ITALIAN GOVERNMENT
CABINET OFFICE

DEPARTMENT OF CIVIL PROTECTION

Health & Environment Risk Service

General Guidelines for psycho-social interventions to be adopted in the event of catastrophes

INDEX

INTRODUCTION

In the context of intervention in support of victims of catastrophic events, it is necessary to pay close attention to the problems of a psychological or psychiatric nature which may arise in the persons directly affected as well as those involved in the relief services. Manifestations may be acute or they may develop over time with repercussions in the long term.

Both natural disasters and those caused by humans, can be categorized, with reference to the Official Journal n. 126 of May 12th 2001, on the basis of their scale as follows:

- catastrophic events of limited range
- catastrophic events beyond the means of local support structures

Both cases can be differentiated from individual and small scale emergencies in that they call for a qualitatively different type of response. In fact the context of a grand scale emergency requires the use of distinct procedures and methodologies which take into consideration the number of people involved and the precariousness of the prevailing environmental conditions.

It is also relevant to note that catastrophes can have a long term effect on individuals and communities, putting their ability to react and adapt under great distress. In fact it can happen that the ability to protect itself which you would normally expect to find in a group of individuals who share the same lifestyle habits, no longer functions. In such cases it is therefore necessary that the psycho-social measures adopted take into careful consideration the specific characteristics of the community and the regional area it inhabits.

Consequently, it is necessary that action taken and measures initiated are well co-ordinated in order to ensure an effective, high quality response to the psycho-social needs arising from a national emergency.

These general guidelines have been drawn up for this purpose, and their content has been divided as follows:

- organisational network, defined by structural reference points & dedicated human resources
- beneficiaries of the services
- action plans

1. EMERGENCY PSYCHO-SOCIAL TEAM (EPT)

According to the different geo-social characteristics and risk levels present in the area, the regions and the independent provinces of Trento and Bolzano arrange for the setting up of teams to provide socio-psychological support to the population in the event of a calamity. Usually these teams are made up of existing resources within the regional Health Services.
These trained teams operate within emergency systems which guarantee intervention both in cases of limited range catastrophes and in cases which go beyond the scope of local support structures.

1.a Objectives

According to the phase of the intervention and as specific needs emerge, the team must be able to:

- Enable deployment of priority measures to ensure the physical survival of the beneficiaries of intervention and look after their psychological well-being through the activation of all personal and community resources;
- Ensure pro-active needs analysis processes as well as responding to spontaneous requests of help;
- Coordinate the support initiatives with those planned/on-going as part of the process of the (health) relief efforts in such a way as to avoid duplication and potential conflict;
- Encourage the processes of self assessment, recognizing the right of everyone to make informed decisions about their own health;
- Safeguard the dignity of the individual during all relief efforts, assisting in the understanding of cultural differences and peculiarities; ensure stigmatisation does not arise, in particular through the labelling of behaviour which, out with the context of the disaster, would seem abnormal;
- Pay special attention to the distribution of information helpful in establishing self defensive behaviour and adaptive reorientation as well as providing tools to facilitate communication, and promote the understanding and use of the information itself;
- Ensure the accurate collection and storing of data relevant to the intervention, so as to enable constant monitoring of the relief procedures.

1.b Organisation

Normally, members of the team will be identified by the Region through its own personnel services. Personnel selected, which can be complemented by resources from voluntary associations, local corporations and professional bodies etc., must be adequately trained in the tasks to be performed in the event of a major catastrophe, inclusive of field training.

In order to be able to respond immediately in emergency situations, the team must be part of the health organisation's main emergency service with its logistical and radio communication support. The manager (of the team) will arrange the operations in the disaster area in line with the hierarchy according to the command and control structure stated by the competent authorities.

The team will work in close proximity to the Advance Medical Post (AMP) and the assembly point, gathering and addressing location, either from a fixed or a mobile base unit. This must be a secure place with adequate space available both for private interviews and group activities and coordination.
Staff should be identifiable by their green jackets or overalls with the initials "PSIC" printed on them.

