

Treating Family Survivors of Mass Casualties: A CISM Family Crisis Intervention Approach

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ABSTRACT: *Critical Incident Stress Management (CISM) approaches emphasize the needs of families in crisis as one component of comprehensive service delivery. The need is particularly true for family survivors of mass casualties. This paper presents one CISM theoretical approach to these family survivors that is based on both the general principles of crisis intervention and recent findings in the field of psychological trauma. The model outlines three stages that many family survivors encounter as well as the time lines, tasks, and primary feeling states in each stage. Specific strategies for intervention in each stage are presented. The implications are discussed. [International Journal of Emergency Mental Health, 1999, 1(4), 243-250]*

KEY WORDS: bereavement; CISM; family crisis intervention; family survivors; mass casualties; posttraumatic stress disorder

Critical Incident Stress Management (CISM: Everly & Mitchell, 1999) is an integrated, comprehensive, multicomponent crisis intervention approach to critical incidents. CISM (Everly & Mitchell, 1999) spans a continuum of services from pre-crisis preparedness to acute care services to post-intervention procedures that address the psychological aftermath of critical incidents and prevent or mitigate the potential onset of posttraumatic stress disorder (PTSD; American Psychiatric Association, 1994; Everly & Lating, 1995; Flannery, 1994, 1999). The acute care services during these incidents often include individual, group, and family interventions. These and other CISM interventions (Everly & Mitchell, 1999) have been demonstrated to be clinically efficacious and cost-effective (Everly, Flannery, & Mitchell, 2000; Flannery, 1998).

The past decade has witnessed the emergence of several successful approaches to family therapy (Boss, Doherty, LaRossa, Schumm, & Steinmetz, 1993; Carlson, Sperry, & Lewis, 1997; Doherty & Baptiste, 1993; Figley, 1989; Rosenblatt, 1994). These approaches have demonstrated the effectiveness of working with family units to improve family communication, augment family resources, and increase family member problem-solving skills to maintain equilibrium and

enhance performance during family system dysfunction. One approach has been family crisis intervention (Hoff, 1989; Kinney, Haapala, & Booth, 1991; McCown & Johnson, 1993; Sugarman & Masheter, 1986), which has utilized crisis intervention principles to augment family resources and empower family functioning.

While undoubtedly excellent family crisis intervention treatments are provided during critical incidents, a review of the published peer-reviewed literature from 1967-1998 yielded only sixty-nine papers and book chapters that focused primarily on family crisis interventions by the police (e.g., Blanton, 1976; Dutton, 1984; Buchanan & Chasoff, 1986; Dodson-Chaneske, 1988), on similar intervention by health care providers for families impacted by serious mental illness (e.g., Shields, 1969; Rubenstein, 1972; Seywert, 1984), and on interventions with children by a wide array of child care specialists (e.g., Dillihay, 1989; Pollock, 1986; Reder, Lucey, & Fredman, 1991). Only two papers (Harris, 1991; Shamai, 1994) have clearly focused on PTSD and family needs. Harris (1991) provided a five-step crisis intervention approach for the family of an adolescent rape victim and Shamai (1994) described a clinic telephone outreach program to provide support to Israeli families during the Gulf War. In general, these family crisis intervention papers indicate a dearth of empirical findings and few linkages to the field of psychotraumatology.

Of particular importance in this latter area are family

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survivors of mass casualties who may have been traumatized by critical incidents. Natural disasters; man-made disasters such as airplane crashes, structural building failures, and high-rise fires; acts of violence such as mass shootings in schools and other public areas; and civilian casualties in combat are overwhelming life events that present a complicated coping process for family survivors. These events vary in intensity, duration, and severity. The needs of individual surviving family members may differ greatly, as may the needs of different families themselves. In these circumstances, an appreciation of the insights gained from family crisis intervention, the study of psychological trauma, and the principles of crisis intervention may be of important assistance to emergency mental health professionals who are asked to respond effectively to these situations of chaos.

The purpose of this paper is to present a concise, theoretical approach to the needs of family survivors of mass casualties that can be readily applied by emergency mental health service providers in the field. The approach incorporates the strengths of CISM crisis intervention approaches (Everly & Mitchell, 1999), family crisis intervention findings (Figley, 1995), and important principles garnered from the field of psychological trauma (Everly & Lating, 1995; Flannery, 1994, 1999).

Family Survivor Crisis Intervention: The Basic Approach

The Nature of the Critical Incident for Family Survivors

Critical incidents that are traumatic in nature are usually sudden, unexpected, potentially life-threatening events over which a person has no control, which would sufficiently

frighten most reasonable persons, and which overwhelm the person's capacity to respond. The experience of being psychologically traumatized can occur in direct victims of these critical events as well as persons, including family members, who witness these events happening to others (Figley, 1993,1995).

