Coping with Catastrophe: Organising Psychological First-Aiders

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The recent terrorist attacks in the United States of America and the widespread fears of anthrax poisoning and spreading of smallpox that followed, raise the question of how New Zealand health professionals might respond to the casualties were similar events to occur here. The matter has often been raised before, but now the new Director of the Ministry of Civil Defence and Emergency Management is determined to have it addressed. As a start, this paper draws on international expertise and local experience to outline the kind of psychological first-aid service that should be made available to disaster casualties. In clinical justification it holds middle ground on the efficacy of such intervention between the advocates and the critics, lists the particular topics about which interveners should be informed, sketches the essentials of their involvement, and asserts that some conditions will require specialist treatment. It accepts that the implementation of the proposal would require further discussion with the relevant professional societies, voluntary agencies, and the statutory bureaucracies that have responsibility for dealing with other aspects of trauma and social disruption.

The events in New York and Washington on 11 September 2001 left around 3 000 dead on the sites where the three planes crashed and many thousands of people in stages of grief and shock throughout the country. Teams of crisis responders swung swiftly into action, locating themselves conveniently in available spaces, alerting their networks to the problems to be addressed, and calling for 'restraint, patience, preparation, and professionalism' (September 11 Updates, 2002). In short time leading educationalists, clinical practitioners, public authorities, and trauma relief organisations updated web-sites, and some mounted a series of one-day transitional courses to upgrade the knowledge of recent recruits.

Several official and unofficial agencies were involved with the counselling response, and the full weight of their commitment has yet to be known. But in the first eight weeks after the event throughout America, the Red Cross alone had 135,800 mental health and grief contacts. Soon more detailed information should be available about the kind of problems presented around the impact and the recoil stages of the attacks. On the organisational side, trained mental health volunteers on the sites worked long hours, and in their state of marginal fatigue they did not receive kindly the reminder of a sceptic that they were accountable, scientifically and clinically, for their work – especially when the media took up the issue. Nor did they appreciate the spontaneous offers of help from unknown clinicians whom they described disparagingly as 'trauma tourists' for being in a heightened state of arousal and displaying the well-known signs of the convergence phenomenon with an uncontrollable impulse to be at 'ground zero'.

For their part the trained reinforcements brought in from neighbouring States were annoyed to find that even in such an emergency their professional credentials had to be checked before they could lend a hand. Others en route were frustrated by the unavoidable air transport delays caused by the fears of further terrorist attacks, and by the typical 'hurry up and wait' orders they received. But on reflection some realised that they had a useful role to fill at home without being at the epicentre of the disaster. They came to see that their existing clients might be dependent on them for help in dealing with the ramifications of the terrorist attack on the nation, and that new clients might be referred to them for grief, anxiety and depressive reactions associated vicariously with the event.

For those on site, questions arose as to what kind of agency intervention model they were better to adopt – either that of American Red Cross, or Critical Incident Stress Management, or Green Cross, or an amalgam – and what kind of debriefing system should be provided, and how soon

after the event. Then came the kind of help the debriefers themselves would need to recalibrate their experiences daily before re-entering the fray. In their normal practice the health professionals were familiar with the long-term effects of burnout (Wilson & Lindy, 1994), but not all appreciated that the intense pressure from emergency work also produced adverse emotional and physical effects – called compassion fatigue, countertransference, secondary traumatic stress, or vicarious traumatisation. The American Psychological Association went so far as to advise practitioners to respond by recognising professional challenges, attending to self-care strategies, adopting professional support, and enhancing their commitment to those in need (cf. www.apa.org/practice/practitionerhelp.html - accessed 28/11/01).

Even experienced workers were caught by surprise and affected adversely by shock in the face of the sheer destruction, utter carnage, gruesome sights, and the nauseous smells of mass casualties in New York, and it took them time to be fully functional again.

The American experience raises questions as to how we might cope in New Zealand were a scaled-down version of the disaster to occur in this far less densely populated country. Here the mental health network is thinly spread, overloaded, and for the most part unfamiliar with the elements of immediate disaster trauma. More than that, there could be dormant inter-agency issues still to be addressed: in times of emergency in the past various factions have been seriously at odds with each other, some resenting the deployment of national staff to help out local units, and others quite reasonably resenting outsiders flocking in to ride roughshod over locals that were providing an adequate service.