1.c Psycho-social manager

Within its own organisation, the Region identifies an officer to head psycho-social support, who carries out the following tasks:

- coordinates the writing of the team's action plan of intervention on the basis of the specific territorial risks, of the network of psycho-social structures present in the area of authority, of their capacity for treatment and their staffing levels;
- defines within the Plan the activities the team must carry out in an emergency with regard to the victims of the community concerned and to the relief workers, collaborating with the institutions during the various planning phases and arranging the availability of materials and means necessary to carry out operations;
- contacts the team in the event of an emergency
- ensures intervention in the disaster area immediately after a catastrophic event occurs, managing the team's operations in coordination with the Health Disaster Manager;
- reports to the head of "Function 2" who has the task of managing all problems relating to health aspects of the emergency following set up of the Coordination Centres (**Local Operational Centre -Provincial Operational Centre**).
- arranges staff tour over;
- carries out an evaluation of the results obtained and sees to any necessary modifications in order to improve the intervention plans for future emergencies;
- coordinates, in close collaboration with the local health services, long term follow-up activities.

2. SERVICE BENEFICIARIES

The primary beneficiaries of psychological-psychiatric support in an emergency are the direct victims of sudden and explosive events, independently from the extent of material damage caused.

Witnesses to events which have caused serious injury to, or put at risk the lives of others, must also be considered potential beneficiaries; relatives of the victims, even if afar from direct involvement; relief workers, voluntary and professional, who have in any way given their assistance to victims and survivors. Apart from single individuals, beneficiaries of intervention can be whole social groups such as families, relief teams, team operators or other groups: in such cases the intervention is directed to maintain or re-establish positive, constructive relationships.

In circumstances where it is necessary to identify priorities for the supportive action, precedence will be given to the weakest groups, i.e. children, the elderly, the disabled, those previously diagnosed as mentally disturbed etc.

Independently from the nature of the catastrophic event, it is convenient to make a prior evaluation of the risk factors in a particular emergency situation, in order to be able to anticipate psycho-physical problems which may occur to relief workers. Once health operators have begun intervention at the site of a disaster, their work must be assured through constant monitoring to identify any signs and/or symptoms of potential stress conditions and/or psychological disorders.

3. INTERVENTION IN RELATION TO SCALE OF THE DISASTER

3.a A catastrophic event of limited range

A limited range catastrophic event, according to the definition provided by the Official Journal n. 109 of May 12th 2001, is characterized by the integrity of the relief structures in the affected area and by a time limited (less than 12 hours) intervention by the emergency health care services.

In the case of a maxi-emergency, the C.O. 118 (911/999 Commanding Officer), activates the extraordinary Relief Plan, also alerting the Officer for the team referred to. The latter reports to the Director of Health Relief Services (DHRS), who coordinates relief efforts at the site of the disaster.

It is foreseeable that the said team will be required to remain in service for longer than that of the AMP, with which it is in constant touch, so as to be available to all the personnel which has taken part in relief operations.

At the end of the emergency phase, some functions and basic intervention measures must be ensured for the benefit of the psychological health of the population affected.
Individuals who develop psychological and psychiatric disorders (including those of post – trauma stress), must have access to appropriate psycho-social support services in the area to allow them uninterrupted therapy.
Evaluation must be made of the intervention carried out during the emergency, with particular reference to field work.

3.b Catastrophic events which go beyond the scope of the local emergency structures

In a situation generally characterized by devastation across a wide area, by large numbers of victims and by an often very difficult coordination of operations, the team must go into action simultaneously with the other emergency health intervention measures.
Under these circumstances psycho-social support will be offered, as far as possible, in the phase immediately following the event.
With the activation of the various Coordination Centres which act as bases for Official Bodies, Administrations and Voluntary Associations which may have come from outside the affected area, management of psychological – psychiatric aspects should be brought within the scope of Function 2 “health and social care”.

