Rapid Response Mutual Aid Groups: A New Response to Social Crises and Natural Disasters

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The authors describe a newly developed model of intervention that responds rapidly to "events"—natural disasters or political and social crises. The model focuses on community response to the event to identify a previously undefined population as constituting a community of sufferers. It also highlights the efficacy of service delivery wherein the relationships among social workers are egalitarian and cooperative.

CAN PROFESSIONAL caregivers respond to the needs of the individuals and families who face life-threatening experiences, or "crises," such as the effects of chemical waste in Love Canal, the nuclear explosion on Three Mile Island, the hostage taking in Iran, the volcanic destruction of Mount Saint Helens, or the crash of a DC-10 airplane in Chicago? To answer this question, one must appreciate that most social service agencies operate within restrictive parameters: Traditionally, these agencies provide medical, psychiatric, or concrete services that are mobilized when the individual defines himself or herself in need of professional service. Thus, the service is constricted by and linked to the identification of the "client" as an individual who is unable to cope adequately with the event or who is pathological. This article discusses an alternative model of practice—a synthesis of crisis theory, mutual aid groups, and the community psychiatry movement—to deal with the aftermath of a social crisis or natural disaster by focusing on the community of sufferers created.

The literature on disaster intervention is ambiguous regarding the meaning of "crisis." At times, crisis is defined relative to the author's personal experience or focus or it is explained by an account of a specific event, such as the flood at Buffalo Creek, the DC-10 plane crash in Chicago, and the fire at the Beverly Hills Supper Club.[1] At other times, "crisis" is used interchangeably with "disaster." At still other times, "disaster" is used, apparently, to evoke images of human suffering that are more graphic than those suggested by "crisis"; but this use fails to provide a clear definition of the event itself.

This lack of clarity can lead policymakers to see and to respond to people's needs in radically different ways. The federal government's 1974 Disaster Relief Act defines disaster in terms of natural phenomena—hurricanes, volcanic eruptions, tidal waves, or catastrophes caused by human error—"which cause damage of sufficient severity and magnitude to warrant major disaster assistance."[2] The Ohio State University Disaster Relief Center, however, appreciates that the effects of an event can go beyond the loss of property, life, and limb, altering completely the quality of life that people lead. With this understanding, the center defines disaster as

> An event, concentrated in time and space, in which a society, or a relatively self-sufficient subdivision of a society, 'undergoes severe danger and incurs such losses to its members and physical appurtenances that the social structure is disrupted and fulfillment of all or some of the essential functions of the society is prevented.[3]

Quarentelli and Dynes note that to define a disaster simply in terms of the physical event limits and often diffuses the critical identification of the human and social problems associated with such an event. For this reason, they focus not on the description of an event but on the "collective response of the community."[4] Such a definition permits an examination of the severity of an event (so that, the greater the response, the more severe the event) as well as provides the information needed to activate those systems that deal with the event (for example, community, familial, and intrapsychic systems). Fritz circumscribes Quarentelli and Dynes's notion of collective response by conceptualizing a "community of sufferers." The membership of this community is recruited from the (often) fortuitous involvement in the dangers and privations imposed by the agent of disaster.[5] Both definitions focus on the *social* response to events.

EVENTS

The model presented here is based on the integration of Quarentelli and Dynes's and Fritz's perspective and

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definitions. "Event" is used in the place of "disaster" or "crisis" to avoid the tendency to limit the phenomena to the imagery evoked by these two words. Event refers to the actual phenomenon that has impact on and that creates a community of sufferers. Thus, an event is understood to be the integration of phenomena and impact. Within this framework, events can include physical forces, such as natural phenomena or those resulting from human error, or social forces, such as factory closings, strikes, assassinations, and the taking of hostages. Events also include the loss of property or limb or the change in individual or familial or community opportunities for employment, financial success, political expression, a sense of security, and well-being.