The following examples illustrate these types of conflict. At the time of the 1979 Mt. Erebus aircrash in Antarctica the local clergy in Auckland were at loggerheads with the Oakley Hospital social workers as to which party should operate the hotline that the hospital set-up for bereaved families and friends who were waiting at the airport for the return of the ill-fated one-day scenic flight. Subsequently more volunteers offering support called the hotline than people requesting the support. No alternative outreach programme was put in place. The Police had a Disaster Victim Identification Team in operation, but no psychological debriefing programme either for them or for those that worked with them had been considered until an outsider initiated the matter (Taylor & Frazer, 1981). After the Aorangi floods in South Canterbury in March 1985, an official from outside tried to override the sterling work of a local community based volunteer. In March 1987, after the Edgecumbe earthquake in the Bay of Plenty, the staff of the local hospital and of the Social Welfare Department were at odds because of a long-standing feud over the handling of child protection cases, and they did not cooperate on earthquake casualty matters. In two instances after the earthquake, the local clergy were under pressure from their colleagues outside the area to admit 'carloads of counsellors' at a time when no such help was needed (Taylor, 1988). In November 1990 at Aramoana in Otago, local psychologists and social workers regarded the Victim Support staff sent by national office to help its Dunedin group as intruders.

Then at times our own emergency organisations have paid lip-service to the effects of traumatic stress, at best asserting that if it arises at all it applies to other people and not to its own heroic staff, and at worst steadfastly denying the evidence. In fact during the Gisborne Cyclone Bola floods in March 1988 none other than the Director of Civil Defence at the time decreed that there would be no stress! However, and not unexpectedly, a later review of the same Ministry found that the lack of concern for staff welfare on such operations left much to be desired (Civil Defence Review Panel Report, 1992). But to be fair it has to be said that no preparations to deal with casualties of catastrophe could ever meet fully the demands that will be encountered 'on the day'. The most to be expected is that training schemes would be sufficiently robust to meet the basic needs of any population and be flexible enough to address some of the unique problems that inevitably will arise.

Organisation and Training

In America, the National Voluntary Organizations Active in Disasters (NVOAD) was established in 1979 with responsibility for addressing the short-term needs of disaster casualties. It operates between the Federal Emergency Management Association (FEMA) and the extensive network of government and voluntary agencies in which the National Organization for Victims Assistance (NOVA) and the American Red Cross (ARC) are to the fore. Then there are others such as the Critical Incident Stress Management group (CISM) and the Green Cross that respond mostly in connection with employee assistance programmes.

The CISM is well known in Australasia, having operated in this region with the emergency services since the early 1980's (cf. Mitchell 1983). Not yet so well known is the Green Cross Foundation that was established in 1995 to specialise in post-disaster work on the initiative of Charles Figley after the Oklahoma City bombing. It provides a comprehensive three-tiered training service for its staff that entails progressive coursework and supervised practice leading to certification. The first tier teaches principles of immediate support leading to certification as a Field Traumatologist. The second offers more skilled intervention for leading to recognition as a Certified (Clinical) Traumatologist, and the third offers project supervision and staff training leading to the title of a fully-fledged Master Traumatologist.

The ARC, CISM, and Green Cross have separate training courses that from inspection of their material have much content in common. For example they all:

- focus on the clinical signs and symptoms of acute and chronic trauma while being aware of those of other psychiatric disorders
- differentiate between reactions attributable more to recent trauma than either to unresolved psychiatric disorder or to normal grief
- indicate the kind of support casualties might require at

different stages of disaster recovery and makes clear where it should be provided

- acknowledge the spiritual components of behaviour
- outline procedures by which casualties might be induced to convert their raw sensations into manageable memories, and
- require potential helpers to be sufficiently self-disciplined and responsive to organisational demands to work as required without embarrassment, stress, and fatigue.

If anything the courses might be light on the cross-cultural implications of trauma-work, on the needs of children and the elderly, on the classification of disasters and disaster casualties, and on the organisational aspects of disaster and recovery. But their nurse/psychologist/social worker designers seem to be open to suggestions for including such topics.