It is useful to distinguish an acute phase in the operating plan, whose characteristics can be superimposed on those described above, and a short to transition phase which ends with a long-term phase. As in the case of a limited range catastrophe, it is difficult to foresee the specific duration of each phase.

Interventions in *Transition phase*
During the acute phase the activities are mainly directed to the safeguard of the people involved by taking them away from the risky area and providing them with first aid health relief, psychological support and satisfaction of basic needs.

Later on new needs will arise in connection with the population adaptation to the precarious living condition and with the psychological social and practical consequences of the catastrophic event.

During the transition phase the team will not only deal with activities supporting the population, but also with those reinstalling the pre-existent social support network or creating new alternative networks as to reinforce the local resources and solidarity programs within the community.

It is essential to look for a constant collaboration among all the other members involved in disaster management as well as with the community's own institutions, by verifying the availability of existing structures (public health facilities, mental health facilities, social assistance facilities, private health facilities).
Furthermore it is important to encourage access to medical and social facilities, to identify the people who have been treated and what kind of therapy they have received during the emergency . The information on risk factor evaluations and on individual as well as on general vulnerability must be made available to the requesting services of interest for the purpose of periodic check -ups and long term follow up of the cases.

4. TRAINING

Training is an essential factor in emergency situations, since it represents one of the basic resources in prevention strategies.
An in depth knowledge and effective dissemination of information of potential high risk scenarios, of management procedures and of the most correct behaviour codes to adopt in emergency states may, in fact, improve surveillance levels, reduce response time, and strengthen effective response behaviour patterns in order to best face and react to threats as well as to limit the damage caused by catastrophic events.
Research has proven that a part of individual and collective stress levels resulting from disaster events may be reduced by an adequate degree of preparedness, both at an individual level as at a collective one.
The general aim of any of training in this field is to disseminate and reinforce effective strategies designed to face dangerous events, by readily activating processes of perception selection as well as complex cognitive processes emerging from intensely emotional experiences and non ordinary communication patterns. In this sense, every training program must necessarily include effective communication methods, decision making, evaluation systems, emotional control and dissemination of common procedures within the different hypothetical scenarios.
Professional experts working in the socio- psychological field must be adequately trained to operate within a collective emergency context. Among their activities we wish to point out the following ones:

- spreading information to the population on stress management techniques and response to critical
- situations
- joining family members back together
- collecting data for post-emergency evaluation
- disseminating information regarding the population's basic needs

Attachment 1

PATIENT PROFILING -TRIAGE

Triage refers to the criteria selected by the relief operator for subject classification procedures from priority therapeutic intervention (seriousness of the clinical condition and decision to put off or start therapeutic intervention immediately) and identification of the patient's kind and modality of admission to the health facility set up by the emergency relief plan. This patient profiling process must provide an evaluation of both the psychological and psychiatric consequences of the catastrophe, and must be directed primarily to the victims, to the categories at greater risk and to the more troubled relief operators suffering from either emotional, cognitive or behavioural dysfunctions.

The evaluation procedures must be conducted very carefully by taking into consideration the specific context in which the disaster has occurred as well as the specific demands or priorities expressed by the subject and also by granting the subject's privacy rights to avoid the risk of stigmatization.

Procedures

For the triage plan to work effectively on all the various relief operational levels, we must realize that:

- the operations require adequate space availability by taking into account the patients' right to privacy;
- the procedures must be related to the particular scenario in question and must be carried out by operators coming from different training experiences.
- the protocols must be simple, easily memorized and carried out, based on reliable and easily reproduced guidelines for priority assignment procedures.
- evaluations and prescribed therapy must be recorded and the relative documentation must be kept in a file easily and readily accessible.
- triage activities must not slow down or interfere with other rescue operations.

