
WORKING PAPER SERIES

**CRISIS INTERVENTION:
IT IS NEITHER COUNSELING NOR THERAPY**

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LEARNING OBJECTIVES

Clinicians will learn about:

- the need for special training in crisis intervention;
- the elements of critical incident crisis intervention;
- the stages and process of CISD;
- the difference between debriefing and defusing;
- compassion stress, compassion fatigue, burnout and their differences; and
- the need for more and better research in crisis intervention.

CRISIS INTERVENTION: IT IS NEITHER COUNSELING NOR THERAPY

We live in a time of great stress. Not only are we subject to natural disasters and accidents caused by human error, we are now concerned about weapons of mass destruction; weapons used, not only against the military, but also against the civilian population. This threat of terrorism is universal. Mental health professionals everywhere must be prepared to treat individuals and communities that are ill prepared for the chaotic aftermath of a disastrous critical incident caused either by nature or by humans (NIMH, 2002).

This lesson will be limited to critical incident crisis intervention (CISD) for mass violence situations, circumstances that involve those who witness or are involved with a tragic incident where there is death, serious injury or a very real potential for loss of life. These are not traumatic situations that can be dealt with by crisis intervention counseling as taught in university programs. Generally the usual counseling situations—family strife, relationship terminations, economic disaster, suicidal ideation, etc.—are not as immediately menacing and are not within the scope of this article. This lesson attempts to clarify some of the contradictions evident in the literature.

Early mental health intervention by qualified counselors specially trained in the methods of CISD, sometimes called Psychological Debriefing, reduces mass violence trauma, the harmful psychological and emotional effects that can follow exposure to violent disaster (NIMH, 2002). More imme-

diately intervention for survivors is defined as defusing, crisis intervention that occurs soon after the incident and on or near the site.

When CISD is promptly and properly used it dramatically reduces the development of posttraumatic stress syndrome (PTSD) for survivors (Davis, 1993; Mitchel, 1988). Crisis intervention as psychological first aid is initially necessary for disaster survivors, first responders and other rescuers to help them cope with compassion stress and compassion fatigue while they stay on the job. This should be followed by CISD as part of the whole process of critical incident stress management CISM.

POSTTRAUMATIC STRESS DISORDER

PTSD is a psychiatric disorder that can occur following involvement or witnessing life-threatening events such as natural disasters, terrorist incidents, military combat or serious accidents. People who

suffer from PTSD often suffer from nightmares, flashbacks and sleep disturbances, among other symptoms. An individual's ability to cope socially, emotionally or intellectually can be forever limited by the emotional trauma resulting from involvement in a serious disaster.

POSTTRAUMATIC STRESS DISORDER was not formally recognized as an aftermath of traumatic experience until the American Psychiatric Association added PTSD to the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (APA, 1980). This was soon followed by Mitchell's article on critical incident stress debriefing (CISD) (Mitchell, 1983). As skilled as mental health professionals are in diagnosis and treatment of emotional disorders, they may have little or no concept about how to work

most successfully with survivors of a large disaster. They also may have little idea of how to come out of this experience personally intact.

CRITICAL INCIDENT STRESS DEBRIEFING

CISD, is not psychotherapy, nor is it a substitute for psychotherapy. CISD requires specialized training that differs from training in psychotherapy. (Everly, G.S.,1999; Everly,G.S., Welzant,V., 2002). CISD also

differs from the usual crisis intervention taught in university programs.

CISD is *not* psychological first aid applied for relief in situations that include everything from school violence, date rape, homicide, and natural and man made disasters exposure to sudden death, violence or any situation that can cause an extreme change in the psychological and physical behavior of survivors as well as rescuers (Davis,1992; Mitchel,1983).

Some mental health professionals have extended themselves to learn the techniques of critical incident crisis intervention; most have not done so. Traditionally, fire, police and EMT personnel have been trained as the first responders to a disaster. Indisputably, they do an excellent job. However, the mental health professional, properly trained in critical incident crisis management (CISM), should be much better able to care for the emotional needs of survivors and families affected by a major disaster. A CISM trained mental health professional should be included in every psychological debriefing to insure success of the procedure. CISM includes everything from pre-crisis preparation, through psychological first aid of crisis intervention, through defusing, CISD and all the way to mental health follow up for survivors and rescue personnel, everything before, during and after the event (Mitchell, 2002; Mitchell, J.T. & Everly, G.S., 2003). Few university programs have incorporated into the curricula an understanding and application of appropriate techniques to treat trauma caused by major disasters.

Many private and government organizations like the American Red Cross, the International Critical Incident Stress Foundation (ICISF), National Organization for Victim Assistance (NOVA) and Critical Incident Response Training, among others, have filled this need with the development of critical incident intervention training programs. An increasing number of social agencies are incorporating Crisis Intervention Stress Management (CISM) for assisting people in need.

