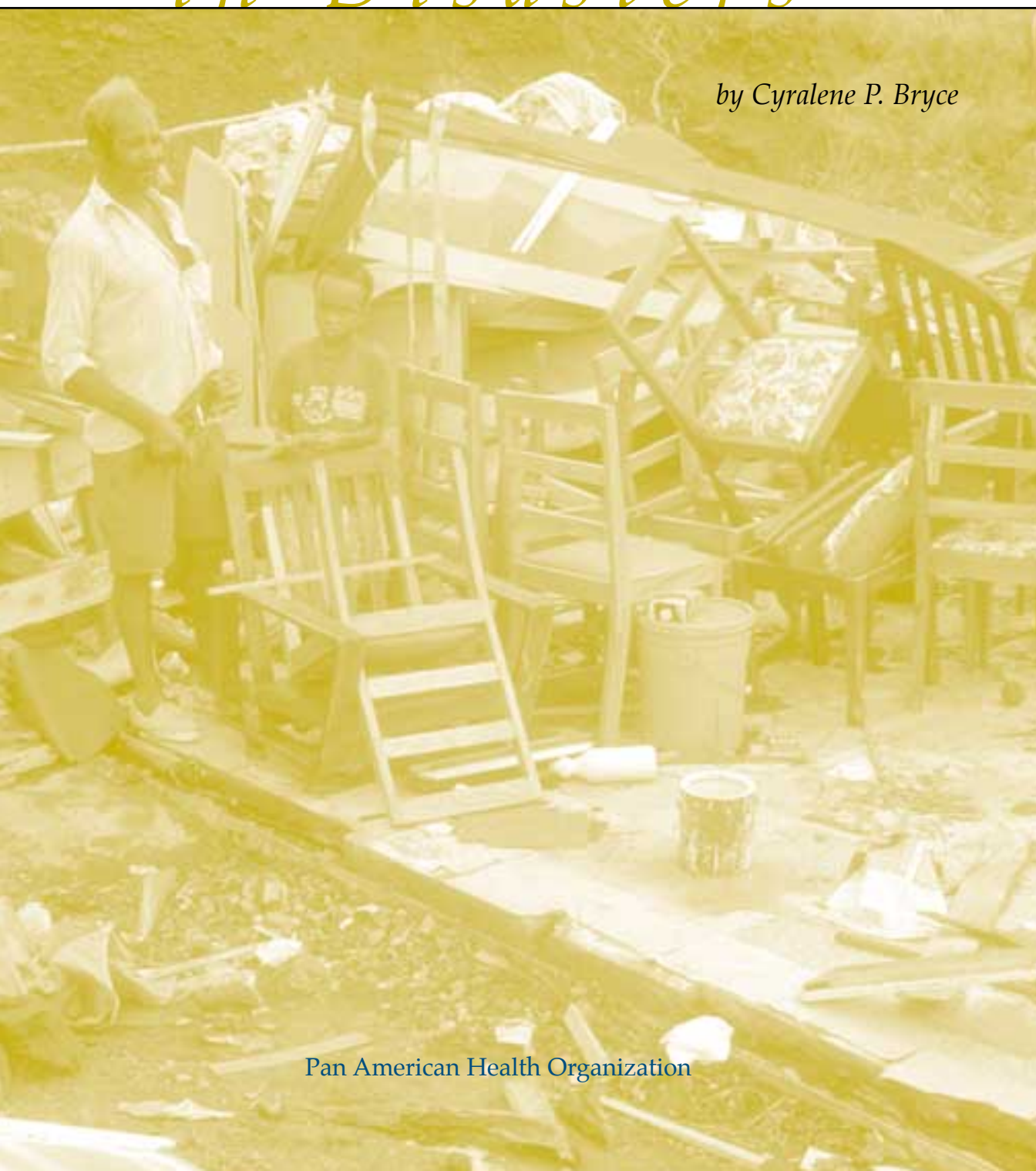
Stress Management in Disasters



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Pan American Health Organization

Stress Management

in Disasters

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Emergency Preparedness and Disaster Relief Coordination Program
Pan American Health Organization
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This workbook was developed by Dr. Cyralene P. Bryce for the Stress Management in Disasters in the Caribbean (SMID) course. It is intended to be used in conjunction with the *Insights into the Concept of Stress* workbook. It is not intended to be a complete text on the subject of stress.

The compilation of this book benefitted from the input of too many persons for them to be mentioned individually. We would, however, like to express our deepest gratitude to everyone for their invaluable contributions and criticisms.

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"When things go wrong and they sometimes will, just pick up the pieces and keep moving, never stand still." –CPB

M O T T O :

Take control and move on.

" You need to be at peace with yourself before you can be at peace with others." –CPB

C O N T E N T S

COURSE OBJECTIVES

1. Define a disaster.
2. Understand the characteristics of disasters.
3. Appreciate the possible impact of a disaster.
4. Describe the psychological profile of the emergency response worker.
5. List the possible occupational stressors encountered by emergency response personnel.
6. Outline the psychological syndromes associated with traumatic stressors.
7. Recognize the common signs and symptoms of post-traumatic stress syndromes.
8. Understand the principles of preventing and managing critical incident stress.
9. Outline the components of the SMID program.
10. Demonstrate crisis intervention and counseling skills in simulated exercises.
11. Demonstrate defusing and debriefing skills in simulated exercises.
12. Be able to plan and implement a SMID program in an organization or in the wider community.

P R E F A C E

It is universally accepted that optimum levels of stress can act as a creative, motivational force that can drive people to achieve incredible feats (eustress). Chronic or traumatic stress (distress) on the other hand, is potentially very destructive and can deprive people of physical and mental health, and at times even of life itself.

Emergency response personnel are unique in that they dedicate their time and energy in assisting persons during stressful times of their lives, for example, after disasters such as hurricanes, volcanic eruptions, earthquakes, etc. By doing this however, they are themselves repeatedly exposed to very stressful situations. Even though their training prepares them to deal with such situations, the reality is that they have a higher than normal risk for developing post-traumatic stress syndromes, including post-traumatic stress disorder (PTSD). Hence, it must be deduced that the repeated exposure of emergency response personnel to critical incident stress does have a potentially deleterious effect on their well-being. It has also been found that the psychological well-being of emergency response personnel dealing with emergency situations can greatly affect the overall outcome of such situations, including the prognosis of the primary victims of the event.

Despite all of this having been well documented and the repeated exposure of the Caribbean and Latin America to natural disasters, the vast majority of countries do not have a comprehensive stress management program in place to preserve the psychological well-being of their emergency response and disaster workers. The Program on Emergency Preparedness and Disaster Relief of the Pan American Health Organization, Regional Office for the Americas of the World Health Organization, took the initiative of bringing resource persons from throughout the region together in late 1998 to develop the Stress Management in Disasters in the Caribbean (SMID) Program.

The SMID Program is a comprehensive, peer-driven, multi-component stress management program which is administered on a volunteer basis and was designed to prevent and to mitigate the psychological dysfunction which exposure to traumatic situations like disasters may cause in emergency response personnel. The program is based on the principles of crisis intervention and critical incident stress management and it is not intended to take the place of professional therapy. Instead, it seeks to provide persons with the knowledge and skills to better understand, recognize and manage their emotional responses to traumatic situations. While the SMID Program was developed with emergency response personnel and disaster workers as its primary target group, the principles of the program, with appropriate modification, can be readily extended for use in the broader community, including with children and adolescents, to prevent and mitigate traumatic stress.

This workbook, ***Stress Management in Disasters*** and the companion workbook ***Insights into the Concept of Stress*** were designed to provide the basic training material for persons who will be providing such a service.

SECTION 1: OVERVIEW OF DISASTERS

What is a disaster?

In this workbook, a disaster will be defined as a serious disruption of the functioning of a society, causing widespread human, material or environmental losses which exceed the ability of the affected society to cope using only its own resources (WHO, 1972).

The typical result is significant disruption of normal living patterns, economic activity and communication systems. Extraordinary needs for shelter, food, clothing, medical assistance and other essential care services may follow.

What is a mass casualty incident?

A mass casualty incident is any incident where the resulting number of casualties exceed the resources of the emergency services to manage them and hence the actual number of persons affected will vary from situation to situation. A mass casualty incident may also qualify as a disaster and produce a scene of carnage so devastating that no description can adequately convey what it was like to have witnessed it. Most persons exposed to such a mass casualty incident experience some psychological dysfunction and a high percentage of such persons need help in coping.

What are the characteristics of disasters?

1. Type of event
2. Familiarity of population with the hazard
3. Predictability of event
4. Avoidability of hazards
5. Suddenness of onset
6. Intensity of the impact
7. Severity of the consequences
8. Duration
9. Course
10. Threat of recurrence

What are the phases of a disaster?

PRE-IMPACT PHASE	CONSOLIDATION PHASE:	The period during which the disaster is known to be threatening.
	WARNING PHASE:	The period when a disaster is imminent and warnings have been announced.
IMPACT PHASE		The period during which the disaster event occurs.
POST-DISASTER	CONSOLIDATION PHASE:	The period immediately following a disaster when individuals are taking stock of the situation.
	REBUILDING PHASE:	The period during which people rebuild their lives and try to bring something positive out of the ruins.

The duration of each of these phases is dependent on the type of disaster, its severity, the pre-disaster standard of socioeconomic development and level of preparedness, the availablity of resources to rebuild and the stress tolerance of those affected.

What are some of the possible consequences of disasters?

1 **Morbidity & Mortality**	• Injury • Suffering • Disease • Starvation • Death
2 **Material Losses**	• Damage • Destruction • Pollution • Economic loss • Resource depletion
3 **Social Disruption**	• Disruption of normal activities • Homelessness • Unemployment • Antisocial behavior • Civil unrest
4 **Psychological Distress**	• Helplessness • Hopelessness • Grief • Guilt • Stress

What factors determine the stressfulness of a disaster?

Features of the disaster:

- Familiarity with the event,
- Avoidability of the event,
- Suddenness of its onset,
- Intensity of its impact,
- Course and duration of the event,
- Degree to which it could be controlled.

Community or societal factors:

- The pre-existing level of resources,
- The community's level of preparedness,
- The community's past experiences with such an event,
- Extent and nature of the damage done,
- Consequent social and/or political unrest,
- Availability of resources to rebuild.

Characteristics of the individual involved:

- Previous experiences with similar events,
- Potential and actual losses,
- Physical or psychological closeness with the event,
- Level of background stress in one's life,
- Effectiveness of one's coping mechanisms,
- Nature and extent of available social support.

The realities of disasters

Although almost every segment of a population will be touched by a disaster, the poor (especially women, children and the elderly) are much more vulnerable to its devastating consequences.

Poverty usually implies sub-standard housing in areas most naturally prone to catastrophes, overcrowding, poor levels of sanitation, a shortage of basic medical services, inadequate levels of preparedness and a lack of resources with which to rebuild.

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Disasters have a way of accentuating social inequality.

The key to preventing epidemics after a disaster is to improve sanitary conditions and educate the public.

When healthy persons die in a disaster, their bodies can be left in the open for up to three days. Admittedly, this will lower the morale of survivors, cause odors and attract flies, but will not cause the transmission of disease. Hence, one needs to deal with the injured first and bury the dead after.

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Epidemics and plagues are not inevitable after every disaster.

Even though isolated cases of antisocial behavior do occur, studies have consistently shown that disaster situations bring out the best in people.

The majority of persons affected by a disaster tend to respond spontaneously and generously to help each other.

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Disasters do not invariably bring out the worst in human behavior.

PAHO/WHO

Disasters do not invariably result in food shortages.

Each disaster has its own unique effects on food supply. For example, floods may destroy crops and food stores while earthquakes hamper the distribution of such supplies.

Relief agencies are now more cognizant of the fact that excessive food donations can result in a dependence syndrome. Consequently, they are more careful to also invest in long-term solutions to food-shortages by donating agricultural supplies such as seeds and tools to ensure a new crop and to help rebuild the local economy.

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Assisting people to rebuild while they remain within their neighborhood and close to their neighbors is economically and emotionally cheaper than relocation to temporary settlements.

Persons at risk and those rendered homeless by disaster situations are usually taken in by relatives and friends with livable dwellings long before shelters can be mobilized to house them.

Those with damaged dwellings tend to prefer assistance in salvaging such dwellings to render them habitable, over relocation to emergency shelters.

"Tent cities" should only be established as a last resort. Instead, many donor agencies are now opting to use the funds that would normally have been spent on tents to purchase building materials, tools, etc., for the affected country. This not only allows affected persons to rebuild but it also serves to stimulate the affected country's economy.

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Only foreign volunteers who possess the specific skills required by the affected territories should go there after a disaster.

It is a myth that populations affected by disasters are too shocked and helpless to take responsibility for their own survival.

For example, one of the realities of any disaster is that local people come to the assistance of those who have been affected.

Foreign volunteers possessing skills already available locally serve only to deplete already scarce resources.

It is imperative that post-disaster assistance to affected communities be governed by the confirmed needs of such communities.