Instruments

The following items must be available for patient profiling procedures:

• **Triage forms** preferably stored in waterproof holders, which must record all of the patient's follow up information regarding transfers, documentation and evaluation of the adopted procedures. The forms must contain the following data: general personal data, priority class assigned, diagnostic hypothesis, therapy prescribed , forwarding directions.

• **Triage tags** in water proof badges, indicating the subject's personal and priority class information. For an easier id procedure the abbreviation **Psic** may be used followed by a numerical code (123) indicating the priority level assigned.

• **Pharmacological supply post** used in emergency treatment**.**

PRIORITY CLASSES

Low Priority (Psi 1)

Subjects suffering from slight psycho-pathological symptoms who require psychological support or pharmacological treatment which can be put off.

Intermediate Priority (Psi 2)

Subjects suffering from serious psycho-pathological symptoms who require specialized psychological and /or pharmacological treatment, after an observation period.

High Priority (Psi 3))

Subjects with serious post traumatic reactions which may cause loss of ability to function independently, reduced consciousness of illness, alteration of cognitive functions, danger to him/herself and to others, therefore in need of immediate specialized analysis and treatment which can't be put off.

PATIENT PROFILING (TRIAGE)

DATE:	___/___/___	**OPERATOR**	PSYCHOLOGST		PSYCHIATRIST	
TIME:		NAME:	SURNAME:			

TREATMENT LOCATION:

PATIENT

SURNAME:	NAME:	SEX	M F

PLACE AND DATE OF BIRTH:

ADDRESS:	TEL:

ORIGINAL LOCATION: ☐AMP ☐ WORKING AREA INDICATE ADDRESS:

ACCOMPANYING PERSON	NAME:	SURNAME:	TEL:

HISTORY OF PSYCHOLOGICAL PROBLEMS	YES	NO	(specify):_____
HISTORY OF PSYCHIATRIC PROBLEMS	YES	NO	(specify):_____

DRUG THERAPY PRESCRIBED (specify DOSAGE and POSOLOGY):

TYPE OF REACTION TO CATASTROPHIC EVENT:	**EVALUATION OF RESOURCES:**
☐ ANXIOUS ☐ SLIGHT ☐ SERIOUS	☐ COPING ABILITY ☐ INDIVIDUAL ☐ COLLECTIVE
☐ DEPRESSION ☐ SLIGHT ☐ SERIOUS	☐ WILLINGNESS TO ACCEPT HELP
☐ DECOMPENSATION ☐ SLIGHT ☐ SERIOUS	

TREATMENT SUGGESTIONS:

ACUTE PHASE	☐ HEALTH ☐AMP ☐HOSPITAL/ FIELD HOSPITAL
	☐SUPPORT OF PSYCHO-SOCIAL TEAM
MID-TERM PHASE	☐ HEALTH FACILITY'S PSYCHOLOGICAL AND PSYCHIATRIC STRUCTURES
	☐ SOCIO-EDUCATIONAL STRUCTURES

CARRIED OUT TREATMENTS:

☐ PSYCHOLOGICAL TREATMENT	☐ PRESCRIBED DRUG THERAPY (DOSAGE AND POSOLOGY) EXCLUSIVELY PRESCRIBED BY PERSONAL DOCTOR
☐ **DISCHARGED**	☐ **DECLINES TO** **SIGNATURE**……

Attachment 2

TRAINING

Specialists involved in emergency must be prepared and trained to carry out the following operations while assisting the victims of the catastrophe :

Welcoming - Reducing the subjects' exposure to traumatic events and their consequences, satisfy their primary and most practical needs, facilitate their communication of emotions and sharing of experiences, work on bringing together family members; help gain back a sense of control over the situation and encourage the return to an active role in society etc.