> *"In centripetal events, the community of sufferers is easily visible."*

It is important to emphasize that the physical or social circumstance of an event need not create a crisis for the people involved. A participant in an event who is able to cope with the ramifications of the situation, that is, an individual who can incorporate it and maintain equilibrium, is someone who is not in crisis. Anyone who responds to the event with a change in his or her homeostasis or functioning has moved into a state of crisis that can range from mild to severe. The present discussion examines interventive strategies both for individuals who are not in crisis but who are at-risk and in the precrisis stage as well as for those individuals who have entered a crisis state.

Centripetal Events vs. Centrifugal Events

Centripetal and centrifugal are the two major classifications for events. Centripetal events affect the preexisting social systems or institutions from which emerge the community of sufferers.[6] These events are often physical disruptions of an environment within which people live and work, as, for example, the events of Buffalo Creek and Mount Saint Helens. Centrifugal events are specific phenomena that occur at a juncture of many social systems. Following the event's occurrence, the community of sufferers scatter to areas unaffected by the event, which spread centrifugally from the locus of the phenomenon.[7] These events may be physical disruptions, such as airplane and train disasters or fires, or they may be social disruptions, such as hostage taking and assassination.

What is critical to this discussion is the differing effect of centripetal events and centrifugal events on the community of sufferers as well as those who intervene and assist with relief. Lindy, through his work with the survivors of the fire at the Beverly Hills Supper Club, discovered a phenomenon he compared to the intrapsychic stimulus barrier, which he called the "trauma membrane." The membrane is activated following an event and is composed of an individual or a network of trusted people who serve to protect and buffer the survivors from further external psychic stress by attending to and monitoring their needs. In centripetal events, the community of sufferers is easily visible to the sufferers themselves and to the community at large because the boundaries of need are clearly defined within a geographic space. Thus, following centripetal events, the trauma membranes around individuals tend to "fuse together" to form an inclusive, communitywide trauma membrane.[8] Fritz describes such behavior in the following manner:

> The widespread sharing of danger, loss, and deprivation produces an intimate, primary group among the survivors [or, community of sufferers] which overcomes social isolation, provides a channel for intimate communication and expression, and provides a major source of physical and emotional support and reassurance.[9]

In centrifugal events, there is no one community of sufferers because the survivors scatter to different communities or areas after the immediate impact of the event and because, often, the survivors do not know one another. These survivors do not see themselves as and are not seen by their communities as being part of a community of sufferers. Thus, following centrifugal events, the isolation of the sufferers is heightened by the efforts of those who make up their trauma membrane: Not only are the individuals deprived of the opportunity to share their feelings of stress with fellow survivors, but these individuals also are encouraged by the well-meaning people who comprise their trauma membrane to forget the stressful event.

TRADITIONAL COMMUNITY RESPONSES TO EVENTS

Responses to Survivors

The image of certain community agents—Red Cross workers, firefighters, and police officers—is immediately associated with ministering direct aid to the survivors of a hurricane, explosion, or factory lockout. Typically, firefighters and police officers act to reduce the physical dangers inherent in the event as well as to organize and protect individuals and property in the aftermath of an event.[10] Red Cross workers provide material necessities, for example, the food, clothing, and shelter typically needed in such centripetal events as floods and earthquakes and in such centrifugal events as train and airplane disasters.

Once the physical and material needs of the survivors are addressed, the community provides social support through church and civic groups (that is, the sphere of the protective membrane) and extends the option of community mental health services to those who identify themselves as in need of more intensive and prolonged psychiatric assistance. Often, the individuals or families that utilize these mental health services have also traveled through the service networks of the Red Cross, medical facilities, clergy, or private physicians. These individuals or families often perceive themselves and are perceived by the community as somehow inadequate to the task of dealing with the stresses of their situation. Thus, these people are similar to the survivors of centrifugal events; they are less visible as as a community of sufferers although they are greatly affected by the event.