Every gift to a disaster-affected community has a cost to the recipient country, whether it is the cost of receiving it and transporting it or the cost of its disposal if it proves to be inappropriate.

Disaster affected countries tend to deplete the majority of their resources in the immediate post-impact phase of a disaster. Hence, their major needs for external assistance should be geared towards the restoration of normal housing, primary health care services, water systems, waste disposal systems and income-generating employment.

Consequently, effective post-disaster relief programs are those which take into consideration the fact that international interest wanes as needs and shortages become more pressing.

After a disaster, international organizations providing assistance to affected communities need to work closely with local agencies and members of the community to ensure effective and efficient operations. Local expertise needs to be utilized wherever possible.

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After a disaster, international assistance needs to be tailored to the needs of the affected community. Cash is the most flexible donation.

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International assistance which does not complement the national effort can result in chaos.

PAHO/WHO

The effects of a disaster are long-lasting and do not just fade away within a few weeks like international interest usually does.

After a disaster has struck, things do not return to normal in a few weeks. In fact, the economic, psychosocial and environmental consequences may become long-term disasters in their own right and their effects may last for years.

PAHO/WHO

The psychological consequences of disasters tend to be far more pervasive and long-lasting than their physical ones.

"Years have now passed but it seems like yesterday. I feel lost and empty. I can't get rid of the horrifying memories and the vivid images that remain in my mind. These memories, some of which are very patchy indeed, seem to haunt me all the time and I become very distressed whenever anything - a sound, a smell or a sight - remind me of my ordeal."

The following fictional accounts of natural and man-made disasters can be used as a basis for discussion about the impact of disasters on communities and emergency response personnel.

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Volcanic Eruption

"Despite several drills that were carried out in anticipation of the eruption, no one was prepared for the ferocity of the blast when it finally occurred. Previously dormant Mount Piedre in the center of the tiny Caribbean island of Guanay, which has a population of 20,000 persons, exploded with such fury that the entire island shook and the sky turned eerie red with the glow of molten lava.

"The death toll has so far reached 25 and 9 people remain missing. In the aftermath of the eruption, the majority of the island has been covered with a two-foot cloud of ash, the sky has turned to a foreboding grey as volcanic dust occludes the sun and there are reports of severe respiratory problems among the population. Survivors on the island are now being housed in a 30 square mile area on the eastern coast and the Government is pleading for international assistance. Volcanologists are predicting another major eruption within the next 72 hours."

PAHO/WHO

Hurricane

"Hurricane Lanada, packing winds of up to 160 miles per hour, swept over the hilly Caribbean Island of Toon yesterday leaving a trail of death and destruction. The initial death toll stands at 64 persons, including at least 35 children, but these figures are expected to rise sharply over the next few days as rescue and clean up operations intensify. Rescue teams are working around the clock but their efforts have been severely hampered by on-going floods and mud slides.

"The island's 500-bed General Hospital was totally destroyed. Emergency medical services are being provided at Hopes Private Hospital on the south of the Island which was also severely damaged.

"Officials from international disaster relief agencies arrived on the Island early this morning and they are now sending out an urgent appeal for tents, blankets, canned food and emergency medical supplies."

Hurricane Categories and Wind Speeds:

(a)	Tropical depression:	35 mph
(b)	Tropical storm:	39-73 mph
(c)	Hurricane 1:	74-95 mph
(d)	Hurricane 2:	96-110 mph
(e)	Hurricane 3:	111-130 mph
(f)	Hurricane 4:	131-155 mph
(g)	Hurricane 5:	>155 mph

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Floods

"It has been 2 weeks now since heavy rains caused the River Mama in the Zesta Valley to overflow its banks. For days the densely populated village of Perva on either side of the river's banks was under as much as 20 feet of water at one time.

"Two elderly gentlemen who refused to be evacuated lost their lives in the floods. All of the village's crops were destroyed and thousands of domestic animals drowned in the floods. The proper disposal of the carcasses of these animals is proving difficult and there has been an outbreak of salmonella in two nearby villages.

"Most of the houses in the village, which were made of pine, were washed away as well. An estimated 8,000 adults and 6,000 children have been left homeless. A number of these Perva villagers who are being housed in emergency shelters in nearby villages have come down with gastroenteritis and influenza.

"An interview of persons in the emergency shelters revealed a sense of helplessness and hopelessness and a middle-aged villager summed up his feelings nicely by stating that he didn't know if he was standing on his feet or on his head!"

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Oil Spill

"The romantic Caribbean island of Ailam has a population of 1.5 million persons and is well known internationally for its beautiful beaches, its exquisite cuisine and its water sports. Tourism is the island's major foreign exchange earner. Its west coast is home to 12 of the Island's 14 five-star hotels e.g., Heaven Bay Luxury Resort where the Oscar Award winning movie, "Dreamers' Paradise" was filmed late last year. During the height of the tourist season this year, hoteliers recorded occupancy rates as high as 106%.

"But all that has now changed. Early one morning, residents of Ailam flocked from all parts of the Island in disbelief to see for themselves the damage which had been done to the west coast of their Island. Not even the oldest people on the Island had ever seen anything like this.

"Late the evening before, it had been noted for the first time that the majority of the west coast seas were covered with large 'islands' of what appeared to be crude oil. As the waves bashed against the previously golden beaches they became a greasy, ghostly black. Masses of seriously injured or dead fish, crabs, turtles and birds could be seen all along the coast line. Authorities speculated that a tanker which had passed in the Island's waters two days before might have been the cause of the disaster.

"With exactly one month now having passed since this very tragic incident, thousands of persons in Ailam are now out of work as over 75% of the island's west coast hotels and ancillary businesses have had to close their doors. The Prime Minister has estimated the loss in revenue so far to be well over 50 million U.S. dollars and things are expected to get much worse as potential visitors to the island are now being deterred by overseas travel agents from travelling to Ailam at this time. Elements of social unrest are already evident on the Island and yesterday, the Minister of Finance increased consumption tax from 8% to 12% in a desperate attempt to assist those who have found themselves without a job."

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Ferry Accident

"It was now the 2nd week of the Regional Young Explorers Summer Camp which was being held this year in eastern Seraino. Earlier that morning, a party of 138 Young Explorers and camp officials had set off in a ferry up the River Louda for a scenic tour of the rain forest.

"The river was calm and the weather was enjoyable. Crocodiles basked on the river's edge and monkeys of all descriptions dashed from tree to tree. Herds of healthy buffalo and goats grazed the lush pastures that punctuated the river's banks. Ducks, geese, flamingos and egrets were to be seen everywhere and they intermingled freely.

"Without warning, the River Louda became turbulent and, as if in a rage, it dashed the ferry in which the Young Explorers were travelling. The ferry was tossed against an island of rocks downstream and it sank quickly.

"Rescue divers responsible for the area arrived on the scene quickly but they had to proceed with extreme caution since the waters in which the ferry sank were crocodile infested. Six hours after this very tragic incident, 36 persons were rescued having received only minor injuries and 18 persons who almost drowned are in critical condition in the Intensive Care Unit of the San Viesta Hospital. Thirteen other persons drowned and 8 were mauled by the crocodiles. The remaining 59 persons have not yet been found but a high percentage of them are feared dead at this time. Additional rescue divers are being flown in from all over the region to assist with this operation."

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Airplane Crash

"It was an unusually quiet day at the Seajet International Airport on the Caribbean Island of Uesta. At 17:35 hours an A.L.D. Airlines Boeing 747 jet with 312 passengers and crew destined to Beckdon, South Campden, taxied down the runway.

"Soon after its take off, a loud noise was heard and the rear of the aircraft burst into flames. The fire soon consumed the entire aircraft and the burning wreckage dived into the nearby, heavily populated village of Hillford Terrace and exploded. The charred remains of humans could be seen everywhere.

"Emergency response personnel arrived on the scene quickly and have worked around the clock in this very hilly village to locate survivors of the disaster; 48 hours after the crash, its cause remains unknown.

"Hundreds of injured persons are being treated in the island's two general hospitals. Four emergency medical tents have also been set up near the site of the incident. The bodies of 168 adults and 64 children have been recovered so far but they are so badly disfigured that identification is proving to be very difficult. The death toll is expected to escalate as rescue operations continue."

PAHO/WHO

Riots

"For three consecutive days, riots have disrupted the usually peaceful Island of Botha. The streets erupted with uncontrolled violence following the Government's announcement of its austerity program in which salaries would be cut and basic food prices hiked by at least 15%. Extensive looting and property damage has been reported throughout the capital, Peace Town.

"Initial estimates have put the death toll at 123 persons including at least 12 children and 20 law enforcement personnel. Police were taken completely by surprise at the severity of the violent outbreak. Although the situation is now somewhat under control, the Prime Minister in his national emergency address today indicated that schools and businesses would remain closed until the end of the month. Peace-keeping troops from neighboring countries are expected to arrive on the island by the end of the week by which time the state of emergency should be relaxed."

PAHO/WHO

School Bus Accident

"Yesterday afternoon on East Park Road, during a bout of heavy rain, a bus carrying 30 school children collided with two cars and overturned just feet from the Boulevard Bridge. Loud screams could be heard coming from the bus and there was blood everywhere. Scores of people gathered quickly at the scene making it very difficult for emergency response personnel to function.

"Three of the children travelling on the bus and the bus-driver were pronounced dead at the scene of the accident and six of the children were seriously injured and had to be admitted to the nearby Lakes Field Hospital. Twelve other children suffered only minor injuries and were treated and discharged. The others escaped injury but were understandably very distressed.

"The three occupants of one car escaped with only minor injuries but both occupants of the second car had to be cut free by fire service personnel. The driver of this car was pronounced dead on his way to the hospital. His wife, the passenger in the car, is now stable but in critical condition in the Surgical Intensive Care Unit at Lakes Field Hospital having suffered major head and chest injuries."

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House Fire

"Mrs. Asta had left 4 year old Brittany and 6 year old Percival at home to go to a nearby shop to purchase some vegetables to finish preparing Mr. Asta's lunch by mid-day. On her way back home, she heard people screaming and saw smoke coming from her street.

"By the time Mrs. Asta turned the corner she realized that a whole stretch of houses on her side of the street were on fire—her little wooden house was flat. Mrs. Asta fainted. Brittany and Percival were nowhere to be seen.

"A neighbor stated that a blaze had started in the back of Mrs. Asta's house which was soon completely burned; the blaze spread rapidly to nearby houses. Attempts to rescue the screaming children were futile.

"Fire officials arrived on the scene quickly but the most that they could do was to contain the blaze from spreading any further. The fire claimed the lives of the two children and three elderly, handicapped ladies. Seven houses were destroyed and over 50 persons are now homeless."

End of Section Quiz

Please circle the correct answer.

1.	The consolidation phase of a disaster is the period during which the disaster is known to be threatening.	T	F
2.	Mass hunger is inevitable after every disaster.	T	F
3.	Disasters only cause physical damage, not psychological instability.	T	F
4.	Civil unrest is very common after disasters.	T	F
5.	Disasters have a way of accentuating social inequality.	T	F
6.	Relocating disaster victims in temporary settlements is the best alternative once people's homes have been damaged.	T	F
7.	A community's level of preparedness can affect the stressfulness of a disaster.	T	F
8.	In most disasters, the local population deals with the immediate life-saving needs of that population.	T	F
9.	The threat of recurrence of a disaster makes it particularly stressful.	T	F
10.	International organizations must direct all relief activities in disaster stricken countries.	T	F

Note: Answers to questions are on page 128.

N O T E S

SECTION 2: PSYCHOLOGICAL RESPONSES TO TRAUMATIC STRESSORS

The following is a fictional account, but is representative of psychological response to a traumatic event.

"It was the last day of August when the sunset took on an eerie gloom. As I sat in my office on the fifth floor of the island's largest commercial bank trying to complete another day's chores, the building seemed to shake. But why? As I stopped to think about it, the shaking became more and more pronounced until finally amidst screams coming from everywhere I heard a loud crash.

"Where am I? What is happening? I can't see very well but there is a stench pervading the air and I can't hear anyone no matter how hard I listen. There is a large object on my left leg and a heavy piece of concrete on my chest. It is very difficult to breathe and words fail me to describe the pain that I am feeling. How long have I been here? I feel weak and unable to move. Surely, death can't be far away!

"It is now two months since I have been in hospital recovering from my injuries. Despite the loss of my left leg, it is a miracle that anyone found me and that I was still alive. My relatives are grateful to the rescue workers and the nurses and doctors for saving my life but over the past few weeks I pray to die since life tortures me mercilessly.

"My mood keeps fluctuating and at times I become intensely anxious with bouts of sweating, palpitations, hyperventilation, screaming and hostility. At other times, I feel lost and empty. I can't get rid of the horrifying memories and the vivid images that remain in my mind. These memories, some of which are very patchy, seem to haunt me all the time and I become very distressed whenever anything —a sound, a smell or a sight—remind me of my ordeal. I dislike talking about my experiences and avoid anything that reminds me of them. In addition, I feel very guilty that I have survived and so many of my work colleagues died in the incident.