Without necessarily adopting the same designations, the question arises as to whether a similar model of graded expertise might be adopted in this country for training health professionals to attend to the immediate mental health of casualties, and then if in the affirmative, to consider what kind of organisational structure would necessary for bringing it into operation. In April 1998 a formal NZ Qualification Authority Unit Standard EM/23-2 was registered for trainees in the Civil Defence organisation, but it languished for want of interest. However, the latest draft guidelines of the International Society for Traumatic Stress Studies (2002) touch on some important points, but its emphasis is more on training for service abroad than for service at home. Thus, to answer the questions it might be helpful to explore the notion of psychological first-aid, because once the purpose is agreed, it should be easier to consider the necessary organisational structure for putting it into operation and the funding required to get it moving.

Psychological First-Aid

By definition, disasters are life-threatening events that can overtax the ability of people to respond. Thanks to the pioneering work of Cannon and Selye (e.g., Selye 1976) and now Ursin (2000), it is known that such events activate the central and sympathetic nervous system instantly in a primitive and protective flight, fight, or freeze manner. The activation in turn produces a range of mental, physical, and social reactions that can be quite disturbing either to experience or to witness. Its onset and duration will vary for individuals according to the severity of their traumatic experience, their ability to bring cognitive control to bear on their state of alarm, and their particular supportive pattern of personal, components of the response.

In some instances the reactions of casualties will indeed be minimal, reflecting their stability as individuals, their mastery of previous events, the adequacy of their support systems, and their reserves of resilience with which to meet the unexpected. Such people will be sufficiently resolute to want no help for themselves and be able to offer a hand to others. But for the majority the reactions will be acute and transient, representing a normal response to abnormal circumstances. A few might even exhibit what (Raphael 2000) describes as a 'counter-disaster syndrome' of hyperactive over-activity until they can be induced to switch off and regain a semblance of normality, and should any have residual problems of significance stirred up as a result of the disaster experience they would quite properly become the concern of the conventional mental health agencies. At the other extreme are the most vulnerable, who will also have experienced stressors of greater magnitude and intensity that were unpredictable, uncontrollable, perceived as being most dangerous and threatening, and producing extremes of terror and horror (cf. US National Center for PTSD, 2002). A small minority will find their pre-existing problems compounding their disaster reactions and creating symptoms of psychopathology that will require professional attention (McFarlane & Yehuda 1996).

However, the immediate aim of crisis responders is to help casualties to restore their psychological status quo. Their first task is to get survivors to a place of safety where there is access to medical treatment for physical injuries, protection from sensory reactivation and from the elements, thirst quenching liquid, supplementary clothing, and blankets to prevent heat loss and to counter the other effects of shock. As members of a multicultural society in which for many citizens English is a second language, and in a country that increasingly is becoming a popular tourist destination, they will need either to be multilingual or have access to interpreters to facilitate contact with casualties.

In the process they will facilitate family contacts, and give protection from unwanted intrusions. They will lend an attentive ear to anyone wanting to talk, and take care not to jump to any kind of diagnosis with recommendations for intervention unless the survivors show reactions that are quite extreme. Their immediate aim will be to restore the basic components of life that catastrophe has fractured (cf. Young 1998: UK Resilience 2002). Following Schwartz and Kowalski, (1992) they will not be in a hurry to remove the psychological defences of avoidance, intrusion, and hyper-arousal that individuals might have erected – and will hope that the news media will be of the same mind. But they will look ahead a few days to the time at which individuals will regain their composure and be strong enough to revive a sense of attachment, belonging, commitment, and fulfilment, albeit in some altered form (cf. Young, 2001).

While being alert for signs of acute adversity, crisis responders will avoid the trap of 'pathologising' the transient if extreme responses that disasters often produce, but they will regard trauma as an initial period of unstable adjustment to life-threatening events. They will also take care not to 'revictimise' the casualties by making them over-dependent on them. But should the critical signs persist beyond a few days, they will proceed cautiously within the boundary of their training and expertise to make the symptoms manageable. Should there still be no improvement they would refer the casualties to general medical practitioners for medication and to the established mental health services for their more extensive professional care. While behaviour disturbance, depression, extreme anxiety, and other psychiatric conditions might become manifest, post traumatic stress is the bogey. The National Center for PTSD in the United States gives the prevalence rates for PTSD as

4-5% from natural disasters, 28% from mass shooting, 29 % plane crash into an hotel, and 34% from bombing.