This set of survivors, which may be seen as the psychiatric survivors of events, are a significant focus of the community psychiatry movement. Over the last three decades, studies regarding stress increasingly describe the reduction of ongoing or perma-

nent communities to assist individuals with crises and transitional events[11] and emphasize the need to provide additional nonclerical, nonmedical, nonfamilial support systems to fill the vacuum. In the aftermath of an event, the community mental health systems that respond to societal changes are frequently inadequate to provide emergency services even to those people who are recognized as being sufferers. The Disaster Relief Act of 1974 is a major step in redressing this inadequacy; it provides financial support for counseling and other mental health services for communities that experience an event of such proportion that their need is evident. Unfortunately, the administration of these funds, that is, the inherent bureaucratic regulations and procedures of funding, often tie up the granting of the monies for considerable time periods, thereby decreasing the effectiveness of mental health intervention.[12] Similarly, programs funded by state and local governments to respond to the mental health needs of communities after an event,[13] often are administered from outside the community. Because these programs are external interventions, it is difficult for them to penetrate the trauma membrane that the community has constructed in an attempt to nurture its citizens.[14]

Responses to Helpers of Survivors

In addition to the responses communities traditionally offer survivors in need, communities must also provide responses to another population in need—the people who experience an event not as victims but as helpers. An event can be as traumatic for helpers as it is for victims. For example, a month after the walkway of the Hyatt-Regency Hotel collapsed in Kansas City, rescue workers and police officers recalled vividly their experiences in recovering the maimed bodies; some had nightmares of seeing dead bodies in their bedrooms; others became physically ill at the remembrance of their night's work.[15] In similar fashion, after the 1977 train crash in Sydney, Australia, workers experienced feelings of frustration, helplessness, and guilt about their inability to undo the crash or to help the victims in a meaningful way. In addition to the concern with community workers who engage in relief work, increasingly, focus is given to the delayed shock response of several groups of individuals. These groups include people who witness and survive an event; those connected with someone involved in the experience; and those who did not experience the event, but who view themselves as possible victims, such as neighbors of victims or people who missed the train or airplane involved in a mishap.[16] How can communities identify and serve these individuals and their families?

To respond to this question, social service agencies must recognize that the wearing away of the defensive, protective membrane is idiosyncratic to the event and to the community, the individual, and the family affected. In addition, the development of a delayed response may occur for certain individuals after the community has mobilized itself, provided emergency services, and returned to its daily functioning. The dynamics of these community processes can be compounded both by these individuals' continued emotional engagement in the event and the simultaneous discouragement they receive from others about ventilating their feelings "at this late date." These forces may leave individuals suffering from delayed shock response to face increasing isolation and fears concerning their adequacy. By the time such persons turn to or are directed to mental health facilities, their confidence and their general sense of well-being are eroded or damaged.

Critique of Traditional Responses

Several common characteristics emerge among the traditional approaches to events. These characteristics converge in the failure to meet certain critical needs. People with cognitive and emotional responses to events, for example, often fail to get immediate attention from formal community networks and are discouraged from expressing stress within the trauma membrane that is developed by families and friends. Frequently, people with delayed responses and people whose suffering is hidden have the doubly difficult task of integrating the event in their lives as well as in coming to terms with their response to the event, which is viewed as being unusual. Formal services may not be immediately available for these individuals because of a lag in the provision of services following the event. Moreover, these services may require that the individuals have a self-identification as or be externally labeled as "pathological" or "inadequate to cope" with the experience of the event. Finally, the nature of the events—especially of centripetal ones—creates the additional struggle of "outsiders" who must develop ways to penetrate the trauma membrane created by the individual, family, or community.[17]

RAPID RESPONSE MUTUAL AID PROGRAM: THE MODEL

The model the authors propose to provide services to individuals, families, and communities following an event is called the Rapid Response Mutual Aid Program (RRMAP). There are three components to the model: the suprastructure (or the coordinating council), the program matrix, and the RRMAP groups. In the following description of the model's components it must be remembered that these components only come into being in response to an event; they are ad hoc, not permanent, structures.