Information - *Provide simple, accurate and reliable information:*

- on the causes, evolution, and consequences of the event;
- on emergency services readily available (service accessibility);
- on the family relatives conditions;

To collect, verify and spread information with respect to the persons involved in the event (dead people, physically injured victims, hospitalized and missing people)and of the media operators; to register personal data of the treated victims with the list of treatments carried out; evaluate information requests coming from specified groups (children and adolescents; the elderly, disabled people either physically or mentally) and the need to give out information in different languages.

Clinical treatment - Analyse the presence of emotional reactions, disturbed behaviour and/or significant alterations of the cognitive sphere which could be linked to potential pathological organic problems, to identify the subjects requiring immediate psychological- psychiatric assistance (for acute and serious conditions, which may reduce the ability to function independently, interrupt relief operations and cause danger to themselves as well as to others) and who require further diagnostic analysis, indicate the cases requiring medical treatment and not in need of psychiatric assistance; provide immediate (not to be put off) psychological and psychiatric treatment to those experiencing serious emotional reactions, troubled behaviour and significant dysfunctional cognitive reactions.

Psycho-social support – To carry out individual as well as family and group psycho-social support by the employment of recognized intervention methodologies, to provide treatment during the initial phase of the patient's elaboration of loss by death within the context of specific situations (identifying dead bodies, participating to ceremonies or rituals within the community) or dealing with more practical issues such as (access to medical and social emergency services; access to administration and legal services dealing with financial, work or habitation related problems); to carry out both individual and group counselling for social operators in charge of educational activities and as a support resource for the community.

ATTACHMENT 3

GLOSSARY

AMP Advanced Medical Post
Functional support system for identification and health treatment of victims, located on the outer border of the safety-area , or in a central area in relation to the catastrophe area.
It may be set up as a temporary structure (tents, containers), both in a functional area destined to the gathering of victims, the setting up of first treatment resources and from which to plan evacuation to health facilities of the injured victims.

Catastrophe
An event involving a significant number of victims as well as the network of infrastructures of a specific territory causing a sudden disproportion between relief demand and available resources. The catastrophe usually lasts for a long time (minimum 12 hours).

Catastrophe of limited scale
An event involving a significant number of victims, but no damage to the infrastructure network of a specific territory; lasting a shorter period of time (less than 12 hours) therefore requiring a limited rescue operations effort.

Chain of Relief Services
Series of functional/structural devices available for the victims' relief operations in a catastrophe.

Provincial Operational Centre - (CCS)
The Center represents the highest ranking coordination body set up by the Civil Protection at a provincial level. It is comprised of all the responsible operators from the various structures present on the local provincial territory. The CCS's activities focus on pointing out strategies and necessary operational support in order to overcome the state of emergency through COM's coordination.

Municipality Operational Centre – (COC)
The operative Center that support the Mayor for the management and coordination of relief operations in emergency crisis.

Local Operational Centre - (COM)
The operational Center working at local level under the jurisdiction of several Municipalities supporting the activities undertaken by the different Mayors
.
(LEMA) Local Emergency Management Authority - (DICOMAC)

Represents the main National coordination body for the Civil Protection structures involved in the area hit by the disaster. It is activated by the Department of Civil Protection after the state of emergency has been officially declared.

Health Disaster Manager
MD with adequate experience and training, present on the operative field and responsible for the local management of all health support devices. He works close with the MD in charge of coordinating the Operative Station 118, and with the Team Officer on the technical relief field (VVF) as well as with the Police Forces.

DSM-IV
Diagnostic and Statistical Manual of mental disorders, American Psychiatric Association, 1994.

Support Functions
Management procedures relating to the various activity and reference sectors within the Coordination Centers established during the emergency crisis. A person in charge is appointed per each separate function, related his/her specific sector, who in ordinary situations is responsible for data update and in emergency becomes responsible for coordinating relief operations.

Function 2
Function 2 – Human health, veterinary and social assistance- to be activated on a Emergency Coordination Operative level (DICOMAC, CCS, COM, COC).