PAHO/WHO

"I have only been recently weaned off the ventilator and yesterday Dr. Browne, a psychiatrist, visited me for the first time. He thinks that I'm suffering with that PTSD thing and he has started me on medication and assured me that I'll be better. Well, I've heard him but how can I really believe him? He can't possibly understand what is happening to me!"

What is a traumatic stressor?

Any event which is outside of the realm of normal human experience and very distressing is a traumatic stressor or critical incident. Such events usually involve a perceived threat to the physical integrity of the individual and evoke reactions of intense fear, horror and/or helplessness. ***It should be noted, nonetheless, that tragedies have frequently been the source of new ideas, discoveries and technologies.***

Examples of traumatic stressors include:

- Line of duty injury or death,
- Injury or death of children,
- Serious automobile accidents,
- Fires,
- Floods,
- Hurricanes,
- Mud slides,
- Volcanic eruptions,
- Earthquakes,
- Major explosions.

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What is psychotraumatology?

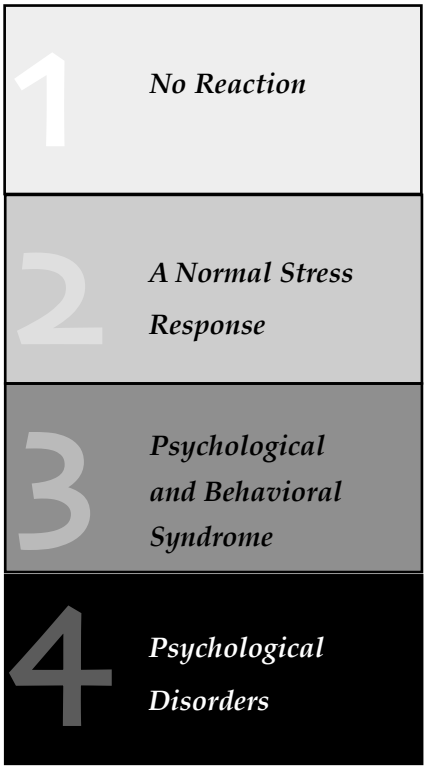
Psychotraumatology refers to the study of psychological trauma. Four major influences can be identified as having set the foundation for this field; they are disaster psychology, the psychology of violence and war, law enforcement psychology and the occupational health considerations of persons who routinely work in traumatic situations.

Who are the potential victims of a traumatic stressor?

Depending on the type of exposure to a traumatic event, we can classify potential victims into three categories:

1 **Primary Victims**	Those individuals most directly affected by the event, e.g., the persons whose houses are blown down in a hurricane.
2 **Secondary Victims**	Those individuals who in some way observe the consequences of the traumatic event on the primary victims, e.g., bystanders, rescuers and emergency response personnel.
3 **Tertiary Victims**	Those individuals who are indirectly affected by the traumatic event as a result of later exposure to the scene of the trauma or to the primary or secondary victims of the trauma, e.g., family members of primary or secondary victims or passers by.

What are some of the possible psychological and behavioral responses of persons after they have been exposed to a traumatic situation?



Exposure to any serious event can have negative short- or long-term consequences which may include deterioration in one's physical and/or psychological well-being, impaired social and occupational functioning, relationship breakdowns, and attempted and successful suicides.

The possible range of reactions are very complex and they vary enormously in severity and type. They are also very dependent on the individual affected. Such reactions range from negative feelings to psychiatric disorders and they pass through a series of phases. One third of those exposed to a traumatic stressor experience little or no distress, one third experience moderate distress and the remaining one third have severe distress. Such reactions may be immediate or delayed and other stressors in one's life may influence this process.

It should be noted that there are persons who, when exposed to traumatic stressors like a natural disaster may experience distress but retain their ability to objectively appraise the situation and decide how to manage it. Such persons tend to lead and console others and organize rescues.

Sometimes exposure to traumatic stressors can produce very intense arousal which may overwhelm the individual's coping mechanisms. Such hyperarousal is thought to come about because of the dysfunction of a number of inter-related neurochemical systems in the brain, e.g., the noradrenergic system, the opiate system and the hypothalamic-pituitary-adrenal axis. Minimization of the intensity and duration of such arousal decreases the resultant neurochemical dysfunction which in turn decreases the risk of a post-traumatic stress syndrome developing.

Like adults, children and adolescents who are exposed to traumatic stressors show a wide range of complex reactions which may also be immediate or delayed. These reactions tend to differ from those of adults in that they are age-dependent, they can have a profound effect on the child or adolescent's future development and they are strongly influenced by the adults with whom the child or adolescent may come into contact. Nonetheless, the majority of children and adolescents do quite well after exposure to traumatic situations.

Of those people who experience a distress reaction:

1. Some may recover on their own with only minimal assistance from their support network;
2. Some benefit from the services of a stress management team; and
3. Some need professional assistance to achieve maximal recovery.

By whatever means, the majority of persons exposed to such stressors achieve satisfactory levels of recovery. The memories of a traumatic incident may persist, but even in such cases the impact can be significantly reduced if managed appropriately. Obtaining appropriate assistance can make the difference between a fairly short, painful reaction and a prolonged, complex, more painful one.

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What are the possible phases of such responses with respect to disaster situations?

PRE-INCIDENT *(if appropriate)*	PRE-IMPACT PHASE:	The majority of persons make some effort to prepare for the potential impact of a disaster. Others become indifferent and deny that there is any impending danger and still others become anxious and somewhat disorganized. A few persons remain quite calm and focused.
	WARNING PHASE:	During this phase a greater proportion of persons tend to become agitated and over-react but a few continue to remain calm and purposeful.
IMAPCT PHASE		Persons tend to be fearful and they attempt to cope by either giving up, running away or rescuing others.
POST-INCIDENT	HEROISM PHASE:	During this phase, efforts are made to survive and to recover property. This is a time of great altruism and overwork with possible irritability and exhaustion.
	HONEYMOON PHASE:	Persons tend to share their experiences. Good outcomes are anticipated and hope and elation prevails.
	DISILLUSIONMENT PHASE:	Disappointment occurs when aid is not as readily forthcoming as was anticipated and some people are seen as less fortunate than others. Depression often follows.
	REBUILDING PHASE:	People need to accept that they must depend on themselves if they are going to move on and rebuild their lives. Failure to do this leads to bitterness and animosity.

What constitutes a normal distress response after exposure to a traumatic stressor?

Critical incidents are typically sudden, intensely distressing events which are outside of the realm of normal human experience. Because they are so sudden and unusual, they can have a strong emotional effect on even well-trained, experienced people.

Approximately 86% of individuals exposed (directly or indirectly) to a traumatic event or critical incident tend to have some kind of reaction within 24 hours of the incident but such reactions may be delayed for days to weeks. Stress reactions of this kind constitute "traumatic stress" or "critical incident stress" and they may be mild, moderate or severe.

These are ***common reactions of normal people*** in response to an ***abnormal situation*** and their occurrence does not indicate that the person has developed a psychiatric disorder.

Such reactions may range from negative feelings to a wide range of physical, cognitive, emotional and behavioral signs and symptoms to post-traumatic stress syndromes. Any combination of these manifestations may go together to constitute a normal distress response.

Depending on the nature of their involvement with the traumatic event persons may experience various negative feelings. Survivors of the trauma may experience feelings of shock, uncertainty, helplessness, isolation, guilt, fear and anxiety, and they may blame themselves and/or others for what happened. In contrast, responders to the trauma tend to experience feelings of inadequacy, frustration, powerlessness, fear, insecurity and guilt. Finally, relatives of both survivors and the injured or deceased may experience feelings of shock, uncertainty, helplessness, separation anxiety, grief and guilt; they may also blame themselves and/or others for what happened.

Below is a list of some of the most common physical, cognitive, emotional and behavioral signs and symptoms which may follow exposure to a traumatic event.

Physical:

- Rapid heart rate
- Elevated blood pressure
- Increased perspiration
- Difficulty breathing
- Feeling faint
- Tremor

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Cognitive:

- Racing thoughts and/or feeling confused
- Memory impairment
- Poor attention span and concentration
- Difficulty making decisions
- Intrusive memories and/or flashbacks
- Change of one's awareness of one's surroundings

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Emotional:

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- Feeling overwhelmed and/or detached
- Hopelessness and/or helplessness
- Fear and/or avoidance of similar situations
- Irritability
- Anger and/or hostility
- Grief
- Questioning of one's religious values

Behavioral:

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- Hyperarousal
- Social withdrawal
- Sleep disturbances
- Change in eating habits
- Loss of interest in previously pleasurable activities
- Substance use
- Absent-mindedness and being prone to accidents

Finally, exposure to a traumatic stressor may result in post-traumatic stress syndromes which are characterized by three clusters of signs and symptoms and which do not meet the diagnostic criteria for a diagnosis of post-traumatic stress disorder (PTSD). Below is a list of the three clusters of signs and symptoms.

Re-experiencing:

- Recurrent, intrusive and distressing recollections of the event
- Recurrent and distressing dreams about the event
- A sense of reliving the experience
- Illusions
- Hallucinations

- Dissociative flashback episodes
- Intense physiological and psychological distress on exposure to internal or external cues that symbolize or resemble the traumatic event in any way

Hyperarousal:

- Restlessness
- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Racing thoughts
- Inability to concentrate
- Hypervigilence
- Exaggerated startle response

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Avoidance:

- Avoidance of thoughts, feelings or conversations associated with the trauma
- Avoidance of activities, places or people that arouse recollections of the trauma
- Inability to recall an important aspect of the trauma
- Markedly diminished interest or participation in significant activities
- Feelings of detachment or estrangement from others–social withdrawal
- Restricted range of feelings–numbing
- Sense of a foreshortened future

If unmanaged, approximately 22% of persons who experience critical incident stress will still be symptomatic for 6 - 12 months after the event and approximately 4% will be at risk for developing post-traumatic stress disorder (PTSD).

What are some of the possible psychological and behavioral syndromes associated with traumatic events?

- Denial and/or indifference
- Resistance to evacuation
- Excessive substance use
- Despair and "paralysis"
- Panic
- Survival guilt
- Post-incident dependence


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What are some of the possible psychiatric disorders which may be associated with exposure to a traumatic event?

- Acute stress disorder
- Post-traumatic stress disorder (PTSD)
- Generalized anxiety disorder (GAD)
- Panic disorder
- Adjustment disorders
- Major depression
- Substance-related disorders
- Brief psychotic disorder
- Somatoform disorders
- Dissociative disorders
- Personality disorders


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What is post-traumatic stress disorder (PTSD)?

PTSD is a formally recognized psychiatric disorder which may result from exposure to a traumatic event, where a traumatic event is any event which would be markedly distressing to almost anyone and which often produces intense fear, terror or helplessness (American Psychiatric Association, 1994). ***However, recent research in this field has placed greater emphasis on a person's subjective response to the trauma than on the severity of the trauma itself.***

The lifetime prevalence of PTSD is 1%-3% in the general population, 15%-20% in emergency response personnel and 26%-30% in Vietnam War Veterans.

Despite these high figures, it is still believed that the prevalence of PTSD is significantly under-reported. With respect to emergency response personnel it is even further under-reported for the following reasons:

1. The destruction of the personal illusion of invulnerability,
2. The fear of alienation by peers, and
3. The fear that concerns will be raised about the possibility of a previously undiagnosed or undisclosed weakness.

J.L. Herman (1992) has described a variant of PTSD referred to as ***"Complex" PTSD*** which may result from chronic traumatization or repeated bouts of acute traumatization.

PTSD is characterized by impaired functioning and three clusters of symptoms that follow a psychologically distressing event which is considered outside of the range of ordinary human experience:

1. Re-experiencing,
2. Hyperarousal, and
3. Avoidance.

What factors increase one's vulnerability to developing post-traumatic stress disorder?

1. Exposure to severe injury or abuse;
2. Associated feelings of intense fear, horror or helplessness;
3. Socioeconomic background;
4. Background levels of stress;
5. Genetic - constitutional vulnerability;
6. Dysfunctional personality traits, cognitions or behaviors;
7. Perception of an external locus of control;
8. A history of childhood trauma;
9. Inadequate social support or family dysfunction;
10. Associated fatigue, starvation, dehydration or extremes of temperature;
11. Exposure to various substances, e.g., recent excessive alcohol use;

12. Associated feelings of severe guilt or shame;

13. Associated feelings of inadequacy, betrayal or spiritual conflict.

What is the risk of emergency response personnel developing post-traumatic stress syndromes?

Emergency response professionals (emergency response personnel, public safety personnel, nurses, doctors and disaster workers) are at a higher than normal risk for developing post-traumatic stress syndromes because they routinely find themselves working in very traumatic situations. Although the majority of emergency response workers because of their training, experience and mental preparation usually respond to traumatic situations without emotional reactions, various studies have estimated their life-time prevalence of developing post-traumatic stress disorder (PTSD) at 15%-20%.

It is generally accepted that the psychological well-being of emergency response personnel dealing with an emergency greatly affects its overall outcome, including the health of the primary victims of the trauma. Clearly, the development of potentially disabling syndromes in emergency response personnel need to be prevented at all cost.