Coordinating Council

The coordinating council is made up of professionals from a range of institutional settings. The council develops either from personal or professional networks within a community or from an already established professional organization, such as a local mental health association. Council members may maintain ties to their employment institutions (for instance, schools, community mental health clinics, and hospitals), which they may use as a resource for the program, or members may participate in the program independent of their professional employment. Council members, according to their interest or expertise, are delegated certain tasks in response to a specific event. Activities for the council range from liaising with community resources and the media to finding sites for groups, training in the use of the telephone hotline, and training of group leaders. In addition, the council as a whole has the task of defining the type of event for which it would mobilize the RRMAP and the task of initiating that mobilization. Finally, the council has a network of formal members that it can activate for assistance in responding to an event.

Program Matrix

The Rapid Response Mutual Aid Program Matrix is a cadre of individuals who have training in crisis work, are familiar with the operation of the RRMAP, and keep up to date about new developments in crisis intervention and mental health services. Before and after their leadership of a group, the RRMAP group leaders participate in a formal leaders' group that gives the leaders the opportunity to process their reactions to an event and to express their individual reactions to leading an RRMAP group. Group leaders and members of the council provide one another with additional support and counseling when needed.

The professional cadre is involved in a formal network that can be activated at any time in response to an event. For example, the program matrix provides sites for groups to meet following centrifugal events, explores potential sites for groups to meet following centripetal events, and establishes a system for media referral and coverage by local newspapers, radio, and television. Moreover, the matrix sets up links with institutional resources, such as suicide prevention units, medical units, at least one established hotline number for people to contact the council and the professional cadre, and a research library that is available to all council members, group leaders, and RRMAP participants.

Program Groups

The Hotline. The Rapid Response Mutual Aid Program Groups comprise no more than 10 individuals who identify with some aspect of the event and express an interest in participating in a group. The groups are led by two group leaders trained for the RRMAP; the groups meet for one session, with an option of an additional meeting.[18] The response process of the RRMAP groups begins with the potential participant's first call to the hotline number. The telephone call is a cognitive clarification of what it is the individual is seeking and what the RRMAP group offers. The hotline interviewer raises issues that typically emerge during the group process by asking the caller, for example, Have you experienced changes in mood since the event? Do you have memories of similar events in the past? How are you attempting to cope with the event? What methods are useful? What methods do not provide relief? The interviewer is a trained clinician, who screens the telephone caller for actual psychiatric emergencies and, when appropriate, refers the individual for more intensive help to one of the community agencies in the program's network.

The Phases of Support. The fact that the RRMAP group meets once and possibly twice, but no more, often brings the issue of termination into the initial phase and into the process of contracting. The group's beginning phase seeks to develop the commonality of the participants; they share their common experiences of the event and provide one another with helpful information. During this phase, there is clarification and labeling of feelings, and the participants attempt to cope with their feelings. The middle phase focuses on exploring alternative coping methods. During this phase, members express their efforts to overcome this difficult time, viewing themselves as masterful, resourceful actors rather than as passive victims. The termination phase encourages the integration of cognitive and emotional experiences, the solidification of the problem-solving techniques considered in the middle phase, and the process of networking to continue beyond the group meeting. Thus, led by a trained social worker, the RRMAP group assists the individual to understand the event (through information exchange and cognitive function), to react (through expressive function), and to move beyond the event's impact on his or her life (through problem-solving functions). The group offers an empathic process, whereby members experience support and acceptance of their reactions and can begin a healing process through their universalization of the experience and through their reciprocal interaction.[19]