Field Hospitals
A support systems consisting of men and means designed to assist the catastrophe's victims offering intermediate treatment from the initial first aid phase to the definitive prescribed therapy. Emergency surgery as intensive care units for a period of several hours and clinical observation permanence in the hospital are provided. They function as Medical Centers for Evacuation (CME).

Patient profiling (Triage)
Process of patient categorization in the various priority classes according to the assessment of the patient's state and treatment and/or evacuation required.

BIBLIOGRAPHY

Bruce, H. et al. (2002). *L'assistenza Psicologia nelle Emergenze*. Trento: Erickson.

Catarinussi, B., Pelanda, C. (1981),(a cura di) *Disastro ed azione umana. Introduzione multidisciplinare allo studio del comportamento sociale in ambienti estremi*. F. Angeli.

Castelli, C., Sbattella, F. (2003), *Psicologia dei disastri*, Carocci, Roma.

Catapano F.; Malafronte R.; Lepre F.; Cozzolino P.; Arnone R.; Lorenzo E.; Tartaglia G.; Starace F.; Magliano L.; Maj M. (2001) Psychological consequences of the 1998 landslide in Sarno, Italy: a community study *in Acta Psychiatrica Scandinavica*, December 2001, vol. 104, no. 6, pp. 438-442(5).

Ciceri, M.R. (2001), La Paura, il Mulino, Bologna.

Costantini, E., Ponticelli F. (1999), "Catastrofe ed emozione veemente" *Psicobiettivo*, n. 3, vol. XIX.

Covello, V., Sandman, P.M., (2001) "Risk Communication: Evolution and Revolution" in Wolbarst A. (ed.) *Solutions to an Environment in Peril*. John Hopkins University Press 164-178

Cuzzolaro, M., L. Frighi (1998), *Reazioni umane alle catastrofi. Aspetti psicosociali e di igiene mentale*, Fondazione Adriano Olivetti, Roma, Gangemi Editore.

De Felice, F., Colaninno C. (2003), *Psicologia dell'emergenza;* Franco Angeli, Milano

Dipartimento della Protezione Civile (Decreto pubblicato nella Gazzetta Ufficiale *Criteri massima per l'organizzazione dei soccorsi sanitari nelle catastrofi*- Predisposta dalla Presidenza del Consiglio dei Ministri 1995— serie generale- n.81 del 6 aprile 2001).

Dipartimento della Protezione Civile, giugno 1997: Linee-Guida sull'Organizzazione Sanitaria in caso di catastrofi sociali.

Dipartimento della Protezione Civile, "Il metodo Augustus" DPC informa n.4 giugno 97

Duglas, M. (1991), *Come percepiamo il pericolo*. Milano: Feltrinelli.

Doutheau, C. (1987), "Les reaction de panique" in AA.VV. (a cura di L. J. Courbil) *Medecine en situation de catastrophe*, Masson.

Federal Emergency Menagement Agency – FEMA (1994). Community Emergency. Response Team: participant Handbook: Washington DC.

Fenoglio, Maria Teresa (2005), *Psicologi di frontiera*, Realizzato a cura dell'associazione Psicologi per i popoli, www.psipp.org.

Giannantonio, M. (a cura di), (2003) *Psicotraumatologia e Psicologia dell'Emergenza*, Salerno, Ecomind.

Katz C.L.; Pellegrino L.; Pandya A.; Ng A.; DeLisi L.E. (2002), Research on psychiatric outcomes and interventions subsequent to disasters: a review of the literature; *Psychiatry Research*, vol. 110, no. 3, pp. 201-217(17).

Kertzer, D.I. (1981), "Aspetti politici delle calamità naturali" *Laboratorio Politico* n. 5-6, settembre dicembre.

Le Bon, G., (1980), *Psicologia delle folle*, Longanesi.

Lo iacono A., Troiano M. *Psicologia dell'emergenza*. Editori Riuniti.