Apart from repeated exposure to traumatic situations, what other factors might predispose emergency responders to experience critical incident stress?

Emergency response workers tend to have personality traits that help them to do a good job, but these same traits may increase their vulnerability to stress reactions. These traits include:

1. High levels of internal motivation;
2. An action-oriented approach to challenges;
3. A dedication to their jobs which they view as life-long careers;
4. A need for stimulation and excitement;
5. A rescue personality with a willingness to take risks;
6. A need to see quick results;
7. A strong need to be needed;
8. A tendency to deny the possibility of being affected emotionally by traumatic incidents;
9. Reluctance to accept change;
10. A need to be in control and to do a perfect job.

It must also be noted that organizational stressors can raise the job-related stress levels of emergency response personnel which would in turn increase their susceptibility to critical incident stress reactions. Below is a list of possible organizational stressors:

1. Inappropriate reward for the job done;
2. Unreasonable demands;
3. Lack of opportunity for participation in the decision-making process;
4. Problems with feedback;
5. Too much uncertainty;
6. Poor organizational style;
7. An unsupportive or threatening work environment;
8. Poor staff relations;
9. Lack of opportunity for self-actualization and career development.

The following account is fictional, but is an illustration of a situation in which organizational stressors exist and put staff performance at risk.

The Quality Assurance Committee of the Hopetown General Hospital called an urgent meeting with the Chief of the Medical Staff, the Matron and all medical and nursing staff attached to the Accident and Emergency Department of the hospital.

The Committee was very concerned that despite there having been no increase in the number or change in the spectrum of cases being handled by the Department, the number of acutely ill persons dying in the Department, the number of complaints from users of the Department and the number of medico-legal settlements related to the Department had increased steadily over the past year, with an all time high last month.

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The problem seemed to have started about two years before when a new style of management was implemented in the Department. Staff who attended the meeting appeared to be quite frustrated, demoralized and disillusioned. They complained about:

1. *Inadequate staffing of the Department;*
2. *Frequent staff changes;*
3. *Unreasonable working hours;*
4. *Very poor staff relations;*
5. *Unhealthy competitiveness among staff at all levels;*
6. *A very dictatorial and ill-defined management hierarchy;*
7. *Over-emphasis of the status quo;*

8. *Lack of opportunity for staff to participate in the decision-making process;*
9. *Feedback only about poor performance;*
10. *Gross insensitivity of senior management;*
11. *Clear evidence of favoritism;*
12. *Lack of accountability for all;*
13. *Verbal abuse from the public and poor security;*
14. *Lack of cooperation from interfacing departments.*

At the end of the emotionally charged four hour meeting, the Chairperson of the Committee thanked staff for their frankness and expressed surprise at the majority of information that had come to light. She then pledged to have the matter thoroughly investigated during the upcoming month. In the meantime, she promised that there would be urgent recruitment of 8 doctors and 20 nurses, even if only on a part-time basis initially.

Before the official closure of the meeting, one young nurse who was new to the Department advised that there was also an urgent need for a comprehensive stress management program to be put in place for staff in the Department.

Is it possible for emergency responders to be overwhelmed by the magnitude of some traumatic events?

Emergency responders can sometimes be so overwhelmed by the nature and/or magnitude of a traumatic event and by the conditions under which they have to function that their performance is significantly impaired. If this does happen, the affected person must be allowed to withdraw from the scene.

It must be understood by everyone that if an emergency responder feels the need to withdraw from a situation this does not mean that he/she has "copped out" or that he/she is ineffective. Instead, withdrawal should be viewed as a form of mature and responsible behavior which should be highly commended. Such an individual may still be able to function effectively in routine situations.

All emergency responders should be trained to recognize when they have become dysfunctional. If such a situation does occur the responder should report to their supervisor and withdraw from duty.

Exercise:

What impact did exposure to a recent traumatic stressor have on you?

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Try to remember the most recent traumatic event to which you were exposed within the last 24 months.

What was your involvement with that incident?

_____

_____

_____

What was the date of the incident?

_____

Read each symptom below carefully, then circle the answer which best describes the frequency of any of the symptoms that you may have experienced after exposure to the traumatic event. Please see Appendix 1 for an interpretation of the total score.

		Never	*Sometimes*	*Often*	*Always*
1.	Any reminder brought back feelings about the experience.	1	2	3	4
2.	I felt afraid of and avoided similar situations.	1	2	3	4
3.	I tried not to think of and/or talk about the incident.	1	2	3	4
4.	I felt numb and detached from the incident.	1	2	3	4
5.	Pictures of the incident kept popping into my mind.	1	2	3	4
6.	I would try to deny that the incident did really happen.	1	2	3	4
7.	I would dream about the incident.	1	2	3	4
8.	I would think about the incident even when I didn't want to.	1	2	3	4
9.	I would get very strong feelings about the incident.	1	2	3	4
10.	I would find it difficult to fall asleep because of pictures or thoughts about the incident that would keep entering my mind.	1	2	3	4
11.	I would try very hard not to get upset when I remembered or thought about the incident.	1	2	3	4
12.	I became irritable and hostile for no good reason.	1	2	3	4
13.	I lost interest in my job and in previously pleasurable activities.	1	2	3	4
14.	I started using substances, e.g., nicotine, caffeine, sedatives, hypnotics, cannabis, cocaine, etc.	1	2	3	4
15.	My eating habits changed.	1	2	3	4

16.	I became socially withdrawn and found it difficult to relate to other people.	1	2	3	4
17.	I felt overwhelmed and helpless with no sense of a future.	1	2	3	4
18.	I had difficulty concentrating and/or making decisions.	1	2	3	4
19.	My thoughts would race and/or I felt confused.	1	2	3	4
20.	I felt guilty and/or started to question my religious values.	1	2	3	4
21.	I experienced memory impairment and/or became accident prone.	1	2	3	4
22.	I became preoccupied with possible unknown threats.	1	2	3	4
23.	I felt anxious.	1	2	3	4
24.	I felt "moody" and/or depressed.	1	2	3	4
25.	I experienced a number of unexplained physical complaints.	1	2	3	4

Total Score: _____

Exercise:

As a service provider, what is your level of work-related stress?

Read each statement below carefully, then circle the best answer to each question as it relates to the preceding 12 months of your life and find the total score. Please see Appendix 1 for an interpretation of the total score. Note carefully that tests like these serve only to alert us that there may be a problem.

		Never	*Sometimes*	*Often*	*Always*
1.	I feel that too much is expected of me.	1	2	3	4
2.	Just thinking about going to work makes me feel angry.	1	2	3	4
3.	I view the persons whom I have to serve as objects.	1	2	3	4
4.	I feel as if my job is "eating away my flesh".	1	2	3	4
5.	I feel overwhelmed and helpless.	1	2	3	4
6.	I have become isolated at work.	1	2	3	4
7.	I feel frustrated with my job.	1	2	3	4
8.	I find it difficult to concentrate at work.	1	2	3	4
9.	I use coffee, tobacco, alcohol and/or other drugs to try and cope.	1	2	3	4
10.	My work no longer brings me satisfaction.	1	2	3	4
11.	I am unable to empathize with others.	1	2	3	4
12.	I no longer care about the quality of my work.	1	2	3	4
13.	My job leaves me feeling emotionally exhausted.	1	2	3	4
14.	I am unable to provide a personalized service.	1	2	3	4
15.	I find it difficult to make decisions at work.	1	2	3	4
16.	My work attendance is poor.	1	2	3	4

17.	I feel the need to resign my job.	1	2	3	4
18.	I have become irritable and confrontational on the job.	1	2	3	4
19.	I dislike my job but I work because I need the money.	1	2	3	4
20.	My work performance has declined and I seldom finish anything.	1	2	3	4
21.	My work relations with my co-workers and my boss have declined.	1	2	3	4
22.	I feel inadequate and/or like a failure with respect to my job.	1	2	3	4
23.	I get suicidal and/or homicidal ideas because of my job.	1	2	3	4
24.	I have become disorganized on the job.	1	2	3	4
25.	I have become absent-minded and accident prone at work.	1	2	3	4

Total Score: _____

End of Section Quiz

Please circle the correct answer.

1.	Major depression can occur after exposure to a traumatic stressor.	T	F
2.	Re-experiencing, arousal and psychosis are the three basic signs and symptoms that may follow exposure to a traumatic stressor.	T	F
3.	Emergency service personnel are usually eager to admit that they may be having a distress reaction.	T	F
4.	The death of a child is not a very traumatic event.	T	F
5.	A feeling of confusion may result after exposure to a traumatic stressor.	T	F
6.	Exposure to traumatic stressors can produce very intense arousal.	T	F
7.	PTSD is a formally recognized psychiatric disorder.	T	F
8.	The intensity and duration of the stress reaction after exposure to a traumatic stressor can be minimized.	T	F
9.	Memory impairment may follow exposure to a disaster situation.	T	F
10.	The incidence of PTSD is believed to be significantly over-reported.	T	F

Note: Answers to questions are on page 128.

N O T E S

SECTION 3: AN OVERVIEW OF SMID

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Despite the fact that stress management after exposure to a traumatic event has been highlighted for some time now, some people still believe that it is either not needed or that only weak and inadequate persons need such support services. Meanwhile, many people suffer through the painful reactions which they experience in silence.

What is SMID?

Stress Management in Disasters (SMID) refers to a comprehensive, peer-driven, multicomponent stress management program that is administered on a volunteer basis. It is designed to minimize the psychological dysfunction that exposure to traumatic situations like disasters may predispose emergency response personnel.

The SMID Program is based on principles of crisis intervention and critical incident stress management and it is not intended to take the place of professional therapy. Instead, it seeks to provide persons with the knowledge and skills to better understand, recognize and manage their emotional responses to traumatic situations.

While the SMID Program was developed in Caribbean countries with emergency response personnel and disaster workers as its primary target group, the principles of the program, with appropriate modification, can be readily extended for use in the broader community, including children and adolescents, to prevent and mitigate traumatic stress.

What is the rationale behind the SMID Program?

Disasters need to be viewed as longitudinal processes where different types of interventions will be needed at different phases of the disaster. After the physical damage from a disaster has been cleared, there are layers and layers of emotional devastation left behind. For this reason, you can not just treat the physical symptoms and expect the emotional ones to go away. But unfortunately, all too often instead of being proactive about managing challenging situations we tend to be reactive and suffer the consequences.

Unfamiliar disasters are more likely to be psychologically disturbing than familiar ones and those with sudden and unanticipated onset are more stressful than anticipated ones. Disasters that expose persons to life-threatening situations, major injury or death and those that have an intense impact and result in extensive damage are more likely to be associated with stress reactions. In addition, disasters that are prolonged or followed by long periods of the threat of recurrence after the initial impact may be especially stressful.

The hyperarousal that may result from exposure to traumatic stressors like disasters is thought to come about because of the dysfunction of a number of inter-related neurochemical systems in the brain, e.g., the noradrenergic system, the opiate system and the hypothalamic-pituitary-adrenal axis.

The severity of hyperarousal and its harmful effects have been found to depend on the individual's subjective response to the stressor and to how they rate their ability to deal with it. *People who generally cope successfully with stressful situations have a variety of personal attributes that minimize the levels of distress to which they are exposed. Such persons know how to approach situations for which they do not have a readily available response.* These observations have been further substantiated by recent research in the field of post-traumatic stress disorder (PTSD) which now places greater emphasis on a person's subjective response to a traumatic situation in determining their risk for developing the disorder than on the severity of the trauma itself. In addition, even though formal research in this area is lacking, it has been consistently observed that prompt interventions to minimize the intensity and the duration of the hyperarousal that follows exposure to traumatic stressors decreases the resultant neurochemical dysfunction. In other words, we do have some control over what happens to us psychologically after we have been exposed to traumatic situations.

Emergency response personnel and disaster workers are unique in that they are repeatedly exposed to very stressful situations. Even though their training prepares them to deal with such situations, the reality is that they have a higher than normal risk for developing post-traumatic stress reactions, including post-traumatic stress disorder (PTSD). It can be deduced that the repeated exposure of emergency response personnel to critical incident stress does have a potentially deleterious effect on their well-being. In addition, it has been

found that the psychological well-being of emergency response personnel dealing with emergency situations can in turn greatly affect the overall outcome of such situations, including the prognosis of the primary victims of the trauma.

It was realizations like these that led to the development of this SMID Program. Initially developed for emergency response personnel and disaster workers in the Caribbean, this program is aimed at preserving the psychological well-being of such personnel by assisting them to prevent, mitigate or better control the stress reactions they may experience after exposure to traumatic situations. Like any other stress management program, the basic strategies to be employed are avoidance of possible stressors, minimization of the resultant stress arousal and the reduction of any such arousal which does occur. For such a program to be effective, there needs to be appropriate and on-going preparation for coping with the eventualities of traumatic situations like critical incidents and disasters.

What are the goals of SMID?

