & Fontaine, G. D. (1973). Counseling for the Vietnam veteran. *Journal of College Student Personnel*, *14*, 153–155.
- Raphael, B. (1986). *When disaster strikes: How individuals and communities cope with catastrophe*. New York: Basic Books.
- Rivers, W. H. R. (1918). War neurosis and military training. *Mental Hygiene*, *2*, 513–533.
- Rose, S., & Bisson, J. I. (1998). Brief early psychological interventions following trauma: A systematic review of the literature. *Journal of Traumatic Stress*, *11*, 697–710.
- Salmon, T. W. (1919). The war neuroses and their lessons. *Journal of Medicine*, *59*, 993–994.
- Schuster, M., Bradley, D., Stein, M., Jaycox, L. H., Collins, R. L., Marshall, G. N., et al. (2001). A national survey of stress reactions after the September 11, 2001, terrorist attacks. *New England Journal of Medicine*, *345*, 1507–1512.
- Shalev, A. Y., Peri, T., Canetti, L., & Schreiber, S. (1996). Predictors of PTSD in injured trauma survivors: A prospective study. *American Journal of Psychiatry*, *153*, 219–225.
- Shatan, C. F. (1973). The grief of soldiers: Vietnam veterans self-help movement. *American Journal of Orthopsychiatry*, *43*, 640–653.
- Shatan, C. F. (1978). Stress disorders among Vietnam veterans: The emotional context of combat continues. In C. R. Figley (Ed.), *Stress disorders among Vietnam veterans: Theory, research and treatment* (pp. 43–52). New York: Brunner/Mazel.
- Silver, R. C., Holman, E. A., McIntosh, D. N., Poulin, M., & Gil-Rivas, V. (2002). Nationwide longitudinal study of psychological responses to September 11. *Journal of the American Medical Association*, *288*, 1235–1244.
- Solomon, Z., & Benbenishty, R. (1986). The role of proximity, immediacy and expectancy in frontline treatment of combat stress reaction among Israeli CSR casualties. *American Journal of Psychiatry*, *143*, 613–617.

- Solomon, Z., & Mikulincer, M. (1987). Combat stress reactions, posttraumatic stress disorder, and social adjustment: A study of Israeli veterans. *Journal of Nervous and Mental Disease, 175*, 277–285.
- Solomon, Z., Shklar, R., & Mikulincer, M. (2004, November). *A window of opportunity for psychological first aid: PIE revised 20 years after the Lebanon War*. Paper presented at the annual meeting of the International Society for Traumatic Stress Studies, New Orleans, LA.
- Wilson, J. P. (1978). Conflict, stress and growth: The effects of the Vietnam war on psychosocial development among Vietnam veterans. In C. R. Figley & S. Levantman (Eds.), *Strangers at home: Vietnam veterans since the war* (pp. 123–166). New York: Praeger.
- Young, B. H., Ford, J. D., Ruzek, J. I., Friedman, M. J., & Gusman, F. D. (1998). *Disaster mental health services: A guidebook for clinicians and administrators*. St. Louis, MO: National Center for PTSD, Department of Veterans Affairs Employee Education System.