This discourse will consider some behaviors that you may see in survivors and some techniques to support and empower clients in their return to more stable functioning. The first thing to remember is that nothing you can say or do will quickly ease the pain of a deep loss. However, if you are not careful, you may do or say something that will increase the unwanted effects of the trauma. If CISD groups are undertaken at a time when people are sensitive and

Critical Incident Stress Debriefing (CISD) is not psychotherapy, nor is it a substitute for psychotherapy.

highly susceptible to suggestion, harm may be done. Prompt crisis intervention along with CISD properly used will do much to prevent PTSD as an outcome of serious trauma. However, it is essential that the debriefer is well trained and experienced to insure success and prevent any negative effects. (NIMH, 2002; Dyregrov, A., 1998).

There are several important factors to keep in mind about CISD. It:

- is not therapy nor a substitute for therapy.
- should be applied only by those specifically trained in its uses is (usually) a group process, group meeting, or discussion designed to reduce stress and enhance recovery.
- it is based on principles of crisis intervention and education.
- may not solve all the problems presented during the brief time frame available. Sometimes it may be necessary to refer individuals for treatment after a psychological debriefing.
- may accelerate the rate of “normal” recovery, in normal people, who are having normal reactions to abnormal events. (Mitchel, J., 1983).

Psychological debriefing (PD) also known as CISD is a formal meeting done individually or in small groups. It is generally held after an unusually stressful incident, strictly for the purpose of dealing with the emotional residuals of the event. (Weaver, J.D., 1995).

An essential axiom in this work is that abnormal behavior is to be expected in an abnormal situation. The usual psychotherapy diagnosis is of no value. The symptoms exhibited are a normal response to a terrifying situation. Normalize; do not diagnose nor try to treat the symptoms. This is crisis intervention, not therapy. Confusion reigns in the immediate aftermath of any disaster, no matter how small or how few victims there are. Crisis Intervention begins with psy-

chological triage; which survivor is most in need of immediate psychological first aid? What can be done without delay to reduce the stress this survivor is currently experiencing. The elimination of harmful behaviors may reduce the possibility of later PTSD. These negative behaviors include, but are not limited to, indulging in drugs, alcohol, tobacco or food, working too much, sleep deprivation, risk-taking and withdrawal from available support systems (Shultz, J. M., 2004).

The immediate need is psychological first aid, not CISD. People are not ready to manage their emotional reactions so soon after subjection to major stress. Their need is to be able to vent and have some support? This is a defusing. Reality testing, accurate information, caring and a chance for the person to vent should be offered. Some time must elapse before the individual can benefit from the more formal CISD (Mitchell, 2002; Watson, P. 2003).

Critical incident stress management, CISM, uses the techniques of psychological debriefing and defusing, the best tools available at this time to help the survivor move toward normal functioning. Defusing is psychological first aid, the act of removing the stresses to diminish arousal in a situation of escalating tension. This technique is used immediately following the traumatic event. Defusing is a brief, less structured procedure to establish control of circumstances that are in danger of escalating. Defusing may be informal or may follow an abbreviated CISD format. The format for defusing as psychological first aid is threefold:

- Introduction—who are you and why are you there?
- Exploration of the nature and impact of the event.
- Normalize and educate about the stress response.

This early intervention may eliminate the need for a formal CISD.

Debriefing as used here differs from the use of the term in the military where it means interviewing the individual immediately after return from a mission to attain information (Merriam-Webster). Psychological debriefing (CISD) is a structured set of interventions that work to provide relief to survivors and rescue workers after involvement in a catastrophic event. Even though rescuers are monitored for symptoms of fatigue, intervention may not occur until some time after they realize and admit to themselves that they are no longer fully functional (Shultz, J.M., 2004).

PSYCHOLOGICAL TRIAGE

Every person involved in a catastrophic event suffers from stress ranging from slight to incapacitating. Rescue workers, medical personnel, mental health professionals, families of the victim and everyone else directly involved including survivors is effected. The normal reaction of a person caught in a violent situation is fight, flight or freeze. Anyone who experiences or is a witness to a trauma loses the ability to perform as effectively as they did before the experience. There are visible signs to watch for so that the most vulnerable clients and workers can be quickly helped.

The first step in a psychological triage to observe carefully, select and give priority to those clients who are withdrawn, seem confused or show symptoms of a trance state. Although panic does occur in disasters, it is rare. Certainly, anyone in a panic state needs to be calmly defused. Among the people who are likely to suffer the most from confusion and disorganization are children and elderly with some dementia. Among the very agitated are people who normally are the most structured want to get everything orderly and controlled quickly, and they can't do it.

It is important for the professional to identify highly vulnerable individuals and groups from those just noted and to defuse or make appropriate

referrals for them. (Shultz, J.M., 2004). Very careful observation of survivors and rescue workers can provide early detection. Trauma may cause changes to occur that can negatively effect physiological, psychological, intellectual and/or behavioral performance if not treated properly.