1. To help persons to understand the possible responses that may follow exposure to a traumatic stressor;
2. To provide persons with the knowledge necessary to better manage stress reactions;
3. To promote worker health and well-being;
4. To prevent traumatic stress reactions; and
5. To accelerate recovery and restore functioning after a traumatic stress reaction.

How should disaster-related mental health interventions be organized?

- Give clear and concise warnings and advice;
- Buffer the news of traumatic loss and avoid grotesque details;
- Temper the media, while emphasizing that the provision of accurate disaster-related information is vital;
- Involve critical decision-makers in the community in all disaster-related interventions;
- Before deciding on the type of mental health services to be offered, seek advice from representative groups of survivors;
- Whenever possible, make use of available local expertise to provide such services;
- Stabilize crisis situations and attend to more basic needs like food, clothing, shelter and safety before embarking on trauma therapy;

- Embark on active outreach programs—persons most in need of mental health services tend not to seek them;
- Provide socially and culturally appropriate, well-coordinated mental health interventions which offer a full range of services and cater to the needs of children and adolescents as well as adults;
- Ensure that interventions are prompt and personalized;
- Provide adequate opportunity for persons to verbalize their experiences, thoughts and feelings;
- Seek to empower survivors so that they assume a state of independence and not dependence—direct them to available resources and services;
- Encourage the formation and activities of local support networks;
- Stress the importance of learning from one's experiences and those of others and moving on;
- Elicit feedback from those persons for whom the services were intended.

When should such interventions occur?

R. Post (1992) argues that early intervention may prevent a neurologically lowered threshold for excitation from developing within the central nervous system (CNS) subsequent to exposure to intense distress. Thus, early intervention may prevent the development of a cellular "memory" of the trauma in the excitatory neural tissues.

In addition, victims of traumatic stressors usually employ psychological defences to protect themselves from further stimulation. The resultant barrier can unfortunately also stop such persons from making use of assistance being offered by others. With time, this barrier becomes less and less penetrable.

For these reasons post-trauma interventions need to be prompt if the individual is going to derive maximum benefit from them.

How do stages of managing distress reactions relate to disaster situations?

As in the phases of disaster management outlined in Section 1, managing stress reactions in disaster situations follow similar stages which can be summarized as: awareness and preparedness prior to an event and consolidation and rebuilding following the impact of a

disaster. Various aspects of how best to approach the stages of the disaster and stress management are summarized below.

It should be kept in mind that preparedness is the key to managing stress reactions. Reactions to disasters are largely influenced by the psychological well-being and coping skills of the affected individual prior to the disaster. The stability of his or her home, job, community and country are also very important factors that will influence how that person responds to the challenges of a disaster situation.

1 Pre-disaster	2 Impact	3 Post-disaster
• **Awareness** • **Preparedness**		• **Consolidation** • **Rebuilding**

Awareness

Awareness of stress reactions in disaster situations can be accomplished through education, acceptance, self-assessment, and assessment of one's environment, as outlined below.

Education:

- Gain insight into the realities of disaster situations through word of mouth, the media, books, videos, lectures and discussions;
- Understand the nature of the stress response and its possible consequences;
- Learn about effective stress management techniques.

Acceptance:

- Acknowledge one's vulnerability to the potential consequences of exposure to chronic or traumatic stressors;
- Accept the fact that for preparedness efforts to be effective that they must be on-going;
- Acknowledge that assistance may sometimes be needed when dealing with stressful situations.

Self-assessment:

- Identify one's strengths and one's weaknesses;
- Assess the effectiveness of one's coping mechanisms;
- Learn to objectively assess one's stress levels.

Assessment of one's environment:

- Learn to recognize the stress reactions of others;
- Objectively assess the vulnerability of one's family and one's community to potential stressors;
- Identify potential sources of assistance and support in the event of a disaster situation.

Preparedness

Preparedness in terms of management of stress reactions includes physical, procedural and psychological and social aspects.

Physical preparedness:

- Build "safe" structures;
- Ensure adequate maintenance of such structures;
- Always keep reserve supplies in case of an emergency;
- Take the necessary precautions once disaster threatens.

Procedural preparedness:

- Have clear contingency plans in the event of a disaster;
- Make sure that such contingency plans are understood by all those who could possibly be affected by them;
- Organize regular group training sessions (for families, organizations, communities, etc.) and drills that include rehearsal of survival techniques;
- Have adequate insurance in place at all times.

Psychological and social preparedness:

- Keep abreast with current and accurate information about possible disaster situations;
- Routinely practice effective coping skills;
- Become part of a healthy community and social network;
- Participate earnestly in relevant community activities.

Consolidation and rebuilding

Consolidation and rebuilding are the most important post-disaster stages. Approaches to managing stress reactions for emergency response personnel during these phases are outlined below.

Consolidation

- Try to appraise the situation as accurately as possible;
- Take control of your response to the situation;
- Avoid unnecessary exposure to traumatic scenes;
- Have positive but realistic expectations of the future;
- Seek assistance as deemed necessary;
- Recognize the need to manage wisely and pool available resources.

Rebuilding

- Recognize the need for self-reliance;
- Accept that the process will take time and that assistance from outside sources will tend to decrease with time;
- Devise a plan, focus on short-term necessities and prioritize activities;
- Come up with various strategies for achieving this plan, evaluate them and choose the option which appears to be most appropriate;
- Implement the strategies chosen and carefully monitor the implementation process;
- Learn from your experiences and from those of others.

What are the techniques used in SMID?

Techniques employed in SMID in preparation for, during, and following a disaster are outlined below.

(1) Pre-Incident Measures

(a) SMID Team formation

(b) On-going education programs

(c) Regular stress-relieving activities

(d) Briefing prior to deployment at a specific incident

(2) On-scene support:

(a) Rest and food

(b) Limiting exposure and reassignment

(c) One-to-one crisis intervention

(d) Advice to supervisors when necessary

(e) Peer support

(f) Professional personnel support

(3) Post-incident measures:

(a) One-to-one crisis intervention

(b) Reassignment

(c) Peer support

(d) Professional personnel support

(e) Significant-other support services

(f) Informal group discussions

(g) Recreational activities

(h) Stress management education programs

(i) Demobilizations

(j) Defusings

(k) Debriefings

(l) Follow-up services

(m) Referral options

Education programs

Education is the single most important SMID component. People who are forewarned about traumatic stress are generally able to recognize the signs and symptoms of it earlier, seek help when it is needed and cope with such reactions better. Education programs may be pre-service or in-service and they should include briefings prior to deployment.

The techniques used in such programs may range from the distribution of information leaflets to the formal training of SMID Team members.

The best stress education takes place before persons have been exposed to a traumatic event. Hence, prior to commencing active duty, all recruits, trainees, volunteers and other

personnel should receive an orientation to the possible psychological demands of their work. Prior training is not always possible, but it should be emphasized that stress education, even after the fact, can be helpful in providing useful information which can help to reduce emotional turmoil and restore a person to normal functioning.

Any education program should make use of videos, sound tracks and photographs that orient the participants in the program to the "sights and sounds" which they are likely to encounter. This technique is known as *trauma immunization.*

Discussion of some of the following topics during training may prove beneficial.

1. Understanding human behavior,
2. Family dynamics and family-life education,
3. Adaptive personality traits,
4. Adaptive social and interpersonal skills,
5. Physical and mental health promotion,
6. Social support networks,
7. Peer support,
8. General stress,
9. Occupational stress,
10. Critical incident stress,
11. Post-traumatic stress syndromes,
12. The impact of disasters,
13. Understanding grief and bereavement.

On-scene support

On-scene support refers to direct support services which are provided at the scene of a traumatic incident. This support is usually provided by trained peer support personnel but mental health professionals and the clergy may also assist. Such on-scene support services are typically offered to individuals and not to groups to minimize further disruption.

The goals and techniques of on-scene support are similar but not limited to those of crisis intervention. There are three basic types of support that may be provided at the scene:

- Brief crisis interventions with emergency response personnel who may be showing signs of distress,
- Advice and counsel for supervisory personnel, and

- Assistance to victims, survivors and family members who were directly involved with the incident.

Interventions should be brief, flexible and focus on immediate concerns only. In such situations, a 5-minute intervention is considered long, and 15 minutes extremely long. If a distressed person at a scene does not show marked improvement by the end of 15 minutes it is unlikely that such a person will recover sufficiently to return to work at that scene.

Possible signs of distress include:

- Crying,
- Screaming,
- Overall loss of emotional control,
- A shocked-like state,
- Staring,
- Wandering aimlessly,
- Isolation from the group,
- Unprovoked outbursts of anger,
- Strange behavior.

Peer support

Peer support interventions offer unique advantages over traditional mental health services especially when the peer-group views itself as being very unique, selective or otherwise "different" as compared to the general population. Peers can most effectively eradicate the myth of unique vulnerability and are in a much better position to offer advice on effective coping and appropriate stress management techniques. Well-trained peers can be very effective.

Support services for significant others

Since individuals are part of larger social groups such as families, organizations and communities, what negatively impacts on them may also indirectly impact on those around them. Consequently, it is important that stress management services be made available to groups of persons that may be indirectly affected by a traumatized individual. Children and adolescents should not be forgotten in this respect.

Support services for significant others include social activities, stress education programs, debriefings and crisis intervention counseling if necessary. On some occasions, the

emergency response personnel may need to be present. Services of this kind should be governed by the needs of the individuals involved. Specific examples of direct services to significant others include:

- Debriefings for spouses after a particularly distressing incident in the community or after a line-of-duty death in an organization;
- Bereavement counseling and follow-up care, as necessary, for the family and relatives of the deceased;
- Follow-up contact with the bereaved family for several weeks after the death;
- Grief seminars for affected families six months after the death;
- Groups for children and for adolescents after a highly traumatic incident that impacted on their parents;
- Advice about child care during times of distress in the family when such distress is directly associated with the work of an emergency services or disaster worker.

Education programs for significant others should include topics and activities such as:

- Understanding human behavior,
- Family dynamics and family-life education,
- Adaptive personality traits,
- Adaptive social and interpersonal skills,
- Physical and mental health promotion,
- Coping with anxiety and stress,
- Critical incident stress,
- Post-traumatic stress syndromes,
- Understanding grief and bereavement,
- Supporting the distressed loved one,
- Understanding children and adolescents in crisis,
- Work place tours and ride-along programs,
- Spouse support programs.

Professional support personnel

Professional support personnel include the clergy and mental health professionals. Mental health professionals are certified mental health counselors, psychiatric nurses, social workers, mental health occupational therapists, psychologists, psychoanalysts and psychia-

trists. All these persons have special knowledge and skills and have received specialized training within their professional fields. It is critical that whoever provides SMID services, whether they be peer or professional support personnel, be properly trained in SMID, counseling techniques, techniques of crisis intervention and post-traumatic stress syndromes. SMID interventions conducted by untrained persons, no matter how well intentioned, may result in significant harm to the recipients of such services.

Follow-up and referrals

Any intervention, ranging from an individual consultation to a formal debriefing, needs to be followed up. Follow-up services include telephone calls, on-the-job visits, peer visits, small group meetings, one-to-one counseling, contact with family members, chaplain contacts, discussions with senior personnel, referral to a professional contact and any other measure which may be deemed necessary in the aftermath of a traumatic event.

What should you do if you've been affected by exposure to a traumatic event?

Below are some guidelines which will assist anyone who has been exposed to and affected by a traumatic event to rapidly return to normal functioning.

- Try to live as normal a life as possible, and do the things that make you feel good;
- Keep away from mind-altering substances;
- Exercise regularly and eat a balanced diet;
- Come to grips with your feelings and be honest about them—you can write them down on a daily basis;
- No need for you to isolate yourself, but take time out for sleep, leisure, relaxation and to be alone;
- Refrain from blaming others or making major decisions, but keep in mind that only by making some decisions will you regain your confidence;
- Let go of your feelings of guilt and self-blame;
- Open up to others and spend time with them;
- Feel rotten if you need to but maintain a sense of humor;
- You can lend a helping hand to others, but overextending yourself is counterproductive;
- Utterances fuelled by anger or ignorance are best left unsaid;
- Remember that you may be accident prone, so be careful;
- Structure your time and keep busy;

- Think realistically and positively;
- Realize that your reaction is neither unique nor abnormal;
- Endeavour to accept your limitations and those of others;
- Seek professional help if necessary;
- Strive for inner peace, and above all, *don't quit.*

What should you *not* do after you or someone else has been affected by exposure to a traumatic event?

1. Don't believe that you have to care for your co-worker if you feel mentally unable to do so. *You won't be able to.*

2. Don't believe that you can't say what you're feeling.
   You need to.

3. Don't attempt to reassure yourself or others that everything is "okay".
   It is not.

4. Don't try to impose your explanation for what happened on others.
   That is just your opinion.

5. Don't blame yourself for what happened.
   This is not the time for accusing anyone.

6. Don't tell other persons that you know how they are feeling.
   You don't.

7. Don't say to the other person to simply forget about it.
   It isn't that simple.

8. Don't feel pressured to respond when someone else is talking to you.
   Just being there and listening is what matters the most to that person.