An Alternate Response to Events: Rapid Mobilization

The model described is presented as an alternative to the traditional responses to an event. First, unlike the more traditional modes of intervention, the RRMAP provides immediate intervention—it mobilizes community resources quickly and responds to people's needs promptly. This characteristic has support in the literature regarding crisis intervention, which focuses on the critical first six to eight weeks following an event as the period of maximum impact for intervention in clients' emotional and cognitive spheres.[20] Early or immediate intervention assists individuals or families in dealing with the special significance of the event for them before the protective trauma membrane fully establishes itself. Immediate attention also enables people to process information about future reactions to events, thereby reducing the impact of such events should they occur. The authors' model can be mobilized within hours of an event; once the event is deemed appropriate, the program network activates media liaisons, public access to the hotline, and group formation. However, because the speed and ability of the community to respond varies from community to community and from event to event, the RRMAP's timetable for intervention is established by the rate of the community's response.

At times, there is easy access to the people who have some connection to a centripetal event; however, at other times, the scatter of those involved in centrifugal events precludes programmatically based intervention. The RRMAP is especially useful in responding to such events because the model can be superimposed on whatever context presents itself: It can focus on the site of an event or, through its network and media liaisons, it can reach those who have already scattered but who may still be able to come to a central site and join with others in participating in an RRMAP group.

The autonomy of the RRMAP makes it free to choose those events it deems most appropriate or necessary to mobilize its groups. This autonomy also accounts for its rapid response: the RRMAP need not wait for the definition of the event as a "disaster" or a "crisis" by the Federal Emergency Management Agency or by any other governmental or community body. The program has no financial constraints on mobilization if certain criteria are not met. Finally, the RRMAP can mobilize when no one else thinks it is necessary to intervene and can join with others when an event requires additional resources and interventive strategies.

The RRMAP is also cost efficient. Without the need for an ongoing structure, intensive costs occur only at the time of the actual mobilization. The

monies needed by the coordinating council to train leaders, produce publicity literature, and maintain a library are minimal. In addition, group intervention is one of the most cost-efficient of the interventive strategies and, clinically, group work results in extremely high levels of impact and success.[21]

Several follow-up studies of disaster relief services examine the tension between the affected community and those from outside who assist the community in recovering from the event.[22] The trauma membrane in these instances heightens communities' historical tendency to be suspicious of outsiders. The premise of the RRMAP is that it will become an inherent and integral part of the community in which it mobilizes a response. Because the RRMAP draws from the community's professional pool and from its established network, the community can identify the program as coming from itself. The council and the trained group leaders increase community acceptance by their general knowledge of the event and of its repercussions in that particular community.

Perhaps the most significant characteristic of RRMAP is that it is primarily a situational/transitional group, or a service for prevention, providing immediate services to all interested without prior labeling or presenting categories.[23] With no inherent relationship between the RRMAP and an ongoing diagnostic structure or process, the message is clear: People react to events, their reactions are natural, and talking about these can be a helpful way for people to overcome their responses.[24] Thus, group participation develops in relation to the event and to the community affected. At times, a congruence exists between more or less natural groupings, such as the family, social service organizations, or neighborhoods[25]; at other times, largely in response to centrifugal events, a new community is created from the shared experience of survivors participating in the groups.

MODEL IN PRACTICE

Social Workers' Cooperative

The Social Workers' Cooperative, or the Coop, was formed in 1976 as a self-help group of MSW-level social workers for the purpose of job finding and professional development. The Coop serves as a forum for seminars, lectures, and discussions on social and social work issues, emphasizing peer cooperation and support. The job exchange has helped over 1,000 social workers in their search for employment in the New York Metropolitan area.

The Coop is an egalitarian group that respects, encourages, and utilizes the unique talents and skills of its members to reach group goals. Moreover, there is little difference in status between the program leaders and the members who participate in the programs. Program leaders are recruited from the new membership and are encouraged to develop new ideas. In this way, the Coop is defined by its membership needs and fosters the development of innovative and supportive group activities.