The initial signs of trauma may include:

- Physical movements may be slow, jerky and unsure.
- The survivor may experience chills, fatigue, dizziness, weakness, pain or fainting.
- Complexion becomes pale and pasty.
- Some people initially exhibit hyper behavior; they babble in a relatively high pitched voice and may have a high blink rate. They may very suddenly distance themselves emotionally and go into a stupor or trance-like state.
- Others may go more immediately into a trance. Watch the eyes; in this condition the eyes may develop a distant, glassy stare. This glassiness can last for 6 to 8 months after the trauma. Voice, facial expression and affect become flat and unemotional (Ottenstein, R.J.,2002, ICISF, no date).

Traumatized individuals may work and interact with others at a reduced level of functioning (Baldwin, (no date). This slow, distant condition has the same physiology as an altered state of consciousness, a hypnotic trance. The person has regressed, thinking and talking in a simplistic, literal manner

(Caplan, 1961,1964; Everly & Mitchel, 1999).

HELPING THE SURVIVORS

Rescue work is chaotic for first responders as well as for the mental health professionals who are quickly on the scene. All rescue workers including

mental health professionals must know what they are doing but cannot be locked into any one narrow approach. Situations are in constant change; therefore flexibility is a basic requirement (National Mental Health Information Center, KEN 01-0097, 2003). By the time everything is well organized, the immediate problems have been taken care of and the rescue work may be getting ready to shut down or transition to a smaller operation.

Start to work with clients by building trust. Crisis intervention begins as soon as possible, close to the site of the disaster. Assess the safety of the area before approaching anyone. The work can be with individuals or with small groups if convenient. Be available and interested. Be laid back but acutely observant. Speak quietly, move slowly and be patient. Victims have been exposed to extreme stress and do not need any more pressure. A situation or place in which they had felt safe proved to be agonizingly hurtful. They have lost trust. Listen to their complaints. Talk to them in a literal, simplistic, warm and empathic manner. Simplistic, literal, realistic commands may be all they can handle at this time. Be credible, direct, and concrete. They may not be able to understand or respond to anything else (Shultz, 2004, Everly, G.S., 1999; Welzant, V., Loewenstein, R.J., 2002).

After a frightful experience, everyone wants to go home to a familiar place of safety where they have valued possessions. However, in the case of a natural disaster, no home may remain. Traumatized people need to somehow make contact with the familiar, to feel a sense of safety. They are in a disposition like that of a person who, immediately after disembarking from a hazardous journey, literally kisses the earth. Some safe point of reference for them must be established. The mental health professional should ensure that each client and his or her family has the basic means to maintain life: food, water and shelter. It is advantageous for the counselor to help the other workers provide these necessities while chatting with each client to ascertain their emotional state.

Survivors need their personal possessions—something from their recent past, a reference point, to keep them grounded and to provide some structure among the chaos. In addition to the basic food, water and shelter where required, the Red Cross provides small stuffed animals for the children, something to hold on to for a secure feeling; mothers also may want a stuffed animal to cuddle for their own comfort. After the family has settled down somewhat and assessed their loss, the Red Cross may assist with funds to help the family in their recovery. The counselor may actually be the only safe point of reference available right now. The counselor should talk to as many people as possible; be accessible, tell clients directly that you are there to help in any way possible. The one rule about catastrophic situations is that there are no rules. Every event is different. Be flexible; use whatever works, but cautiously within the realm of training. Check with a supervisor whenever possible before trying a technique that may be questionable.

Educate the client about the flood of emotions that disaster survivors often experience for at least the first week or two after the event. Survivors can expect intrusive thoughts, ruminations about what might have been, what could have been, accompanied by bouts of crying, inconsistent moods, too much or too little sleep, change in eating habits, distractibility, bad dreams and memories among other unusual emotions and behaviors. Young children may regress to an earlier stage of development; may not want to go to school, may begin to misbehave, may start to do poorly in their studies. These are normal reactions to an abnormal situation. For some clients this emotional response may be delayed for four to six weeks, or even years in some cases. A goal of CISD is to help bring relief to these issues promptly and effectively and prevent the long-term negative results.

The mental health professional may be uncomfortable dealing with this profusion of deep grief

and raw emotions from so many clients. An analogy might be when you fell and cut yourself as a child, your mother or other caretaker would wash the wound and then apply an antiseptic that would hurt. You accepted the pain then because you knew that it was for your own good. It is often necessary to open a wound and cleanse it so that it can heal properly with a minimal scarring. So it is with trauma, a deep psychic wound (Echterling, I.G.,1997; NMHIC, KEN01-0112, 04/03). These wounds may not at all be evident, even to a counselor because many survivors are reluctant to seek formal counseling. This is why the active presence of well-trained crisis intervention counselors is so important as soon as possible after the event. Advanced training is available through the American Red Cross, the International Critical Incident Stress Foundation (ICISF), National Organization for

Victim Assistance (NOVA) and Critical Incident Response Training, among other sources.

It may be too soon to attempt a CISD for the client to the talk about the fear and pain associated with this awful experience. It is appropriate for the counselor to gently encourage some venting. At this point the crisis interventionist will be supportive, will inform the client that abnormal behavior is normal in this abnormal situation.