Figley (1993, 1995) has demonstrated that those who help or want to help the victim may develop signs and symptoms of trauma similar to those of direct victims. This is known as secondary traumatization. This phenomenon has been observed in spouses and children of Holocaust survivors, families of combat veterans, and therapists (Figley, 1995).

A majority of victims experience acute stress disorder (American Psychiatric Association, 1994) with disruptions in reasonable mastery, caring attachments, and meaningful purpose in life, the three domains associated with good physical and mental health. Reasonable mastery is the ability to shape the environment to meet needs; caring attachments to others are comprised of people who share support, companionship, and helpful assistance and a meaningful purpose in life is a reason to invest energy in the world each day. Acute stress disorder also brings with it the symptoms associated with psychological trauma including hypervigilance, exaggerated startle response, intrusive memories of the event, and a tendency to avoid the situation by withdrawing from it physically and psychologically. If these disruptions and symptoms are not resolved quickly, within thirty days, the victims and victim-witnesses may develop untreated PTSD, a state of continued disruptions, symptoms, and chronic dysphoria.

Family survivors experiencing this complicated process appear to encounter three stages: the ambiguity stage, the

Stage	Time Lines	Task	Primary Affect
Ambiguity	Early Hours/ Early Days	Information Gathering	Anxiety
Depression	Succeeding Early Hours/ Early Days	Grieving	Depression
PTSD	After 30 Days	Re-engaging	Chronic Dysphoria

Figure 1: Family Survivors' Stages

depression stage, and the PTSD stage. Each stage has its own time lines, its own tasks, and its own primary affect/feeling state. These are summarized in Figure 1.

The disruptions in mastery, attachment, and meaning, as well as the symptoms associated with psychological trauma and PTSD, are found in each stage but may be present in differing ways.

The Ambiguity Stage

The events of each day require individuals to use their reasonable mastery skills to respond adaptively. Based on past experience with generally similar situations or stimuli, individuals cope effectively with events because they know what to expect and how to respond. The environment or stimulus situation provides adequate information on how to adjust.

When the situation or stimulus event does not provide enough clear information on how to cope, individuals hesitate, limit their responses, and become anxious (Figley, 1995; Flannery, 1994). Depending on the severity of the situation, such as in cases of possible death or other major losses, individuals in these ambiguous situations will become highly anxious, fearful, and may even enter into a state of psychological shock. Individuals in these circumstances are motivated by a need to gather information that will help resolve the stimulus confusion and result in the exercise of reasonable mastery over the situation at hand. The continued absence of clear, unambiguous information may lead to frantic disorganized behavior and states of panic.

Family survivors find themselves in these ambiguous situations in the early hours, and possible early days, of a mass casualty. The confusion and chaos surrounding the critical event results in family members not knowing how to respond. The role of any missing family members may further splinter the family system's functioning and these family survivors may have many immediate questions. Are there any survivors? Is my loved one among them? Had they endured any suffering? What was the nature of suffering? Is our home still standing?

A second set of issues relates to how survivors will cope with the crisis. Family survivors have understandable concerns about their own physical and psychological responses to the event. Commonly, they are unfamiliar with the acute stress disorder and its symptoms that they are experiencing. They may have pre-incident medical problems apart from the crisis that require

care, and they may be concerned about food, clothing, and shelter during the crisis. Family survivors may also be concerned about their own surviving family members who may or may not be present. In a general way, they may also have concerns for other families present at the site who are experiencing the same critical event.

A third set of issues is related to the process unfolding about them. Concerns about who is in charge, who will have the needed information, when that information be available, and how family survivors will be included are common and understandable as family survivors seek to learn who is there in an official capacity and what their exact roles are.

The anxiety and disorganized behavior of family survivors will continue until the needed information is attained. This may take a few hours or a few days before the nature of the losses become fully known.

The Depression Stage

At some point in the early hours or days of the critical incident, the emergency service personnel on-site will make a determination about the extent of loss of life and/or property. When this information is made available to family survivors, many who have been in various states of anxiety will begin to assume a downcast response as the extent of loss becomes clear (Kubler-Ross, 1969). Individuals now have the full information that they need to respond, and the process of grieving and bereavement begins in most survivors. At this time, newer feeling states emerge, such as depression, anger, denial, guilt, survivor guilt, shame, betrayal, and sadness.