The National Centre for PTSD (2000) reviewed the records of more than 50,000 individuals who were involved in 130 empirical studies of disaster, and found 74% to have specific psychological problems, some of which were multiple. These included 65% with PTSD, 37% with depression, and 19% with anxiety. Sixteen per cent were assessed as very severe, 23% as severe, 52% as moderate, and 9% as minimal. There was also a positive correlation between earlier and later symptoms. Delayed onset was rare. Most of the conditions improved during the first year (i.e., the 'evaporation effect', cf. Potts, 1994), but the core group of casualties with chronic (PTSD) did not fare so well, and their symptoms were difficult to treat. For such people, Shalev Bonne, and Eth (1996) suggest that rehabilitative goals should replace the curative.

Consequently mental health professionals involved in trauma work downstream are obliged to consider the conventional criteria in detail; when assessing post-disaster symptomatology, and then they have to make treatment plans accordingly (Dietrich, Baranowsky, Devich-Navarro, Gentry, Harris, & Figley, 2000). In treatment their aim is to create conditions of security that allow casualties to ventilate their feelings and memories, and to take part in a programme of stress reduction in which stimulants are avoided, exercise is encouraged, social supports are utilised, and life styles are re-examined (Davis, Eshelman, & McKay, 1998). They are intent upon trying to prevent memories of trauma becoming firmly embedded in the psyche, the adverse psychosomatic effects of which have been confirmed (Pennebaker & Susman 1988) and the psycho/neuro/ endocrinological effects of which are now under laboratory scrutiny (Ursin, 2000; van der Kolk 1996).

Here it should be noted that at one time the same maxim for the treatment of mental disorder was adopted and applied for the treatment of trauma victims, namely that early detection, intervention, and hospitalisation would lead to early recovery. Subsequent experience of trauma led to the prescription being modified to involve proximity, immediacy, and expectancy for civilian casualties and the military alike (Glass, 1969; Hoiberg & McCaughey, 1982; Milne, 1979) together with the restoration of group and community bonding. But the kind and duration of such psychological treatments have been rarely reported in detail, and their omission has caused endless controversy among clinicians and researchers.

Although psychological debriefing was construed as a preventive rather than a therapeutic measure, particularly as applied routinely to emergency personnel after assignments, there are those that find no evidence of one session intervention reducing psychopathology (Gist & Woodall, 1998; Raphael, Meldrum & McFarlane, 1995; Rose Bisson & Wesseley 2001). The Department of Health (Guidelines Development Group, 2001, s.3.15) in Britain goes so far as to say that 'routine debriefing shortly after a traumatic event is unlikely to help prevent post traumatic stress disorder and is not recommended' – but they make no reference to Foa and Williams (1997) that reaches much the same conclusion about the application of a number of the more orthodox therapies to PTSD. Yet others defend the practice of debriefing vigorously (if primarily because of the positive self-reports it engenders), and they declare deficient the strategies and procedures their critics use to examine the effects (Dyregrov, 2000; Everly & Mitchell, 2000). In her preface to Guidelines Development Group (2001), Parry makes the point that researchers have yet to moderate 'the most prevalent interventions' that are 'more pragmatic and eclectic... with a judicious mix of techniques drawn from varying theoretical frameworks...(as distinct from)...'standardised interventions of pure types of therapy'.

A sage might say much the same for the outcome of early post-traumatic treatment procedures that have received appropriate scrutiny, been applied with discretion, monitored in their application, modified to suit individual needs, and followed-up to ensure that there were no complications requiring further attention. Certainly such a conclusion would be consistent with the gist of both the reviews on the subject made by Litz, Gray, Bryant, & Adler (2002) in the United States and by the Professional Practice Working Party on Debriefing (2002) in Britain.

However, the authorities all agree that many empirical questions remain unanswered concerning the assessment and suitability of individuals, the specifics of the kind of intervention being offered, and the timing of its onset and duration, before appropriate research designs can be developed. Although the North American advisers still insist on the use of the gold standard of trials with clinically and psychometrically robust methods of assessment of specific conditions, randomly allocated trial and control groups, and independently applied follow-up procedures – the application of which might bring rigor mortis rather than rigor in the procedures under review (Lizt et al., 2002, Future research: Point 1), whereas their British counterparts would appear to be more ready to compromise according to the 'non-laboratory' circumstances presented (cf.Cox, 2002).