There are some specific requirements for using crisis intervention to help disaster survivors. The task is to be a supportive listener, to talk minimally. Do not ask, "How are you doing?" The answer will be, "Fine"; and that gets nowhere. Encourage the client to tell about what happened. Ask about the person(s) who have been killed or hurt. "What kind of person was s/he? Describe him/her to me. Tell me more about this person."

The one rule about catastrophic situations is that there are no rules. Every event is different.

"How much do you know about what happened? Tell me about that." Listen attentively; use reflection to help get the whole story out in the open intruding minimally as the client talks. Mirror important emotions encouraging openness. NEVER say, "I know what you are going through." or "Have patience, everything will be fine". "You are lucky it wasn't worse". These comments do absolutely no good and can possibly do harm. There will probably be an angry reaction. "This is my pain. How could you possibly know how I feel?" Even if not voiced, this is probably the client's inner response. Beside, there are no guarantees that all will ever be well again. It is detrimental to promise anything that you personally cannot guarantee.

If there is something not clearly understood, ask for clarification. It may not have been fully thought out in the client's mind and explaining may help client come to terms more fully with the matter. It is more productive to ask for the client to clarify than to attempt to inappropriately interpret what has been said.

Be attentive to body language. If tears start to form and the person says, "I don't want to talk about this." hand him/her a tissue and say that it is important to talk about it; give the client permission to cry if s/he is reluctant to do so. Use the client's body language to open the discussion as much as you can, but keep to the current situation. (Kennedy, R., Korn, M.I., 2001).

Remember not to open up any more emotion than can be handled in that session. This is not therapy; in crisis intervention, less may be more. There is no examination of the client's family or personal history, no questioning about relationships, past or present. The only subject discussed is the response to the present situation. Where clinical issues are evident, referral for ongoing therapy is called for, report back to a supervisor so the referral can be made in accordance with previous agency agreements.

DEFUSING and DEBRIEFING

The primary techniques to use in mass disaster crisis intervention are defusing and psychological debriefing. Defusing may be an informal intervention or an abridged debriefing. It is designed to reduce the tension in a potentially explosive situation involving only a few individuals (Pulley, S.A., 2004). Defusing is early crisis intervention that is used immediately post crisis. It is a brief procedure to relieve the symptoms caused by exposure to a traumatic situation. Defusing also provides an opportunity to triage the survivors. Defusing is a component of critical incident stress management. The client may experience closure or may require the use of other CISM components (Everly, G.S., Welzant, V., Hatherleigh Vol.12, L3 (no date).

Defusing has three components:

- 1) Introduction
- 2) Exploration of the nature and impact of the event.
- 3) Education

Introduction: This is a brief time after the disaster incident. The survivors are confused, distressed and insecure. They may not be asking for psychological help. They need assistance for food and shelter, the basics for survival. There is usually a positive response when a counselor introduces him/herself as a crisis counselor and offers to help. It is necessary to explain that the counselor will help them while FEMA, the Red Cross or some other agency is working on their basic and financial needs. An effective defusing at this early time may provide enough closure so that a more formal PD will not be required (Mitchel & Everly 2003).

Exploration: Ask client to tell of experiences during the event. Clarify, reassure, assess the need for more help.

Education: Clarify unclear points. Summarize the experiences with no criticism. Normalize the responses. Inform about responses that may occur;

be calm and reassuring. Offer future assistance as needed.

Psychological debriefing (PD) also called critical incident stress debriefing (CISD) is a specific technique developed as part of CISM (Mitchel, J.,1983). Initially debriefing was a formal five-phase process to help bring closure to an incident. Everly and Welzant, (2002) believe that at least a day or two or up to two weeks should pass before CISD is attempted. The intent is to bring support and emotional relief to the survivors. If used earlier, the survivors may not have had sufficient time to fully process everything that has happened. They also may be harmed as they are too sensitive and too open to suggestion (Dyregrov, A., 1998; Pulley, S.A., 2004). While this does make sense, in some cases, the survivor may be long gone and out of your reach after a few days. A defusing is in order without delay with a more formal CISD to follow when appropriate.

Currently critical incident stress debriefing (CISD) is a seven-phase process recommended to be used between seven days and three weeks after a catastrophic event. A desired format is group CISD that takes place over two to three hours. There should be both a facilitator and a co-facilitator with a group CISD; the co-facilitator not only assists in the process but is also available to follow out and help any participant who becomes upset and decides to walk out of the group. The key to the success of any defusing or debriefing is to have trained peer facilitators create an open and trusting environment where participants feel safe. The CISD procedure may also be used as a one to one intervention. (Foa, Keane, & Friedman, 2000). CISD is a peer driven action that includes only incident survivors or only rescue personnel along with a team of two or more facilitators. No supervisors or observers are permitted to sit in. Some controversy exists about how best to do crisis intervention. While there has been some research that seems to indicate that debriefing is not

useful and can retraumatize a person, possibly resulting in a negative outcome (Pulley, S.A., 2004; Avery & Orner, 1998; Lee, Slade and Lygo, 1996). Prior reported research does not clearly screen out persons with pre-existing psychological disorders. Everly and Mitchell (1999) have noted that research had often been poorly designed. Often what is done is called 'debriefing'; however, all rescue teams do not use this term to describe the same procedure. Some teams say that they have discarded the use of debriefing based on research findings (Rayford, 2002,) despite other research that demonstrates the value of CISD in reducing long-term after effects of a seriously traumatic experience (Pulley, S.A. 2004; Everly, G.S. & Mitchell, 2002; Dyregrov, A. 1998). There is an urgent need for randomized, well-controlled studies (NIMH, 2002; Foa, Keane, & Friedman, 2000).