Bereaved family survivors need to accept the reality of the event as a permanent change, experience the grief, mourn the loss, accept the new limitations, and review basic values and goals. Although there are great variations in the grieving process, there is a theoretical five stage grieving process that may be of assistance in understanding grieving family survivors (Kubler-Ross, 1969). The first stage is that of *denial*, a period in which the finality of the loss is not fully acknowledged by the survivor. Some may continue to hold out hope in the face of clear evidence to the contrary. Others may continue with routine activities as if nothing has changed. This first stage in the process is followed by a period of *anger*. The person now realizes the limitations and lost dreams associated with the finality of the event. Anger is part of the body's response to changes in familiar routines, to

the permanency of loss, and to the need to move on in life in a new fashion that is not willingly undertaken. The third stage is *bargaining*, where the survivor family tries to barter with God, other family members, and friends to mitigate the true impact of the event. The bargaining period is followed by *depression* as the family survivors realize the full enormity of what has happened and what has been lost. In time, the loss is accepted and the depression is replaced with *acceptance* as the family accepts what has happened, and the process of rebuilding is reluctantly begun.

While not all survivors go through these stages, even those who do may go back and forth between stages over time or remain focused in one stage. Likewise, neither will all family survivors necessarily experience the same stage at the same time nor go through the sequence in the general order noted here.

Further complicating the grieving process are a series of variables that make the loss more difficult to accept (Flannery, 1994). Some of the factors that can complicate the grieving process for survivors include: witnessing the critical incident; relationships to the agent of the loss, if any; death or loss associated with additional types of violence such as torture, rape or mutilation; a past history of personal victimization in the family survivor; a history of violence with the individual involved in the critical incident; the method of death notification; and unwanted demands by the media and/or extended family members.

When the grieving process is being or has been adequately addressed, the work of the emergency mental health professional onsite may be coming to a conclusion. This may represent a potential additional loss for the family survivors and needs to be addressed with the families.

The Posttraumatic Stress Disorder Stage

Symptoms from the critical incident that have continued beyond thirty days may qualify for the medical diagnosis of PTSD. The disruptions in mastery, attachment, and meaning may be present along with the symptoms associated with traumatic events. While there may be intermittent periods of hypervigilance and anger, the avoidant symptoms associated with a general withdrawal from more normal functioning may occur, emotions may become restricted, and a chronic state of dysphoria may follow.

The main task of family survivors with PTSD is to reengage in daily life activities in the spheres of family, career, recreation, and community. Without intervention, the lives of these survivors may remain unduly restricted.

Untreated PTSD, with its painful psychological legacy, may last until death.

Family Survivor Crisis Intervention Strategies

The purpose of the family crisis intervention strategies suggested here is to resolve the symptoms associated with psychological trauma; to restore the disrupted domains of mastery, attachment, and meaning in each stage in order to mitigate the potential negative aftermath of the critical incident; to lessen the possibility of the onset of PTSD; and to lay the foundation for the reemergence of good physical and mental health at a later point in time. This approach incorporates the basic principles of crisis intervention counseling with suggested specific strategies for the restoration of mastery, attachment, and meaning in each of the three stages. The specificity of this approach may enhance the return of the survivor family to a reasonable measure of its pre-incident level of functioning within the frame work of the nature of the loss and, in some cases, may augment the family's repertoire of coping skills for subsequent life events. The symptoms and disruptions associated with the acute stress disorder and PTSD are monitored closely and addressed by specific differing strategies in each stage. These interventions may also be important teaching tools for instructing families about the impact of traumatic events.

General Principles

Each specific crisis intervention should be based on general crisis counseling principles (Everly & Mitchell, 1999; Everly et al., 1999; Flannery, 1999; Sandoval, 1985). These include (1) interviewing immediately in order to mitigate negative consequences; (2) gathering facts so that the family survivors know fully and exactly what has happened; (3) fostering the ventilation or expression of feelings to reduce tension and enhance communication; (4) empowering the survivor family to accept the reality of the event, to avoid decision avoidance, and to restore initial mastery; (5) restoring or creating a caring network of attachments; and (6) assisting the survivors to make some meaningful sense of what has befallen them. False reassurances of any kind are not helpful and further complicate the family's process of addressing the full impact of the event on their lives.

The Ambiguity Stage

As emergency mental health personnel implement these general principles, certain strategies may be selected with

the intent of restoring mastery, attachment, and meaning within the anxious survivor family.