The Coop's Board of Directors, made up of members who demonstrate an active commitment to the cooperative process, provides an administrative structure for the organization, acting as its coordinating council in certain instances. At its monthly meetings, the board develops policy and assists in the coordination of the Coop's activities and projects. The board also handles issues of budgets, fundraising, legal status, volunteer staffing of the office, and facilitating liaisons with various community agencies that provide social services.

Centrifugal Event: The Murder of John Lennon

The Coop has a long-term interest in expanding its mutual assistance model to deal with events that are not related to employment. The murder of rock star John Lennon, formerly of "The Beatles," in New York City, on December 8, 1980, provided an opportunity for the Coop to share its expertise with and to deliver a much-needed public service to the New York community.

Within hours of John Lennon's death the media reported massive outpourings of grief and shock. Several suicides were linked to the shock and depression of some individuals who believed, apparently, that they shared a special intimacy with Lennon. People everywhere were talking about the loss of a hero, a role model, and, even, of an era. Many people reported that no one seemed to be experiencing quite the same anguish as they were experiencing; only a few of these people believed their pain was truly appreciated by others.

To help people who felt such anguish and isolation, the Coop members quickly activated the RRMAP in response to the event of Lennon's murder. The alacrity with which the RRMAP was mobilized and with which it provided services for people in need is highlighted in the day-by-day description of its activities in the following paragraphs.

Day 1 (12/8/80). John Lennon is killed. Media report worldwide mourning and vigils.

Day 2 (12/11/80). A vigil is scheduled for December 14, 1980, in Central Park to honor John Lennon. At the Coop's Fifth Anniversary Party, members discuss the enormous number of people affected by John Lennon's death and how the nation is undergoing a social crisis. With a quorum of board members present, an emergency board meeting is held, and the Coop's Disaster Proposal, a precursor of the RRMAP model developed by a Coop member, is reviewed. The proposal outlines the use of a quick response network to form mutual aid crisis groups for survivors of a disaster. A motion is passed to develop John Lennon groups for grieving fans based on the Disaster Proposal group model. The following tasks are identified and assigned to volunteers:

1. Publicity: Press releases to all media sources regarding 12/14 vigil.
2. Sites for Groups: Identify possible sites for groups through Coop's networks.
3. Hotline: Establish call waiting and call forwarding on the Coop's telephone for a hotline; identify board members to answer telephones beginning 12/15, from 11:00 A.M. to 7:00 P.M.
4. Group Leaders: Coop members identify themselves as group leaders.

Day 3 (12/12/80).

1. Publicity: WNEW (a major rock music station) announces the availability of the hotline and the formation of groups as a public service message. Plans for outreach via public service messages to other media begin.

Day 4 (12/13/80).

1. Publicity: Press releases are prepared by Coop members. Radio stations in the New York Metropolitan area are informed of the formation of

John Lennon groups. Volunteers are coordinated to distribute leaflets at vigil.

Day 5 (12/14/80).

1. Publicity: Over 5,000 leaflets are printed and distributed by Coop volunteers at the Central Park vigil, which was attended by approximately one hundred thousand persons.[26]

2. Time for Groups: Determine the days and times for groups to meet by utilizing schedule information from volunteers.

3. Hotline: The hotline is operated by a professional social worker trained in the RRMAP technique and in crisis intervention. An oral questionnaire is developed for all telephone calls to:

a. Screen out psychiatric emergencies.
b. Begin the process of validation of callers' emotional reactions and support for entrance into a group.
c. Establish a baseline for researching the effect of participating in a group.
d. Ascertain information for the scheduling of the groups.

Day 6 (12/15/80).

1. Hotline: In its first day of operation the hotline handled 25 callers and several inquiries from the media sources.

Day 7 (12/16/80).

1. Group Organization: Distribution of the names of callers to group leaders to enable follow-up calls and group assignment.

2. Group Leadership: The training of group leaders included the leaders' sharing their own reactions to Lennon's death with one another.