There are several stages in CISD; the seven phase format is the most recent development. The earlier model consisting of five phases essentially eliminates the Thought and Symptom Phases leaving the Introduction, Fact, Reaction, Education and Closure (Re-Entry). The Mitchell model suggests that the five stages are more useful when working with young children (Everly,G.S., Mitchel, J.T., 2002).

The seven phase model content includes:

- an introduction,
- stages to elicit the facts,
- expose the thoughts of the individuals,
- exposition of the reactions and emotions aroused,
- symptoms experienced by each participant,
- education to understand expected reactions
- relaxation methods to best deal with the emotions and symptoms. (Calm Breathing, 4-5 full breaths through nose; release through mouth v-e-r-y—s-l-o-w-l-y while saying to self “I am calm; I am relaxed; I am fine.” Another exercise is the muscle tension/relaxation exercises, and there are other simple relaxation techniques

that can be quickly taught.)

- termination.

CISD is voluntary; a client should not be pressured into participation. However, it is possible to ask a client what his/her involvement was in the event. In responding, they may become involved in the psychological debriefing process. A brief description of the seven phases follows:

Introduction: CISD starts with a formal introduction and an explanation of the ground rules. As facilitator, state your name and purpose; “I am Joe Smith, one of the counselors here. A tragic event like you have experienced often causes people to have strange and disturbing feelings. I would like to help you understand and deal with these emotions better.” Generally, people who have been traumatized and terrorized are almost desperate to talk.

Set the ground rules. Inform the clients, “This is not a critique of the incident. Everything discussed will be confidential, privileged information. Whatever is said here must remain in this room. Nothing said here should be discussed at any other time. The only exception is when there is a threat to you or to another person.

Information that is potentially destructive to yourself or others should not be revealed to the group. “If there is something that you believe is self-incriminating, talk about this privately later.” This is especially important when there is a group CISD because some group member may reveal your information and cause harm to you.

Fact Phase: It is important that each person introduces him/herself and tells their role in the incident. Each individual should be encouraged to share his/her experiences during this traumatic time without criticism. Encourage the identification of stressful events. Comments should be kept to a minimum used only to further the narrative. Participants are testing for safety during this time.

Thought Phase: Any thoughts aroused by this experience, however strange they may seem, are shared and explored. “What did you think of when you realized the extent of this disaster?” “What do you think of it now?”

Reaction Phase: A sharing of emotions, feelings and reactions. A time when the participants learn they are not alone in their feelings and responses.

Symptom Phase: A sharing of the symptoms of intrusive thoughts, sleepless nights, stomach upset, fatigue, loss of libido, etc. Once again the participants learn they are neither alone nor unusual (ICISF).

Teaching Phase: This is a discussion to support the usual methods the individual uses to cope with tension and fear. There is no attempt to alter the client’s defense system. At a minimum, educate the client about coping mechanisms for this and future stressors or traumas. Discuss the need to talk to trusted friends, to eat and sleep well and to get some exercise. Teaching of breathing exercises and other adaptive relaxation techniques is included here.

Termination, Reentry Phase: A final chance for the participants to expand on issues that they feel were not fully dealt with. This process provides a meticulous, systematic examination of the physical, emotional and psychological effects of this traumatic incident on the survivor. CISD ends on a positive note with referrals and plans for follow up where necessary.

The complete process of CISD starts at the cognitive level proceeds through the emotional and ends back at the cognitive (Pulley, S.A., 2004; Everly and Mitchel, 1999).

A common response to a human error or terrorism disaster is anger directed at the system, an agency or the person(s) who caused the incident. The survivor’s desire for revenge may be strong. Do not personalize the anger or other feelings. It is

important to listen attentively and acknowledge the emotions, and not reinforce any destructive behavior (Weaver, J.D., 1995).

Guilt and depression are also part of the emotional response. In the case of a survivor of the actual incident, survivor guilt may be evident; “How come I’m still here and all those others died?” A rhetorical question that may best be handled with silence; there is no satisfactory answer. It might help to point out that the survivor has been saved because s/he still has much important work to complete in this lifetime and that there are loved ones who need him/her.

Some responses of the family of a victim may be similar to responses seen in a survivor of the incident. Family members and friends may have been traumatized by the incident although they were not physically present (Watson, P., (2003).