9. Don't be afraid to ask someone else how they are doing.
   Your concern may be very uplifting for them.

10. Don't try to talk someone else out of their feelings even if you don't understand their reactions to an incident.
    Just listen.

End of Section Quiz

Please circle the correct answer.

1.	One should try to live as normal a life as possible after exposure to a traumatic situation.	T	F
2.	A defusing is one possible method of on-scene support which may be used in a disaster.	T	F
3.	SMID is based on the principles of crisis intervention and critical incident stress management.	T	F
4.	Early intervention after a stress reaction is not necessary for maximum benefit to be derived from the intervention.	T	F
5.	Significant-other support services is one post-incident SMID measure.	T	F
6.	When you are experiencing a stress reaction daily use of alcohol may be helpful.	T	F
7.	We have some control over what happens to us psychologically after exposure to a disaster.	T	F
8.	Promotion of worker health and well-being is a SMID goal.	T	F
9.	After exposure to a disaster situation, don't attempt to reassure yourself or others that everything is "okay".	T	F
10.	Adequate sleep and a balanced diet are essential after exposure to a traumatic situation.	T	F

Note: Answers to questions are on page 128.

N O T E S

SECTION 4: AN INTRODUCTION TO COUNSELING AND CRISIS INTERVENTION

Counseling

You are a mental health professional from the National SMID Team and you have been assigned to counsel relatives of one of the elderly gentlemen in the Zesta Valley who drowned after refusing to be evacuated." (See description of event on page 11.)

It is now 6 weeks since Mrs. Asta lost both of her children in the tragic fire which destroyed their home. Mrs. Asta has so far been unable to return to work and her employer has referred her to you as an Employee Assistance Program Counselor for counseling. (See description of event on page 17.)

Crisis intervention

As Human Resource Manager for the Heaven Bay Luxury Resort, it is your responsibility to inform Ms. Vinnel that her services will no longer be required after the end of the month. Ms. Vinnel is 28 years old, a single parent and mother of 5 children ranging from ages 6 months to 8 years. She has been employed at the hotel for well over 10 years. (See description of event on page 12.)

Introduction to counseling

Definition

Counseling is a short-term, theory-based, non-directive, non-judgmental process. During this process, a person *(client)* who is basically psychologically healthy and facing adjustment, developmental and/or situational concerns or problems is empowered to gain awareness of him/herself and of his/her situation and to make decisions through the support and assistance offered by another person *(counselor)* through their relationship.

Peer counseling refers to the provision of such support and assistance by trained peers. It differs from professional counseling in that it is very brief, less formal and not provided by professional counselors. In this context, persons are said to be *peers* when they share a common identity or experience. The commonality may be age, gender, career, education, social orientation or any other self-defined common experience. Peer counseling helps to create a climate in which the client feels accepted, non-defensive and able to talk freely.

Overview

Counseling involves befriending, listening, helping, and empowering. In this context, there have always been counselors, i.e., people who listen to others and help them to resolve difficulties. Nonetheless, over the years counseling has become a profession in its own right.

Counseling deals with personal, social, educational, vocational and empowerment issues and it is conducted with persons who are considered to function within the "normal range". Clients learn how to make decisions and how to formulate new ways of thinking, feeling and behaving.

Counseling focuses on development and on the prevention of serious mental health problems through education and short-term treatment. It emphasizes growth as well as remediation. Counseling differs from *psychotherapy* which focuses on serious problems associated with intrapsychic and personal issues and conflicts. Psychotherapy normally involves a long-term relationship (20-40 sessions over a period of 6-24 months) that focuses on reconstructive change.

There are many types of counseling depending on the issue to be dealt with and the desired achievements. These include supportive counseling, educational counseling, guidance counseling, career counseling, crisis counseling, grief counseling, post-traumatic counseling, management counseling, family counseling, marriage counseling, counseling in medical settings, rehabilitative and mental health counseling, etc.

Counselors also differ with respect to their theoretical orientations which refer to the model or explanation that counselors use as a guide to hypothesize about the formation of problems and their possible solutions. Most counseling approaches, other than eclecticism, fall broadly within four theoretical categories: psychodynamic, behavioral, cognitive and affective. Further elaboration on these approaches is beyond the scope of this workbook.

Indications

Anyone in a state of indecision or who is distressed in any way, whether psychologically, physically, spiritually or practically is a possible candidate for counseling. Counseling is directed towards dealing with life's problems.

Contraindications to brief counseling

- No clear problem
- No real motivation to change
- Unwillingness to participate in counseling

- Unrealistic expectations of the counseling process
- An inability to relate to other persons
- Persons who are grossly out of touch with reality
- Avoidance of emotions and feelings
- Inability to trust
- Evidence of over-dependence
- Reluctance to accept responsibility for one's actions

Note that contraindications to brief counseling may actually be indications for long-term counseling or psychotherapy.

Timing

During a counseling experience, clients explore their present levels of functioning and what needs to be done for them to achieve their personal goals, while counselors focus on the goals which their clients want to achieve. Consequently, a client is ready to benefit from counseling when they have acknowledged the need for counseling and when they are motivated to participate in a counseling relationship.

Group size

Persons may be counseled individually or in groups. The size of such groups will be limited by the needs of the group and the skills of the counselor.

Location

A counseling session can be held in any private, quiet, comfortable environment which is free from disturbances. Professional counselors tend to work in structured environments such as offices but non-professional counselors (e.g., peer counselors) may work in much less formal settings.

Providers

Level of training

Few, if any, persons have the ability to work effectively as counselors without formal education in human development, human behavior and the counseling process. The level of education needed is directly related to the level of work. There are three broad groups of counselors based on their level of training: non-professional, paraprofessional and professional counselors.

Non-professional counselors, e.g., peer counselors, are friends, colleagues, volunteers or supervisors who try to be helpful to those in need; they possess varying levels of wisdom and skill. For such persons some basic training in counseling techniques is necessary.

Paraprofessional counselors are persons who because of the nature of their professions, e.g., doctors, nurses, occupational therapists, physiotherapists, teachers, child care workers, youth counselors, probation personnel, etc., use a range of counseling techniques and have received some formal training in human-relations skills and counseling skills. They work as part of a team rather than as individuals.

Professional counselors are formally trained in counseling to varying levels. People in this group include professional counselors, psychologists, psychiatrists, social workers, mental health occupational therapists and psychiatric nurses.

Desired personal attributes of an effective counselor

No individual possesses all of the qualities of the perfect counselor. Nevertheless, because of temperament, background and experience, some persons are better suited to become counselors than others. Those individuals whose personal attributes match the demands of the profession are more likely to be personally and/or professionally satisfied with their role as counselors.

Below is a list of some of the important personal attributes of an effective counselor:

- Intellectual competence;
- Personal energy;
- Self-awareness, a positive self-image and self-confidence;
- A sense of purpose and satisfaction with life;
- An appreciation for one's strengths and one's weaknesses;
- An ability to maintain appropriate boundaries;
- An ability to communicate effectively;
- An ability to empathize;
- Non-judgmental respect for and an interest in the welfare of others;

- An awareness of and respect for the cultural differences of others;
- Flexibility;
- A sense of humor;
- Respect for confidentiality;
- An ability to be warm, genuine and honest;
- Comfort with power.

Codes of behavior for counselors

- Accept responsibility for attempting to enhance the client's well-being.
- Be committed to doing no harm to clients by avoiding activities that have a high risk of hurting clients, even if inadvertently.
- Respect the client's right to self-determination. Counselors do not have the right to interfere in the lives of their clients by making decisions for them. Instead, they are charged with helping them to think clearly and weigh the possible consequences of their actions.
- Be committed to providing equal and fair treatment to all clients based on need.
- Faithfully honor promises made to clients, being careful not to deceive or exploit them.

Behaviors considered unethical for counselors

- Violation of confidentiality
- Claiming expertise which one does not possess
- Exceeding one's level of professional competence
- Negligent practice
- Imposing one's values on a client
- Creating dependency in a client
- Sexual activity with a client
- Conflicts of interest, e.g., dual relationships
- Charging excessive fees
- Improper advertising

Goals

Counseling focuses on assisting the client to identify, talk about, explore and understand their thoughts, feelings and behaviors and to work out what action they want to take and why they have concerns or problems.

Each client is unique and the goals which are finally agreed upon between client and counselor need to be realistic and governed by the presenting concern(s) or problem(s) of the client and the limitations of the services which are available.

Procedure

Stages of the counseling process

The counseling process can be viewed simply as a three-stage process which involves initiating a counseling relationship, building and working in the relationship and terminating the relationship.

Initiating a counseling relationship involves:

- Meeting the client;
- Discussion of surface issues;
- Setting limits and guidelines, e.g., goals, meeting times, session duration, etc. for the process.

Building and working in the counseling relationship involves:

- Revelation of deeper issues;
- Ownership of feelings and possible emotional release;
- Generation of insight;
- Problem-solving and future planning;
- Action by the client.

Termination of the counseling relationship involves:

- Review and reflection;
- Disengagement from the counseling relationship by the client.

Commonly used interventions and techniques in the counseling process

Certain interventions or techniques are involved in whatever sort of counseling is undertaken. Below is a list of the most commonly used counseling interventions or techniques.

Listening. Listening is by far one of the most important counseling techniques. It is

the process of "hearing" what the other person is trying to say which calls for close and sustained attention by the counselor.

There are three aspects of speech to be noted: the *linguistic aspects* (words, phrases, figures of speech, idiosyncratic forms of speech, etc.), the *paralinguistic aspects* (amount, timing, fluency, tone, etc.) and the *non-verbal aspects* (facial expression, eye contact, gestures, body position, body movement, etc.). The skilled counselor learns to "listen" to all three aspects of speech and tries to resist the temptation to interpret what they "hear". Impressions conveyed by the client's speech should always be clarified with the client.

Skillful questioning and summarizing: During the counseling process, questions may be asked by the counselor for a number of reasons: to encourage conversation, to clarify, to elicit further information or to explore. *Open questions* are generally preferred in counseling to *closed questions* since they encourage longer, more expansive answers and are rather more free of value judgements and interpretations. Nonetheless, by using open questions it is easy to become intrusive and hence the timing of such questions is vital. In addition, *"why"*, *"value-laden"* and *"leading"* questions should generally be avoided.

Accurate summarizing helps both the client and the counselor to better place issues into perspective; the counselor should always seek verification of the accuracy of his/her summary from the client.

Providing information: On occasion the counselor informs or instructs the client in some way and some types of counseling are centered around providing clients with information. Nonetheless, information is best limited to concrete situations, otherwise clients may become dependent on the counselor to provide them with the information which they need, with the result that they become less resourceful.

Giving advice: A common error is to equate counseling to the giving of advice and quite often clients come to counseling seeking and even demanding advice—"Please tell me what to do."

While counselors occasionally have to give advice, they should keep this to a minimum. A counselor's task is not to foster the dependence of their client, but to help them to discover their own solutions to their problems and to accept the consequences of their choices.

Non-judgmental respect: This refers to the ability to unconditionally view the client with dignity and to value them as a worthwhile and positive human being. This has also been termed *"unconditional positive regard"* and it offers a baseline from which to start the counseling relationship.

Empathetic understanding: Empathetic understanding refers to the counselor's ability to perceive accurately the feelings of the client and to communicate this understanding to them. Such empathy is developed through a willingness to listen to both what is said by the client and what is implied.

Warmth and genuineness: With respect to the counseling relationship, the warmth of a counselor refers to their approachability and their willingness to be open with the client; while genuineness refers to the counselor's spontaneity, consistency and authenticity.

Humor: Humor involves giving a funny, unsuspected response to a question or situation. This requires both sensitivity and timing on the part of the counselor and should never be used to belittle anyone. If used appropriately, it can be a very effective clinical tool for relieving tension and circumventing resistance.

Concreteness: One of the major tasks of a counselor is to help the client to identify current thoughts and feelings and to remain in the "here-and-now" mode. In this way, current issues are addressed and problem-solving techniques can be applied directly to those present day issues. The client who talks excessively about what used to be or dreams too much about the future, simply avoids the reality of the present. This is not to say that the client should never be allowed to talk about the past or the present when this is necessary.

The counselor should also be clear and explicit in their dealings with the client and help the client to express himself or herself clearly.

Reflection: Reflection refers to the technique of repeating back to the client their last few words or a paraphrase of these words in order to encourage them to elaborate. It is as though the counselor is echoing the client's thoughts and as if the echo serves as a prompt. It is important that the reflection does not turn into a question.

If used skillfully and with good timing, reflection can be an important method of helping the client to tell his/her story. On the other hand, if it is overused or used clumsily it can be counterproductive.

Use of positive feedback: Often given in the form of attention and praise, positive feedback can act as a very powerful tool in reinforcing desired behaviors.

Use of multifocused responses: Counselors responding to clients in a multifocused manner can enhance their effectiveness. It must be remembered that people receive input from their worlds differently and tuning into the client's preferred modes of perceiving and learning is crucial if change is going to occur. An example of a multifocused response is, "I can feel your anger and see your hurt but I am also hearing your concern."