In short, trauma counselling is not a standard medicine to be applied to everyone regardless of need. Were it used in that way it could be quite unnecessary, create antagonism, confusion, and complications in the nature of a secondary traumatisation. Therefore it makes sense for helpers at the impact phase of disasters to be concerned like all welfare workers with basic issues to ensure the safety of casualties. They should try to connect people with their family and support groups and with their cultural and religious networks. They should also provide pamphlets giving reassurance about any untoward reactions that might arise, and giving details of follow-up contact in such a way as to discourage the production of symptoms by way of a self-fulfilling prophecy. The information in printed form should not tax the concentration of the casualties at a time when their memories might not be functioning too well.

Provision for the follow-up would be necessary because usually it takes between one to three weeks after a major life-threatening event for individuals to draw on their resources, make provisional adjustments to their changing world, and begin working through the normal processes of grief and loss. Should that not occur and they are beset with

troublesome symptoms, they might be encouraged to make contact with trauma clinicians either through normal channels or through some ad hoc outreach programme designed for the purpose.

In this work, as in any other, psychological helpers must be professionally accountable, not only to ensure that they do no harm but to improve the quality of the service they present. Consequently they will keep adequate records, examine their interventions critically, be prepared to respond to challenging questions that others might raise about the appropriateness of what they did or did not do, and accept an obligation to promote independent research into their activities. Already a few tertiary educational institutions in Britain and the US are known to be touching on these matters in their formal courses, and currently a number of psychologists are canvassing for sufficient support to form a Division of Trauma Psychology of the American Psychological Association to advance their academic and professional concerns. There are also interdisciplinary bodies locally, such as the Australasian Critical Incident Stress Association and the Australasian Society for Traumatic Stress Studies, that help members to share their personal experience, professional expertise, and research concerns.

Summary

Sufficient has been said to warrant the establishment of a psychological first aid service in this country for disaster casualties. It could be nation-wide, managed by a responsible organization, and operated at grass roots level by people with a background in health and community service whose training makes them familiar with the somewhat transient symptoms of disaster trauma. It would act as a feeder to the established mental health services people with the more intractable problems. Like all new developments it would need to have a business plan prepared with attention to the costing of core staffing, resources, training, social accounting, and audit. It would also need to have a carefully prepared plan for research to which data could be ordered on relevant human dimensions of performance.

References

Department of Civil Internal Affairs (1992).*Civil Defence Review Panel Report.* Wellington: Author.

Cox, S. (2002). Tools and techniques for evaluating psychological debriefing. In *Professional Practice Working Party. Psychological debriefing* (ch.3). Leicester, UK: British Psychological Society.

Davis, M., Eshelman, E.R., & McKay, M. (1995). *The relaxation and stress reduction workbook.* (4th ed.) Oakland, CA: New Harbinger Publications.

American Psychiatric Association (2000). *Diagnostic & Statistical Manual VI TR.* Washington, DC: Author.

Dietrich, A.M., Baranowsky, A.B., Devich-Navarro, M., Gentry, J.E., Harris, C.J., & Figley, C.R. (2000). A review of alternative approaches to the treatment of post-traumatic sequelae. *Traumatology, 4,* 2-16.

Dyregrov, A. (1998). Psychological debriefing –An effective method? *TRAUMATOLOGYe, 4:2,* Article 1, http//ww.fsu.edu/~trauma/

Everly, G.S., & Mitchell, J.T. (2000). The debriefing 'controversy' and crisis intervention: A review of lexical and substantive issues. *International Journal of Emergency Mental Health, 2,* 211-225.

Foa, E.B., & Meadows, E.A. (1997). Psychosocial treatments for post traumatic stress disorder: A critical review. *Annual Review of Psychology, 49,* 449-480.

Gist, R., & Woodall, J. (1998). Social science versus social movements: The origins and natural history of debriefing. *Australasian Journal of Disaster and Trauma Studies, 1.* http://www.massey.ac.n/~trauma/

Glass, A.J. (1969). Introduction. In P.G. Bourne (Ed.). *The psychology and physiology of stress.* (pp. xii-xxx). New York: Academic Press.

Guidelines Development Group. (2001). *Treatment choice in psychological therapies and counselling: Evidence based clinical practice guideline brief version.* London: Department of Health.

Hoiberg, A., & McCaughey, B.G. (1982): *Collision at sea: The traumatic aftereffects. Report 81/39.* San Diego, CA: Naval Research & Development Command.

International Society for Traumatic Stress Studies. (2002). *Draft Guidelines for International Trauma Training. Version 11.00.* – http:/ /www.istss.org/Guidelines.htm - accessed 1 May 2002.