SOCIOCULTURAL CONSIDERATIONS

Some individuals are normally laconic or not articulate; others may just not yet be ready or willing to talk. In addition to the psychological differences, sociocultural and religious factors are an important element in determining the response to traumatic events. The client’s cultural milieu provides a set of parameters that color the experience, understanding and interpretation of the event. Therefore, one must listen very closely for cultural or religious factors that may modify the response to trauma. An awareness of culturally different use of eye contact, the pace of conversation, and specific body language can assist the counselor.

Western techniques emphasize the need to talk—catharsis as a means of resolution. This may be contraindicated in a culture that views discussion of a traumatic event as inappropriate. Native Americans tend to be nonverbal in the presence of a counselor. They listen and absorb knowledge selectively. Some South American immigrants see eye contact

as hostile and aggressive (Pederson 1976). In some cases the culturally determined response to the traumatized person may reject or stigmatize the victim. This stigmatization or rejection may be perceived as additional injury leading to withdrawal and unwillingness to discuss the event. In other cultures individuals may tend to accept the traumatic experience more easily because of a strong belief in fate or the role of divine intervention.

Denial may be the defense used by some, a refusal to accept that the loved one has been lost in this disaster. They hold on to the hope that their loved one will somehow surface and everything will be all right again. The best thing the mental

health counselor can do is to listen without comment; too much intervention reduces catharsis. It is especially important that the counselor be aware of personal cultural biases and try to be non-judgmental, to openly acknowledge differences and apologize for discrepancies in behavior (Young, M., 1998).

Some people are troubled by the seemingly insensitive "black humor" in regard to a disaster or any tragic experience. Humor may seem unfunny, even sadistic or cruel,

when out of context. However, it does serve a serious purpose. Humor negates trance, reduces trauma, and it does seem to help normalize a difficult situation. When a rescue worker suddenly reacts unfavorably to the humor, this may be a sign of stress and imminent trauma. It is necessary to immediately shift and become quietly supportive of this person. There is no need to exacerbate the pain.

LESS MAY DO MORE

The most a counselor can offer clients is support and understanding. In crisis intervention, less may be better. If a client refuses help, do not move off too quickly. Offer assistance and a willing ear; remain in the physical area and observe carefully. If this person seems intact and there is no sense of danger to self or others, leave them alone. If, on the other hand, there is a feeling of imminent danger, of an emotional break or some self-destructive behavior, stay close by and observe longer. If the feeling persists that danger may possibly exist, report it to someone in charge of the operation. The counselor must trust professional intuition.

Every encounter with a client offers a chance to learn something. Explore with the client what was learned from this catastrophic experience. If something of value can be taken away, some new knowledge leading to more effective behavior, it has not all been for naught. As the session moves toward a close, you want to end on as positive and pleasant an emotion as possible. At some point in the session there may be a hint of a smile; it might be a good move to reflect, "That seems to be a pleasant memory". In this way the intervention moves toward positive thoughts and feelings about the incident or the person lost.

Leave the client with encouragement to help others who have experienced the same or similar incidents, to get out and do volunteer work, to arrange to be with friends and family, to keep as busy as possible. Appropriately discuss spirituality. If the client is amenable, encourage participation in a religious institution of choice. Active involvement with other people will help time pass more easily while minimizing the obsessive thinking about this terrible loss. It will help the client regain some of the positive feelings about being alive.

To review the steps of CISD:

1. Introduction/ground rules.

Some people are troubled by the seemingly insensitive 'black humor' in regard to a tragic experience. However, humor negates trance and reduces trauma.

2. Get the facts/ elicit individual stories.
3. Open an examination of thoughts during and since this experience.
4. Share emotions or reactions relating to this trauma
5. Discuss symptoms -physical, emotional and behavioral-occurring since this experience.
6. Education clients on expectations of a possible emotional rollercoaster with intrusive thoughts and sleep difficulties for a while. These experiences will never disappear, but they will fade and life will go on. Teach relaxation techniques and healthful habits of living and eating.
7. Close with positive emotions and follow-up and/or referral as necessary.

COMPASSION STRESS, COMPASSION FATIGUE AND BURNOUT RISKS

Until now we have been considering the impact of a traumatic event on survivors. It is equally important that the crisis intervention counselor be fully aware of the condition of fellow counselors as well as of the other rescue workers (National Center for Post-Traumatic Stress Disorder, 2003).

A crisis intervention worker is exposed to many extremely emotional situations and people. Individuals who have empathy and understanding of fellow humans choose this work. Certainly counselors intellectualize and use whatever defenses they have for self-protection to enable efficient performance. However, they are not invulnerable to the psychological effects of a traumatic incident.

Everyone involved in critical incident stress management may be exposed to compassion stress and compassion fatigue issues that can affect efficiency in treating clients as well as personal self-composure. Not only are therapists and other professionals, the family and friends of survivors are also vulnerable to secondary traumatic stress (com-

passion stress) and stress disorder (compassion fatigue) (Pulley, 2004).