Days 8 and 9 (12/17 and 12/18/80).

1. Group Liability: Investigation of insurance coverage for leaders and group members.

2. Sites for Groups: Confirmation of locations for groups—a church, a school, and a hospital.

3. Group Organization: Continuation of follow-up calls by group leaders and assignment of callers to groups.

4. Crisis Resources: Compilation of a list of resources in the New York Metropolitan area to be used by the hotline staff and group leaders for individuals in intensive distress. Contact and discussion with Suicide Prevention League and its suicidologist.

Day 10 (12/19/80).

1. Group Liability: Parental release forms written for group members who are under 18 years of age. A waiver of responsibility is written to protect group leaders from malpractice suits.

2. Group Organization: Continuation of follow-up calls by group leaders and assignment of callers to groups. Written questionnaire developed for group participants.

3. Group Leadership: Additional training session for group leaders. Development of telephone information and support network for all leaders. Decision to hold postgroup sessions for all group leaders.

Day 11 (12/20/80).

1. Groups: First three groups, with a total of 28 participants, meet at a local hospital. Leaders assemble following group meetings and share their experiences.

Days 12 to 15 (12/21 to 12/30/80).

1. Groups: Groups continue to meet at space donated by a hospital, a school, and a church. Eight groups meet, with a total of 60 participants.

2. Hotline: The hotline continues until 12/30, handling a total of 180 callers.

Day 16 (1/6/81).

1. Groups: The second session of the groups begins.

Day 17 (1/9/81).

1. Coop Board Meeting: Discussion of the groups' organization and process, with group leaders sharing their perceptions and experiences.

Days 18 to 20 (1/11 to 1/13/81).

1. Groups: The second session of the groups continues. The attendance rate is a consistent 50 percent of the original group members.

Day 21 (1/16/81).

1. Evaluation of Groups: A review of the questionnaire and of the issues discussed by group members.

Day 22 (1/19/81).

1. Groups: The last of the groups holds second session. A total of 88 individuals attended at least one group. A total of 12 groups are held for the first session and seven groups are held for the second session.

EVALUATION AND ASSESSMENT OF RRMAP

Like the Coop itself, the Coop's Lennon project is based on a group model of intervention that stresses acceptance of individual differences as the cornerstone of the participatory process.[27] Events affect individuals in different ways and often lead to the development of new and uncomfortable feelings and experiences. The leaders of the John Lennon groups encouraged, through modeling, over 100 participants to accept their own and one anothers' reactions, feelings, and behaviors. The group participants shared a sense of "we are in this together," thereby enabling a renewed sense of equilibrium mastery and of community.[28] Participants in the groups, both leaders and nonleaders, stated that the experience was extremely beneficial for them. National and international media coverage of the groups provided confirmation that the groups were needed and had benefit.

> *"The group participants shared a sense of 'we are in this together.'"*

Another question, however, must be considered, namely, why was the Coop so successful with the John Lennon groups? A number of factors contributed to the Coop's success, but one—the rapid mobilization to respond to the event—is of primary significance. The Fifth Anniversary party of the Coop, held 72 hours after Lennon's death, provided the moment for crystallization of the idea to develop groups for grieving fans. The structure of the RRMAP model was already in place through the Coop's board and through its membership network. The board, acting as the RRMAP's coordinating council, immediately began coordinating the various facets of the program. Coop members utilized their special talents and professional and personal resources to initiate and develop publicity activities, site finding, and operation of the hotline. For this event, the targeted population was immense and its demographic content was unknown. However, Coop members did know that this population shared a common interest in popular music, particularly rock music and other musical forms evolving from former rock groups. Thus, members contacted those radio stations with programming targeted to this audience so as to advertise the hotline and to offer listeners an opportunity to participate in one of the groups.