The Issue of Ambiguity. As was noted earlier, because information is the key variable in the first stage, certain interventions by emergency mental health personnel may be helpful to anxious families. Each family would likely benefit from a case manager or a team of case managers who would be assigned to a specific family and become that family's support and advocate during the process. Family survivors need to be educated to each step in the process: who are the persons in charge onsite, what are the roles of these persons, and what will be the sequencing of steps. Information about psychological trauma, PTSD, and their symptoms should also be explained. Regular informational debriefings, a rumor hotline, and printed handouts are some basic approaches to information flow and updates. Families should be included in each step, and emergency personnel should not caucus by themselves in the presence of the families as such an event may heighten anxiety considerably. The adequate provision of ongoing information moderates the anxiety levels of the impacted families.

Restoring Mastery. Mastery will be enhanced if the families' basic needs are addressed, allowing them to directly focus on the critical event. Attention should be given to adequate food, clothing, shelter, any medical or disability issues, and adequate communication resources. Families are better served by structured daily activities alone or in concert with the other impacted family members. Generally, they are not well-served by remaining alone in hotel rooms with only constant media feedback. Each family and its members will have differing energy levels and differing thresholds for interpersonal stimulation. As many as possible should be included in walks, relaxation exercises, and aerobic exercises on a regular basis to reduce physiological arousal (Flannery, 1994). For some, the basics of a daily routine may be their baseline level. Others may feel more engaged, helpful, and psychologically comfortable if they are more active. Tasks such as ferrying information to others onsite, contacting other living relatives, and being of assistance with support tasks for the emergency service professionals responding to the incident or for other impacted families are valuable. Emergency mental health personnel can be creative in these early hours in developing tasks to enhance family victim participation and mastery.

Restoring Attachments. Restoring attachments are equally important in these first hours. The emergency mental health

practitioner and the family case managers are obvious first potential attachments. These caregivers can explore pre-incident support networks for each survivor family and can begin to re-link family survivors with their important long-term supports. Linking the impacted families to the extent their individual thresholds permit is another helpful strategy. Included here could be structured group activities such as common meals, religious services, and the like.

Restoring Meaning. The beginning steps in restoring meaning can also begin during these first hours. Why me? or Why our family? are pleas for meaning. The provision of opportunities for ventilation, religious contact or services, and solitude may be helpful first steps in this process. The addition of factual information as the hours pass may also assist family survivors to begin to comprehend what has taken place.

The Depression Stage

At some point, facts about the extent of loss of life and property become clear, and the family survivors become depressed and grief stricken.

The Issue of Depression. As noted above, there are a range of feeling states associated with loss and great variation in approaches to grieving. The ventilation of pain and suffering becomes the central issue; an issue which may be further complicated by the presence of any of the risk factors associated with traumatic events that were listed earlier. Emergency mental health personnel with an understanding of the range of feelings, grieving stages, and risk factors are in a unique position to be of assistance in understanding individual survivor differences and responding accordingly. For example, some may want to talk, others may prefer to be stoic. Some may wish to keep busy to feel in control. Still others may be unable to speak. Emergency mental health responses may vary from active listening to sitting silently at the victim family's side. Common to all of these strategies for responding to individual differences is the presence of a caring emergency mental health provider to ensure that no one is left alone in his or her moment of great pain. Any concerns about possible suicide need to be assessed and monitored closely.

Restoring Mastery. Attention to the basics is required to ensure that family members obtain food and rest and that the loss has not exacerbated some other pre-existing medical problem. Walks, relaxation exercises, and aerobic exercises may again prove helpful as these activities also mitigate the impact of depression (Flannery, 1994). Families may exercise

mastery in implementing burial services, dealing with possibly intrusive relatives, and in coping with the media. These survivor families are often able to assist one another in their common shared sorrow.

Restoring Attachments. Emergency mental health personnel can foster and strengthen potential social supports by assisting family survivors in developing group memorial services on-site and in supporting individual families as they reach out to their own blood relatives. Social isolation by choice should be monitored and gently discouraged as a long-term solution. Fragile, vulnerable families should be protected from the media so that each family unit can adjust to its loss without undue intrusion.

Restoring Meaning. Religious services in common or by differing religious traditions may be helpful in restoring meaning. Small group meetings with the emergency services personnel responsible for the site may allow individual families to review why the event occurred and assist them in integrating the event.

On-site Leave Taking. As the necessary onsite emergency services are completed, family survivors have to deal with the additional loss of the emergency services team. The emergency services team has been an important component in their lives, even in having to be the bearers of the loss. Family survivors may experience additional feelings of sadness, grief, and abandonment, and repeated group discussions with the families and the emergency team members may assist the family survivors in their leave taking.