Burnout is exhaustion, a loss of energy, as a result of accumulated stress in any line of work. Burnout is not related to the trauma of clients; it is relatively predictable. This is another term for a state of depletion that occurs after working too hard and too long. Burnout is usually the result of a bad job situation. Burnout can affect emotional, cognitive or physical behaviors resulting in apathy, disillusion and depression. It leaves the worker as feeling tired or overextended, doing as little as possible, having too much work to do, feeling stuck and stagnant, believing that work is meaningless. Some time off from work or change of jobs may help (Maslach & Leiter, 1997).

Compassion stress is a natural consequence of overburdened physical and emotional systems experienced while working with survivors of a traumatizing event. It is the secondary stress resulting from helping or wanting to help so many traumatized persons. This stress is significantly increased for mental health and family service workers who listen to the difficulties of so many terribly devastated people. The counselor or rescue worker wants to do more, not less, for the devastated people, but is increasingly ineffective.

Compassion fatigue is very different. Compassion fatigue is neither secondary (compassion) stress nor burnout. Compassion fatigue is a state of persistent arousal that arises as a result of caring too much; personally owning the symptoms of others. It may be manifested in one or more ways including intrusive thoughts re-experiencing the event, troubled sleep and dreams along with avoidance of reminders of the event. Workers with compassion-fatigued continue to give of themselves fully, but find it difficult to maintain a healthy balance of empathy and objectivity. This will seriously interfere with ability to do the required work (Pfeifferling, Gilley, 2000; Pulley,

S.A., 2004).

Carefully examine the following list of symptoms. A combination of these may indicate the development of compassion fatigue:

- Abusing drugs, alcohol or food
- Anger
- Blaming
- Chronic lateness
- Depression
- Diminished sense of personal accomplishment
- Frequent headaches
- Gastrointestinal complaints
- Hopelessness
- Hypertension
- Inability to maintain balance of empathy and objectivity
- Increased irritability
- Less ability to feel joy
- Low self-esteem physical or emotional fatigue
- Sleep disturbances
- Workaholism, (Pffifferling, Gilley, 2000).

In counseling a fellow rescue worker, limit their self-disclosure:

- Do not access emotions during the time they need to function. Take care of business at hand; be objective, grieving will come later.
- Normalize the situation. If either a client or worker is crying, this is not a sign of trouble; crying is not non-functional; withdrawal, trance or stupor is. Accept expressed feelings as normal and expected (Everly,G.S., Mitchel, J.T.,2002 pg. 79).

Some people function very well through the emergency only to fall apart later. Good training and drills before a disaster occurs adds to the ability of the worker to function objectively and well during the emergency. Effective training should include an understanding of the chaos that pervades the early stages of a disaster; it should address the procedures, the environment, and emotional aspects of disaster rescue work. The rescue work-

er who is showing symptoms or is obviously upset needs to be promptly defused; each worker should be encouraged to participate in a CISD before leaving the job to go home.

RESCUE WORK IS DANGEROUS BUSINESS

Emergency service workers differ from the average citizen. They tend to be risk takers with obsessive, compulsive traits who can be easily bored. They have very high performance expectations along with a strong need for action. They are guarded about speaking to professional counselors; there is uneasiness that seeking counseling will mark them as weak and perhaps unfit for duty. They prefer to talk to peers and delay seeking professional help (Pulley, S.A., 2004; Kerrigan, D., no date).

Rescue workers are adrenaline junkies who seem tireless and work long hours taking little time out for them. Within the first 24 hours, more than 85% of rescue workers experience stress reactions in response to critical incidents. These symptoms diminish with time. However, about 3% develop PTSD. In order to effectively treat this disorder, the helping counselor must be familiar with the extraordinary pressure on those who provide services during a catastrophic emergency (Pulley, S.A., 2004; Shultz, 2004; Kerrigan, D., no date).

First responders, Fire & Police Rescue workers are under a great deal of stress, although they usually do not admit to it. "It's all in a day's work..." is a frequent response. However, clinical depression is common especially for people who play a role in high profile rescue efforts. A few examples include Robert O'Donnel of the Midland Fire Rescue, Texas who pulled 18 month old Jessica out of a deep well. O'Donnel never recovered from that incident. He lost his job, his family and in 1995, about seven years later, he committed suicide with a shotgun (Lunsford, D. L., 2002, Babinek, M. 1997).

Robert Long shot himself some time after helping rescue nine trapped miners in the Quecreek Mine, PA. (Charney, F., 2003), There were six suicides after the Oklahoma City bombing. These included Terrance Yeaker, the first police officer to arrive on the scene, another police officer and a federal prosecutor who was involved in the McVeigh investigation (Hopkins, J. and Jones, C., 2004). The less dramatic incidence of incipient depression is more difficult to document.

EMOTIONAL CONFUSION

After experiencing a trauma either as a survivor or as a rescue worker, many emotions run amok. Research at Washington University in St. Louis and at the University of Oklahoma showed that one-third of 182 survivors of the Oklahoma bombing had full-blown PTSD and almost half had a post disaster psychiatric disorder.