Lòpez-Ibor J., Christodoulou, G., Maj, M., Sartorius N., Okasha, A., (2005) *Disasters and mental health*, John Wiley.

Mambriani, S. (1994), *La comunicazione nelle relazioni d'aiuto*, Cittadella Editrice, Assisi.

Mambriani, S. (1994), *La comunicazione nelle relazioni d'aiuto*, Cittadella Editrice, Assisi.

Manuale procedurale per la gestione della comunicazione in situazioni di crisi – Dipartimento di Protezione della Protezione Civile, 2000

May, R. (1991), *L'arte del counseling*, Astrolabio, Roma.

Milleri, A. "Previsione del rischio e pianificazione sociale delle emergenze" in *La professione di Psicologo* ottobre 2002.

Morra A., Ciancamerla G., *Organizzazione dei soccorsi sanitari in caso di catastrofe*. Regione Piemonte – Collana Protezione Civile e ambiente –II edizione, Torino, 1991.

Norris F. H., Friedman M. J., Watson, P. J., (2002) "60,000 Disaster Victims Speak: Part I, an empirical review of the empirical literature, 1981-2001" *Psychiatry*, 65 (3): 207-239.
Norris F. H., Friedman M. J., Watson, P. J., (2002) "60,000 Disaster Victims Speak: Part II . Summary and Implications of the Disaster Mental Health Research *;* Summary and Implications of the Disaster Mental Health Research". Psychiatry, 65(3): 240-260.
Oliverio Ferrarsi A. (1980), *La psicologia della paura*, Bollati Boringhieri, Torino.
Pavon, L., Banon, D. (1996), *Trauma, vulnerabilità, crisi*, Torino: Bollati Boringhieri
Psycho-social support in situations of mass emergency (2001) European policy paper concerning different aspects of psychological support and social accompaniment for people involved in major accidents and disasters. Ministry of Public Health, Brussel, Belgium.
Recomendaciones para situations de emergencia colectiva – www.proteccioncivil.org
Regione Piemonte, *L'intervento psichiatrico e psicologico negli eventi catastrofici -linee d'indirizzo*, Protezione Civile.
Regione Piemonte, *Disaster management*, Protezione Civile.
Rudé, G. (1987), *La folla nella storia*, Editori Riuniti.
Santoianni, F. "Il controllo della folla", in *Newton*, n.4 Aprile, 1999.
Swedish National Board of Health and welfare (1991), *Psychological, Psychiatric and Social Management of Disaster*.
Terrorism Information: The Facts – How to Prepare – How to Respond Virginia Terrorism Preparedness.
The Emergency Communication Triangle – U.S. Department of Health and Human Services – Public Health Service Centers for Disease Control and Prevention.
Terr L.C. (1981), "Psychis trauma in children: observations following the Chowchilla school-bus kidnapping", *Amer. J. Psychiat*., 138, 14-19.
Terrorism Information: The Facts – How to Prepare – How to Respond Virginia Terrorism Preparedness
The Family Safety, Guide Six Steps of Preparedness – American Red Crosswww. duracell.com/safefamilies/pages/handbook.pdf
The Emergency Communication Triangle – U.S. Department of Health and Human Services – Public Health Service Centers for Disease Control and Prevention.
Villone Betocchi, G. (a cura di) (1982), *Il contributo della psicologia in situazioni di emergenza*", Palladio.
Young, B.H et al (2002), *L'assistenza psicologica nelle emergenze*, Erikson, Trento.
Zivilschutz- Bad Neuenahr- Ahrweiler (2000),*Workshop Psychological Aspects of the Information of the Public* Akademie fur Notfallplannung und Zivilschutz- Bad Neuenahr- Ahrweiler.
Zuliani, A., (2003), "Reazioni psicologiche e misure di intervento di fronte ad un attacco non convenzionale di tipo bio-chimico" in *Emergency Oggi*, anno IX, n°9, www.emergency oggi.it