Encouraging perceptual change: The perceived more than the actual nature of a given situation tends to be far more important in determining how we rate our ability to cope with a situation and hence the stressfulness of the situation. In addition, people often think that their perceptions and interpretations are accurate when they are not. Consequently, counselors often have to employ various interventions to help clients to change distorted or unrealistic thoughts, desires or goals into more accurate and realistic ones. One possible technique that may be used is the use of leads, e.g., silence, acceptance, paraphrasing, summarizing, confrontation, etc., to persuade and gently point clients in a given direction.

Confrontation: Confrontation is not an attack on a client but a challenge for that client to examine, modify or control an aspect of his/her behavior that is currently improperly used

or nonexistent. Confrontation when appropriately used can produce growth and prompt an honest examination of oneself. Nonetheless, the counselor needs to be sure that the relationship with the client is strong enough to withstand a confrontation and that the timing is right. Usually, it is more productive to confront a client's strengths than his/her weaknesses, e.g., challenging a client to make better use of resources available to them.

Self-disclosure: Counselors may strategically employ self-disclosure to facilitate client trust. Such disclosures should be brief, focused, appropriate, infrequent and not add to the client's problems. It has been found that clients are more likely to trust counselors who disclose personal information (up to a point) and are prone to make reciprocal disclosures.

Use of contracts: Contracts provide a written record of goals that the counselor and client have agreed to pursue and the course of action to be taken. If such a contract is broken down into smaller sections a client may get a clear feeling that goals can be attained and problems solved. The formal nature of a contract and its time limits may also act as motivators for clients who tend to procrastinate. In addition, a contract puts the responsibility for any change on the client and thereby has the potential to empower the client and make them more responsive to the environment and more responsible for their behaviors. Contracts should focus on change and they should not be based on externally driven goals. Escape words like "maybe", "try" and "perhaps" should be avoided in contracts.

Rehearsal: Once a contract is established, the counselor can help the client to maximize their chances of fulfilling it by getting them to rehearse or practice designated behaviors. Such rehearsal may be overt (verbalizing or acting out what they are going to do) or covert (imagining or reflecting on the desired goal). A client may need counselor coaching during the rehearsal period which may involve providing temporary aids to help the client to remember what to do next or it may simply involve feedback about the client's performance.

Homework assignments: Counselors may assign homework to help clients to practice the skills learned in the counseling sessions and generalize such skills to relevant areas of their lives. Homework helps to keep clients focused on relevant behavior between sessions, to see clearly what kind of progress they are making, to become motivated to change behaviors, to evaluate and modify their activities and to take greater responsibility for the control of themselves. For homework to be effective, it needs to be relevant to the client's situation and specifically linked to some measurable behavior change.

Questions to consider prior to engaging in a counseling relationship

1. Am I the appropriate person to counsel this client?
2. Do I have the time to do it?
3. Do I have the client's permission to counsel them?
4. Where will the counseling take place?
5. What time frame am I going to be working in?

"Don'ts" in the counseling relationship

1. Don't tell the client what happened to him/her, let them tell you.
2. Don't ask "why", "value-laden" or "leading" questions.
3. Don't use "shoulds" and "oughts".
4. Don't blame, criticize or embarrass clients.
5. Don't automatically compare the client's experience with your own.
6. Don't become overly analytical.
7. Don't trivialize or invalidate the client's feelings or concerns.
8. Don't offer the client explanations for their thinking, feelings or behaviors, allow them to do that themselves.
9. Don't reduce counseling to giving advice.
10. Don't become impatient and/or appear rushed.
11. Don't become over-involved to the point that you feel overwhelmed.
12. Don't continue in a counseling relationship if you feel threatened by it or inappropriately attached to the client.
13. Don't breach the client's confidence.
14. Don't misrepresent your capabilities to the client.

Confidentiality

Confidentiality is not only central to developing a trusting and productive client-counselor relationship but it is also an ethical and legal issue.

Nonetheless, there are times when confidential information must be divulged to a third party. Below are some of the circumstances that dictate when information *must be* divulged by counselors:

1. When clients pose a danger to themselves or others;
2. When the counselor believes that a client under the age of 16 years is a victim of incest, rape, other abuse or some other crime;
3. When ordered by the court to do so;
4. When a client requests that their records be released to themselves or to a third party.

Transference and countertransference

The counselor-client relationship will greatly influence the outcome of the counseling process. Counseling can be an intensely emotional experience but usually the counselor and the client can work through the transference and countertransference phenomena that result from the thoughts and emotions that they think, feel and express to each other.

Transference is the client's projection of past or present feelings, attitudes or desires onto the counselor. A client reacts to the image of the counselor in terms of the client's personal background and current life circumstances. The way the counselor dresses, sits, speaks or gestures may trigger a reaction from the client. Transference may be positive or negative, direct or indirect. The counselor may initially enjoy transference phenomena that hold him or her in a positive light but such enjoyment may soon wear thin. Some therapists contend that both negative and positive transference are forms of resistance and that as long as the client keeps the attention of the counselor on transference issues, little progress is made in achieving goals. Transference issues nonetheless need to be worked through if the counseling experience is going to be productive for the client.

Countertransference refers to the counselor's projected emotional reaction to or behavior toward the client that may interfere with objectivity. This tends to occur when the counselor's own needs or unresolved personal conflicts become entangled in the therapeutic relationship. Once again, countertransference may be negative or positive, direct or indirect and if left unresolved it can be detrimental to the counseling process.

Being honest about one's limitations

Counselors cannot realistically expect to succeed with every client. Be honest enough with yourself and with your client to admit that you cannot work successfully with everyone. Clients' responses overwhelmingly confirm the value of honesty as opposed to an attempt to fake competence.

Burnout

The process of counseling and coping with others can take its toll on the counselor who may become overwhelmed, depressed, uninterested and irritable when they attempt to function in such a capacity.

Gerad Corey (1996) suggests a number of possible causes of burnout:

- Monotonous work, especially if it is meaningless;
- Investing a great deal of personal energy with little positive feedback;
- Lack of job satisfaction and very little opportunity for self-development and further training;

- Very demanding job, especially if one has very little say over how the job is performed and if the demands are not realistic;
- Working with a difficult population, e.g., poorly motivated clients;
- Unsupportive work colleagues and poor staff-relations;
- Unresolved personal conflicts beyond the job situation.

Below are some techniques that may be used to prevent burnout:

- Become aware of the possible impact of stress on the various aspects of your life;
- Maintain good physical and mental health;
- Cultivate a positive work attitude;
- Vary your work as much as possible and think of ways to bring variety into it;
- Initiate your own projects without relying on others to approve of them;
- Do not over-extend yourself or become over-involved—make sure that your goals are realistic, know your limitations and work within them;
- Become part of an effective support group;
- Nurture healthy friendships and relationships with others;
- Develop a range of interests and hobbies away from your work;
- Consider your education and training needs and attend to them;
- Maintain healthy boundaries with your clients;
- Be assertive and learn how to work for self-rewards and self-satisfaction but seek positive and reliable feedback on your performance from others when appropriate;
- Seek counseling as a means of your own personal development.

Introduction to crisis intervention

Definition

A *crisis* is defined as a temporary state of emotional turmoil and disorganization which follows a crisis event. It is characterized by lowered individual or group ability to cope and there is an elevated potential for positive or negative outcomes. In other words, crises are self-limiting but whether the eventual outcome is positive or negative depends heavily on how they are managed.

Crisis intervention as defined by Mitchell and Resnick (1981) is the immediate and temporary, but active entry into another person or group's situation during a period of stress. This is a form of counseling.

Overview

A crisis event is different from a problem or an emergency. While a *problem* may be stressful and difficult to solve, it can be solved with one's customary problem-solving resources. An *emergency* is a sudden, pressing situation which requires immediate attention, e.g., when someone's life is in danger because of an accident, a suicide attempt or an act of violence. A *crisis* on the other hand, constitutes circumstances or situations which cannot be resolved by one's customary problem-solving resources.

With respect to most people, their mere exposure to a crisis event is not sufficient to produce a state of emotional turmoil. Whether it does or does not, depends on how the situation is appraised and how those affected rate their ability to deal with the event.

The three basic elements of a crisis, i.e., the occurrence of a stressful event, those affected by the event having difficulty in coping with it, and the timing of the intervention, interact to make each crisis unique. Crisis events tend to result in a number of psychological dysfunctions: disorganized thought, preoccupation with insignificant detail, aggression, emotional distancing, passivity, impulsiveness, lowered self-esteem and dependence.

Phases of a crisis

The following are phases of a crisis in the absence of any intervention:

Phase 1 : ***Precipitating Event*** - An unusual, unanticipated, stressful or traumatic precipitating event occurs which is perceived as threatening and overwhelming.

Phase 2 : ***Disorganized Response*** - Those affected begin to show signs of distress and become more and more disorganized as behaviors, skills and/or resources used in the past fail to resolve the crisis.

Phase 3 : ***"Blow-up" Phase*** - Those involved lose control of their thoughts, feelings and behaviors and can exhibit very inappropriate and destructive behaviors.

Phase 4 : ***Stabilization Phase*** - The affected individual(s) begins to calm down as they draw on alternative resources. The individual remains very vulnerable at this time and may "blow up" again if she/he feels threatened in any way.

Phase 5 : ***Adaptation Phase*** - The individual finally calms down and regains full control over her/his actions.

Indications

Anyone in a state of crisis is a possible candidate for crisis intervention.

Contraindications

Persons with overwhelming suicidal or homicidal ideation or poor pre-morbid functioning are not candidates for brief mental health interventions during times of crisis.

Timing

Once a crisis situation exists then the time is right for intervention but the nature and circumstances of the crisis will dictate the type of intervention. Early intervention is always preferable.

Group Size

Crisis intervention may be undertaken with individuals or with groups depending on the circumstances. The size of such groups will be limited by the needs of the group and the skills of the counselor.

Location

While a private, quiet, comfortable environment is to be preferred, where the intervention takes place is more often determined by the nature of the crisis.

Providers

Crisis intervention services may be provided by professionals or by trained non-professionals since persons in crisis tend to be receptive to even minimal help during such periods of turmoil.

Goals

The overall emphasis during crisis intervention is on acknowledging the crisis, reducing stimulation, stabilizing the situation, mobilizing available resources, preventing harmful reactions and restoring those affected to maximal functioning in the fastest possible period of time.

Format for assisting

Recovery from a crisis event depends heavily on the severity of the event, the personal resources of those exposed to the event and the availability of support from significant others. A crisis situation is considered resolved when emotional equilibrium has been restored and when those involved once again feel in control.

The length of crisis intervention varies from one or two sessions to several interventions over a period of one to two months. The techniques which may be employed to bring about resolution of a crisis situation include reassurance, suggestion, environmental manipulation and occasionally psychotropic medications. Occasionally, brief hospitalization may be necessary.

How can you go about assisting someone who is in a crisis situation if you are dealing with the situation for the first time?

1. Establish contact with the person by introducing yourself and offering to assist them;
2. If at all possible remove the person from the stressful situation;
3. Limit their exposure to sights, sounds and smells;
4. Protect them from by-standers and the media;
5. Provide the person with adequate food and fluids but avoid foods which contain alcohol, caffeine or those rich in salt, sugar or fat;
6. If at any time you have to leave the distressed person, have someone else stay with her or him;
7. Inquire from the person what happened, how they are doing and allow them to talk about their experiences, concerns and feelings;
8. Explore with the client what the crisis means to them and why they think it happened. Assess their strengths and their needs;
9. Reassure the person that their reaction is a normal one and that most people recover from stress reactions;
10. Discuss possible solutions to the existing problem(s) and encourage the use of effective coping skills;
11. Assist the person to make decisions if necessary;
12. Restore the person to independent functioning and make provision for him/her to be followed up or assist him/her in obtaining acute care;
13. Terminate the intervention.

In more protracted crisis interventions, the principles of the intervention remain the same:

(a) To establish rapport with the person in crisis;

(b) To explore in detail the events that led up to the crisis and the significance of the crisis;

(c) To identify the maladaptive responses which the crisis triggered;

(d) To come up with and examine more adaptive alternative responses;

(e) To decide on a plan of action which resolves the crisis and restores the affected person to independent functioning;

(f) To review what happened so as to facilitate learning and growth;

(g) Termination of the intervention.

Cautions

Below are some "don'ts" to bear in mind when dealing with persons in crisis:

(1) Don't probe a person in crisis to the point where she or he feels under attack;

(2) Don't criticize or embarrass persons in crisis;

(3) Don't "preach" to such persons;

(4) Don't become overly analytical;

(5) Never question beyond the point where "closure" can be attained;

(6) Don't become impatient and/or appear rushed;

(7) Don't draw unnecessary attention to the person in crisis;

(8) Don't say the opposite of what you mean;

(9) Don't trivialize threats of suicide or homicide;

(10) Don't become over-involved to the point where you feel overwhelmed.

End of Section Quiz

Please circle the correct answer.