A major popular radio station in the New York Metropolitan area immediately agreed to announce the hotline and the groups' formation; this station's response was critical in gaining access to the otherwise large and diffuse community of sufferers. The public service announcement, which acknowledged people's intense reactions to Lennon's death, was soon picked up by other similar stations, widening the entry of the program into the community. The media validated the reactions of anonymous individuals as being real and identified for these people the opportunity for more personalized support through participation in the RRMAP group.

The Lennon family also seemed to understand the need of Lennon's fans to come together in a sharing of experience. The vigil was a focus for many during the first week: it rekindled the community of the 1960s and allowed the open and unabashed revelation and expression of grief.[29] The decision of the Coop's board members to use the vigil as another vehicle for announcing the program was based on the assumption that for many fans the vigil by itself might not be enough. The vigil would allow fans a time to air their feelings in general, but it would offer little opportunity for the personalization of their feelings and for their movement toward an integration and resolution of their intense feelings. Coop members handed out leaflets at the vigil to reach those who might otherwise go home alone, or who might have no supportive network, or who would not be given permission to grieve. In this way, members attempted to reach the population at risk.

The Coop's prior history as an ongoing organization serving a professional community gave credibility to its efforts to organize the hotline and John Lennon groups.[30] The Coop's decision to provide the groups as a public service also heightened its acceptance as a supportive endeavor for people in need rather than as a commercial endeavor attempting to gain by exploiting the circumstances surrounding the murder.

One final, extremely critical feature in running the John Lennon groups was the role and attitude of the leaders. In their work with mutual aid groups, and especially with those groups dealing with transitional crisis, Schwartz and Baldwin discuss the need to avoid stigmatization of the group's participant as a mental health patient and to avoid perpetuating a discrepancy between the group leader's status and that of the group's members.[31] Because the Coop's members shared with the larger community the shock of John Lennon's death, the RRMAP also took into account the wide range of reactions among the volunteer leaders. Thus, in addition to the group process described earlier, the volunteer leaders' formal training sessions included their anticipation of the actual experience of running an RRMAP group. Through this process, prospective leaders shared their feelings about Lennon's death and what they had done to cope with their reactions. They also discussed the need to distinguish the John Lennon groups from therapy groups and to watch for anyone who might need further assistance. In this regard, information was disseminated on crisis intervention theory and appropriate resources for group members who might need additional referrals. Following the meetings of the RRMAP groups, the leaders reconvened into groups. The purpose of these groups was to open up the reactions of the leaders to their groups, to share feelings of frustration and impotence, and to begin to address new feelings that had emerged while listening to group members share their, at times, extremely intense and powerful reactions to Lennon's death.[32]

REPLICATION OF THE MODEL

The authors believe that their experience with the John Lennon groups demonstrates the vitality of a new model of practice and highlights the benefits of providing service to the general public and to the at-risk population following an event. The replication of the RRMAP model from coordinating council to program matrix to actual groups is enhanced by the inherent flexibility of the model's structure, which enables it to work successfully in communities, regardless of size and functional purpose.

However, there remain some key issues that this present article cannot address and that warrant further exploration. For instance, in communities without an already receptive organizational structure, who will develop the necessary suprastructure for an RRMAP and how? What kinds of responses from the established mental health community can be anticipated and how can they be constructively utilized? If the suprastructure is developed solely for the purpose of operationalizing the RRMAP group, how can it establish its credibility in the community before the first event takes place?

Although the RRMAP can exist on a relatively small budget, several questions must be considered: How will the RRMAP finance its activities? Should fees be charged for the RRMAP's services?

Finally, the authors have seen the success of the RRMAP in New York in defining one event as appropriate to mobilize its services. With so many different kinds of events having impact on so many divergent communities, what mechanism and criteria should suprastructures utilize to define future events as appropriate for the mobilization of that particular community's RRMAP? The occurrence of more events, the further use of the RRMAP, and the development of more formal research will no doubt better equip us to answer these questions.

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