The Red Cross and Nancy Anthony of the Oklahoma City Community Foundation both agree that the rescue workers were the hardest hit but the last to seek help. It is vital for the rescue worker and the counselor to keep this in mind the CISD services available for personal use (Hopkins, J. and Jones, C., 2004; Salmon and Sun, 2001).

How can these suicides be understood? One can only speculate about what happens to these brave, dedicated rescuers who become so despondent that they take their own lives. Earlier we commented on the personality characteristics of first responders. These action-oriented people who have such high expectations of themselves and their ability to do this daring humanitarian work may feel guilty and speculate that they should have done more than they did to help. They may feel that all the recognition that they received was undeserved. At the same time they feel despondent and neglected that the limelight on them has gone out. There also may be a feeling of emptiness that, currently, there is no heroic work for them to do. Survivor guilt may

also add to their confusion and despondency. Why are they alive when their good friends died? After the World Trade Center disaster, many fire fighters buddied to help wives and children of fallen comrades (CBS News.com. 2003).

These men obviously grieved the loss of a close friend and felt responsible to help the families. They worried about the well being of their adopted families, perhaps sometimes more than they did about their own wives and children. There was very real concern and anxiety about the future of these deprived families. Surviving firemen spent a good deal of time with the family of a deceased buddy. Feelings of guilt about surviving while their friends did not are very powerful. These emotions and behaviors, the anxiety, the concern, the need for frequent contact, in some ways, are not unlike and may be mistaken for a love attraction. A significant number of the rescue workers divorced their own families to marry the 'buddy' (Dominus, S, 2004: (CBS News.com. 2003).

These and other situations make it imperative that all rescue workers be pretrained long before they are called to respond to a disaster, that they are made aware of the emotional risks that are part of the job, that they are assured that counseling and CISD are an important part of their training. And most important, that using these professional services will not cause them to be labeled as weak or unfit for duty. CISD counselors need to be included in the training of all Police, Fire, EMT and other first responders so these mental health professionals are familiar and trusted. CISD professionals must warn team leaders of those workers who show signs of extreme stress so that they may be replaced before they not only damage their own health but endanger the their teammates (Eshel, D., 2003).

Every rescue worker is strongly encouraged to take every seventh day off to relax, energize and reduce the possibility of compassion fatigue or burnout. Members of the disaster mental health team are in an unusual situation. They are not first

responders; they are rarely in harms way. A disaster counselor does a 12-hour shift and then goes out to dinner with others on the job. Is the counselor still working? Does that 'third ear' ever turn off? Although there is nominally a day off and evenings for relaxation, the counselor at a disaster site is effectively on duty 24/7 as long as other workers or survivors and families are present. It is therefore, imperative that disaster mental health personnel also observe and talk to counseling colleagues to effectively defuse each other. At the end of a series of long hours exposed to the pain of many people, the debriefers are emotionally exhausted. They must take the time to care for themselves; they must practice what they preach and personally be defused and psychologically debriefed. An experienced crisis counselor who has not been involved in this disaster should be called on to do this CISD. (Potter, D., LaBerteaux, P., 2002).

Every rescue worker and counselor must be offered a psychological debriefing when they sign out of the site to go back home. A week or so after returning home each worker should receive a follow-up phone call to see how s/he is. It is important that workers returning home be aware that it can be very hard for loved ones to understand and accept leaving the family to help others while at home they are worried about the dangerous conditions on the job.

Rescue workers thrive on adrenaline; crisis intervention work is exciting and can become habit forming for those who fit the profile (Pulley, S.A., 2004). There is a need to balance the attraction of this work and the needs and demands of family with other aspects of a full life.

Supporting the emotional health of survivors of a major disaster as well as the rescue workers is a relatively new field. Many interventionists are trained police, fire fighters, or EMTs. While these individuals can be trained to do competent CISD work; trained mental health professionals have the basics to be the most effective. However, some mental

health professionals may have the hubris to believe that they already know how to do CISD without specific training; this is definitely not so. In order for this work to be successful, it is essential that critical incident counselors be very well prepared in this specialty. It is not part of their normal preparation. It requires considerable specialized training and experience to be competent in the field of crisis intervention.

The basics are:

- Listen Carefully.
- Be calm and patient. Spend unpressured time with them.
- Offer to listen and help even when they have not yet asked.
- Keep to this disaster only. Do not open any emotional avenues that cannot immediately be dealt with.
- Be realistically reassuring. Do not promise what you cannot control.
- Do not personalize their anger and frustrations.
- Be empathetic; tell them that you are truly sorry that such an event has devastated them. You want to understand and assist them as best as you can. **NEVER SAY "It Could Have Been Worse"** or anything like that.

This discourse is only a brief overview of the field. Much research remains to be done to more fully understand the painful, emotionally destructive effects of large-scale disasters and how to prevent and treat these debilitating problems. It is important to know that an opportunity exists to be on the cutting edge of this new developing treatment for emotional difficulty. (NIMH, 2002).

Each of the references below will lead to other informative works. If mental health practitioners are exceptionally fortunate, they may never be called upon to use their critical intervention skills. However, the reality is that major disasters do frequently occur and we must be prepared to help.

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