Litz, B., Gray, M., Bryant, R., & Adler, A. (2002). *Early intervention for trauma: Current status and future directions.* National Center for PTSD.http://www.ncptsd.org/facts/disasters/fs_earlyint_disaster.html

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

McFarlane, A.C., & Yehuda, R. (1996). Resilience, vulnerability, and the course of posttraumatic reactions. In B.A. van der Kolk, A.C. McFarlane, & L. Weisaeth (Eds.). *Traumatic stress: The effects of overwhelming experience on mind, body, and society.* New York: Guilford.

Milne, G. (1979). Cyclone Tracy: Psychological and social consequences. In J.I. Reid. (Ed.), *Planning for people in natural disasters* (pp. 116-123). Brisbane, Australia: University of Queensland Press.

Mitchell, J.T. (1983). When disaster strikes. The critical incident debriefing process. *Journal of Emergency Service, 1,* 36-39.

National Centre for PTSD. (2001). *The range, magnitude, and duration of effects of natural and human-caused disasters: A review of the empirical literature.* http://www.ncptsd.org/facts/disasters/ fs_range.html.

Pennebaker, J.W., & Susman, J.R. (1988). Disclosure of trauma and psychosomatic processes. *Social Science & Medicine, 26,* 327-332.

Potts, M.K. (1994). Long-term effects of trauma: Post-traumatic stress among civilian internees of the Japanese during World War 11. *Journal of Clinical Psychology, 50,* 681-694.

Professional Practice Working Party. (2002). *Psychological debriefing.* Leicester, UK: British Psychological Society.

Raphael. B. (2000). *Disaster mental health handbook: An educational resource for health professionals involved in disaster management.* North Sydney, NSW: Centre for Mental Health.

Raphael, B., Meldrum, L., & McFarlane, A.C. (1995). Does debriefing after psychological trauma work? *British Medical Journal, 310,* 1479-1480.

Rose, S., Bisson, J., & Wesseley, S. (2001). Psychological debriefing for preventing post traumatic stress disorder (PTSD). (Cochrane Review). *The Cochrane Library,* Abstr.

Schwartz, E.D., & Kowalski, J.M. (1992). Malignant memories: Reluctance to utilize mental health services after a disaster. *Journal of Nervous & Mental Disease, 180,* 767-772.

Selye, H. (1976). *Stress in health and disease.* London: Butterworths.

Seligman, M. (1995). The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist, 50,* 965-974.

September 11 Terrorist attack updates. (2002). http://www.icisf.org/ 911updates.htm.

Shalev, A.Y., Bonne, O., & Eth, S. (1996). Treatment of posttraumatic disorder: An overview. *Psychosomatic Medicine, 58,* 165-182.

Taylor, A.J.W. (1988). Coping with the earthquake. In Q.W. Ruscoe (Ed.), *Walking on jelly: The Bay of Plenty earthquake,* (ch.8.). Wellington, NZ: Department of Scientific and Industrial Research.

Taylor, A.J.W., & Frazer, A.G. (1981). *Psychological sequelae of Operation Overdue following the DC10 air crash in Antarctica.* Wellington, NZ: Victoria University.

UK Resilience (2002). London: Civil Contingencies Secretariat, Home Office Communications Directorate. http://www.coordination.gov.uk/contingencies/dwd/index.htm - accessed 1 June 2002.

US National Center for PTSD. (2002). *What is post-traumatic stress disorder?* http://ww.ncptsd.org/facts/general/fs_what_is_ptsd.html - accessed 1 June 2002.

Ursin, H. (2000). Psychosomatic medicine: The state of the art. The Finnish Medical Society Duodecim. *Annals of Medicine, 32,* 323-328.

van der Kolk, B.A. (1996). The body keeps the score: Approaches to the psychobiology of post-traumatic stress disorder. In van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (Eds.). *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (ch.10). New York: Guilford.

van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (Eds.) (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society.* New York: Guilford.

Wilson, J.P., & Lindy, J.D. (Ed.). (1994). *Countertransference in the treatment of PTSD.* New York: Guilford.

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.* Menlo Park, CA: VA Palo Alto Health Care System.

Young, M.A. (1994). (2nd ed.). *The Community Crisis Response Team training manual.* Washington DC: National Organization for Victim Assistance.

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