The Posttraumatic Stress Disorder Stage

Recent years have seen the emergence of treatments for PTSD that focus on restoring mastery, attachment, and meaning (Everly & Lating, 1995; Flannery, 1994; van der Kolk, McFarlane, & Weisaeth, 1996) as well as therapists who are trained specifically in these counseling procedures for untreated PTSD. Frequently, the emergency mental health practitioner is not readily available if and when PTSD should emerge in family survivors at a later date. However, these emergency practitioners are able to assess for the possible presence of severe disruptions in mastery, attachment, and meaning as well as the symptoms associated with the acute stress disorder of psychological trauma and with PTSD. If such disruptions and symptoms suggest the need for further evaluation and treatment off-site, family survivors could be given a list of therapists who are qualified to treat PTSD and who reside within reasonable commuting distance of the family. Referrals to family therapists who specialize in addressing

the impact of trauma are an excellent potential referral. The emergency practitioner could offer to serve as a referral resource to the PTSD counselor.

Discussion

The crisis intervention model for family survivors of mass casualties presented here suggests that the basic family crisis intervention procedures used for police (Dutton, 1984), children (Reder, et al., 1991), and families impacted by serious mental illness (Seywert, 1984) may be adapted for the needs of families confronting the extreme stress of mass casualties. The model also suggests that the basic principles of crisis intervention may be augmented by recent advances in the study of psychological trauma and PTSD to enhance the effectiveness of emergency mental health personnel in developing specific intervention strategies for different families and for the same family as the nature of the critical incident before them unfolds in its different stages.

The conceptual model presented here uses a format that maximizes ease of retention by emergency personnel and offers wide latitude in developing individual family treatment plans by individual crisis counselors or teams of counselors. The model offers the potential to maximize family involvement and to reduce unnecessary suffering. The approach has implications for both service delivery and research.

Service Delivery. The range of individual victim differences during a critical incident varies considerably, and the general approach noted here can be modified to be responsive to these needs. For example, the impact of a mass casualty critical incident may place added stress on single parents and pre-incident dysfunctional family units. A single parent's anxiety may increase greatly during the ambiguity stage with both the realization of the event itself and the fact that the parent may be the sole resource for the children. Similarly, the dysfunctional family may have been significantly depressed prior to the incident and may become almost overwhelmed by the grieving of the depression stage of the critical incident. This may be especially true if the family dysfunction included acts of physical or sexual abuse or other major unresolved conflicts with the missing family member. An awareness of these needs and issues can assist emergency services personnel in providing the needed resources to these families.

This model may also be helpful in other non-mass casualty

situations where the issues of ambiguity and depression are present. The drive-by shooting of a child with the family's wait in the emergency room, or the abduction of a child with the family's long vigil at home are both instances of single potential casualties where the psychological timelines, tasks, and feeling states may be similar to those of mass casualties. This model may also be of assistance to neighbor witnesses to either individual or mass casualties, as the issues of ambiguity and depression with possible subsequent PTSD may also confront witnesses. A family crisis intervention approach that incorporates awareness of trauma could be readily fielded for these victim witnesses.

Many crisis response teams, including those that serve the nation's major airports, are in the process of developing family assistance programs as part of the command structure in the event of critical incidents. The approach outlined here could be easily fielded in a family assistance center and could provide a common conceptual framework for the mental health emergency personnel responding to the critical event.

Research. The family crisis intervention model presented here is supported by anecdotal clinical evidence. However, this model and most of the literature on all types of family crisis interventions require rigorous experimental testing, including controlled, randomized outcome studies. These family intervention studies will need to address common weaknesses already noted in crisis intervention studies (Everly et al., 1999).

Studies will need to specify which type of critical incident was addressed, what categories of families received services, and what services were provided. In time, the research findings may provide service providers and researchers with a list of

common effective interventions that appear effective and could help to clarify the various methodological strategies that were employed so that comparison and generalizations between studies would have enhanced reliability and validity.

Even in studies that address known methodological issues in this research area (Everly et al., 1999), sensitive outcome measures will remain problematic. Since formal self-report written inventories may likely be too intrusive and less valid in the midst of the crisis, one approach might be to train emergency service personnel to assess the impact of these critical incidents by providing ratings, repeated mental status assessments, and other less intrusive approaches to assess the disruptions and responses of the family survivors. The response to the family crisis intervention model presented here may also be assessed through behavioral measures such as the ability to return to work, absence of subsequent stress-related medical visits, absence of continued family conflict, and absence of family social isolation. Clinical practice as well as experimental findings may well indicate the need to modify the general approach presented here.

Conclusion

Family survivors of mass casualties and similar violent events need the most psychologically sensitive, efficacious interventions that can be fielded. The CISM family crisis intervention model presented here that incorporates an awareness of the traumatic aspects of the event encountered by these families may be one helpful step in that direction.

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