1.	Peers can most effectively eradicate the myth of unique vulnerability.	T	F
2.	The mere exposure to a crisis event is sufficient to produce a state of turmoil in all persons.	T	F
3.	At the scene of a traumatic event aimless wandering may be a sign of distress.	T	F
4.	Peer counselors are professional counselors.	T	F
5.	Deliberately creating dependency in a client is unethical counselor behavior.	T	F
6.	Transference is the client's projection of past or present feelings, attitudes or desires onto the counselor.	T	F
7.	Peer counselors need to be warm and caring.	T	F
8.	The ability to listen is an important counseling skill.	T	F
9.	Crises are self-limiting.	T	F
10.	Counseling is equivalent to giving advice.	T	F

Note: Answers to questions are on page 128.

N O T E S

SECTION 5: THERAPEUTIC GROUPS

What is a group?

Broadly speaking, a group consists of three or more persons who influence each other and are influenced by others. Beyond this, little else about groups is accepted as consensus.

How extensively is group therapy used?

Group therapy has been recognized as a therapeutic procedure for many years. Groups of all varieties are now available to cater to those seeking help for serious psychological problems, to those experiencing situational crises and to healthy individuals who wish to expand their self-awareness and increase their level of interpersonal functioning.

What are some of the possible group variables?

1. Setting
2. Group size
3. Group composition
4. Membership selection
5. Group content
6. Group goals
7. Duration of the group
8. Group norms
9. Group dynamics
10. Therapeutic factors
11. Leadership style
12. Frame of reference
13. Group cohesion

Based on various combinations of these variables there are five types of groups:

1. Therapy groups
2. Training groups
3. Guidance groups
4. Counseling groups
5. Encounter or sensitivity groups

What is terminology used regarding groups?

The *group content* refers to what the group discusses, while the *group process* refers to how the discussion is conducted. To be an effective group member or leader, one must be able to both participate in the discussion and observe what is going on. *Group cohesion* refers to the interacting forces that keep the group together. Group cohesiveness can be evaluated by such factors as whether or not members attend regularly, whether they are punctual and the level of trust and mutual support that members express toward each other. *Group norms* are closely related to group cohesiveness and refer to the formal and informal rules that govern what is considered to be appropriate behavior within the group. It is important that groups establish their formal norms at the outset of the group experience. *Group goals* refers to the desired achievements of the group. *Group dynamics* refers to the interaction among members of a group, each of whom is dependent on the other. The group is capable of exerting pressure on a person to change their behavior, but that person also influences the group.

How is a group established?

1. Decide on the type of group to be set up;
2. Substantiate that there is a need for such a group;
3. Decide on the goals of the group;
4. Choose an appropriate setting for the group to meet. The place chosen should be safe, private, consistently available, comfortable and contain adequate furniture;
5. Identify a suitable group leader (that person may change as the group evolves);
6. Establish formal norms for the group, e.g., group size, group composition, eligibility for group membership, times, duration and frequency of meetings, life span of the group, protocol for admitting new members to the group, unacceptable behaviors of group members and the consequences of such behaviors, etc.;
7. Select and orient potential group members (usually the responsibility of the group leader);
8. Hold the first group meeting.

What are the stages of group development?

Formative Stages of a Group (months)	1	Search for meaning
	2	Conflict, dominance and rebellion
	3	Development of group cohesiveness
Advanced Stages of a Group (months to years)	4	Further group development with possible issues of sub-grouping, of a group conflict and self-disclosure
	5	Termination

When is group therapy contraindicated?

1. When the person is not motivated to participate in the group;
2. When the person is in a state of crisis and other members of the group are not;
3. When the person is deeply depressed and/or suicidal or homicidal;
4. When confidentiality is essential;
5. When the person has an unusual fear of speaking;
6. When the person's interpersonal skills are very poor;
7. When the person has very limited awareness of his or her own feelings, motivations and behaviors;
8. When deviant sexual behavior is involved;
9. When the person's need for attention is too great to be managed in a group;
10. When the person is acutely manic or psychotic.

What are the benefits of groups?

Yalom (1995) notes that the group process provides numerous healing factors intrinsic to the group itself. Some of the benefits of the group process are:

1. Generation of feelings of hope and optimism;
2. A sense of safety, comfort and support;
3. Identification of common goals and issues;
4. Exchange of useful constructive information;
5. Interpersonal learning and imitative behavior;
6. Recapturing the nurturing role of the primary family group;
7. Opportunity for verbalization and catharsis;
8. Encouragement and empowerment of participants;
9. Reduction of the sense of isolation and uniqueness;
10. Self-understanding and normalization of one's experiences;
11. Reduction of shame, guilt and stigmatization;
12. Enhancement of one's interpersonal and socializing skills;
13. An awareness of existential factors;
14. Unselfish regard for the well-being of others;
15. Prompt and direct feedback about one's behavior.

What are the limitations of therapeutic groups?

1. Some persons need individual help before they can function in or conform to a group.
2. The group can become caught up with "group process issues" and not spend enough time addressing individual concerns.
3. Some persons may find it difficult to be open and honest in a group setting.
4. Some clients and counselors expect too much from the group experience.
5. The counselor's role is very diffuse and therefore more complex since he/she must be able to simultaneously focus on the concerns of each client, respond to the interactions among group members and observe the dynamics of the group. For that reason, some persons may benefit at the expense of others from the group.
6. There is always the danger of breaches of confidentiality.

7. Pressure to conform to group norms can cause group members to inappropriately substitute the group's norms for their own.
8. Some clients fail to use knowledge gained during the group experience to improve their functioning in daily interactions.
9. Some clients misuse the understanding and acceptance of the group experience by venting their problems to the group without making any attempts to change their behaviors.
10. There is always the danger of psychological damage to group participants if the group's leadership is inadequate.

What are effective group leadership strategies?

1. To listen and observe;
2. To use effective communication techniques;
3. To be warm, caring, empathetic and genuine;
4. To afford each group member non-judgmental respect;
5. To give and encourage feedback which should be descriptive and not evaluative;
6. To gently confront discrepancies and disruptive behavior;
7. To use open-ended questions and leads, encouraging members to gain insight into their feelings and the sources of these feelings;
8. To be able to summarize and reframe problems in a more positive light;
9. To stay focused on the matter at hand, i.e., to be concrete;
10. To link the commonalities of the experience among group members so as to encourage member-to-member communication and dispel feelings of uniqueness;
11. To model desired behaviors;
12. To effectively manage transference issues and problem group members.

What are some of the more difficult character types to have in a group?

1. The monopolist
2. The acting-out, angry or disruptive person
3. The silent or withdrawn person

4. The psychopath
5. The critic
6. The insensitive or crude individual
7. The narcissist
8. The help-rejecting complainer
9. The borderline
10. The psychotic person

End of Section Quiz

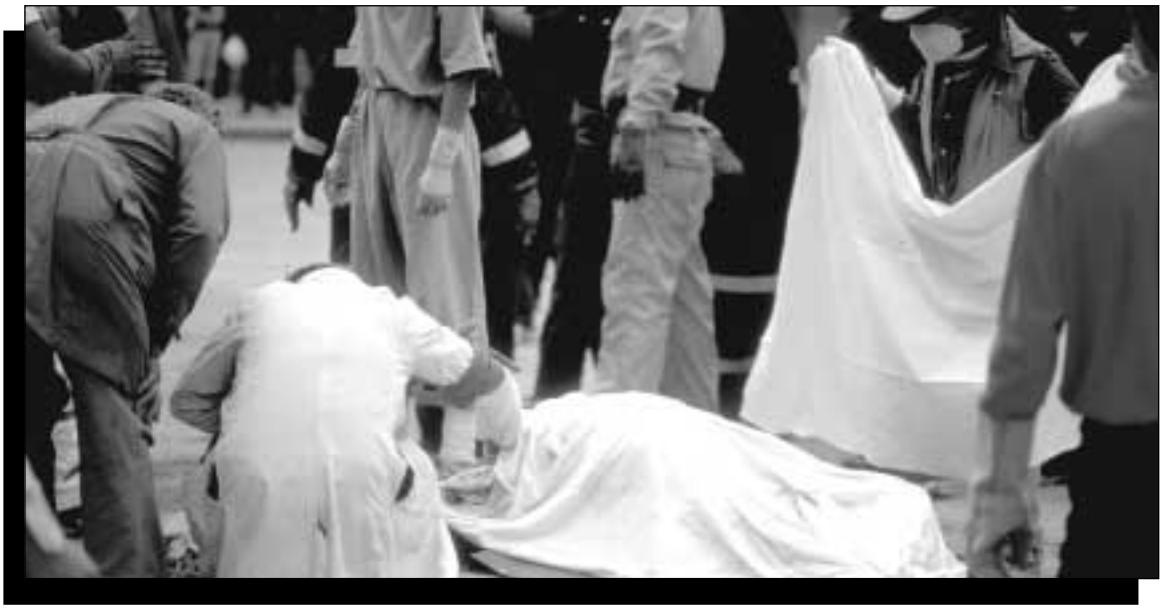
Please circle the correct answer.

1.	Poor group leadership can be harmful to participants in a group.	T	F
2.	Group leaders need to be concrete.	T	F
3.	Narcissists are difficult to manage in a group.	T	F
4.	Group dynamics refer to what the group discusses.	T	F
5.	Formal group norms can be established as the group evolves.	T	F
6.	Persons in a state of crisis are usually managed in groups.	T	F
7.	The group experience provides an opportunity for verbalization and catharsis.	T	F
8.	Group leaders must always be male.	T	F
9.	Some persons may not benefit from a group experience.	T	F
10.	Group cohesion refers to the interacting forces that keep the group together.	T	F

Note: Answers to questions are on page 128.

N O T E S

SECTION 6: DEMOBILIZATIONS AND DEFUSINGS



PAHO/WHO

The Lakes Field Hospital SMID Team conducted a defusing for the eight paramedics who had worked at the scene of the tragic East Park Road accident. (See description of event on page 16)

DEMOBILIZATIONS

Definition

A ***demobilization*** is a brief, informational and rest period immediately after personnel have been released from active duty at the scene of a large scale (requiring 100 personnel or more) traumatic incident, and before they return to routine duties.

Overview

A defusing can be substituted for a demobilization if the size of the incident allows for the lengthier defusing process and if the personnel are not too weary. It is not a one-off procedure and there is always a need for follow-up services to be provided after a demobilization.

Contraindications

Demobilizations are not indicated for the following:

- Use after routine events;
- Use for small scale incidents;
- Use after a line-of-duty death;
- As a substitute for debriefings or psychotherapy.

Providers

Demobilizations can be provided by any trained SMID Team member. Mental health professionals do not have to be present.

More than one group of persons is handled in a demobilization at any one time. Each group is assigned to its own circle of chairs in the presentation room and has its own SMID Team presenter.

Location

The facility where the demobilization is going to be conducted should be near enough to the scene of the incident for personnel to be easily transported there once they have been released from duty. It should consist of two large, adjacent rooms: one to provide the information sessions in small work groups and the other to provide food and rest.

The media and other uninvolved persons must be denied access to the place where the demobilization is being conducted.

Goals

1. To provide information about the incident and the reactions of the personnel involved;
2. To provide information about stress reactions, stress management and available support services;
3. To provide an opportunity for rest and food before returning to routine duties;
4. To mitigate the impact of the event;
5. To establish positive expectations about the future;
6. To do a preliminary assessment of the well-being of the personnel after the incident and their need for follow-up services.

Procedure

A demobilization consists of two main segments. The first segment is a 10-15 minute period in which personnel are given information which might be helpful to them in understanding and managing possible stress reactions. The second segment is a 20-30 minute period of time to eat and rest before returning to normal activities.

Each team of workers (e.g., disaster workers, policemen and firemen) are handled as a "unit" in the demobilization. Each "unit" sits in a set of seats that are arranged in a circle. It is best to keep fellow workers together (for example, fire-fighters with fire-fighters who work together on the same operation units) since they derive support from each other.

No one except the team member presenting in the demobilization has to speak but if anyone wants to speak then they may do so. No note taking or record keeping is allowed.

Demobilizations usually take the following format:

- An introduction by the presenter;
- A brief description of a demobilization;
- An assurance that the talk section of the demobilization will be limited to 10-15 minutes and that the knowledge to be gained will be potentially beneficial;
- A 10-15 minute talk which should include:
  - (a) A description of the nature and course of possible stress reactions that may follow exposure to a traumatic event;
  - (b) An assurance that stress symptoms are normal under the circumstances;
  - (c) A description of the common cognitive, physical, emotional and behavioral signs and symptoms of stress;
  - (d) Brief suggestions about managing stress reactions;
  - (e) Outline of the various follow-up services that will be available;
  - (f) An invitation for anyone who wants to make a statement or ask questions to do so;
  - (g) A summary statement.
- The distribution of handouts on stress reactions and stress management techniques;
- The provision of food (low in salt, fat and sugar) for 20-30 minutes in a separate room;
- Announcements by senior personnel and the return of personnel to normal duties;
- The availability of SMID Team members to the group once the demobilization is over.

Cautions

Demobilizations can sometimes prove difficult to organize because of the logistics of providing such a service.

Only persons who have been released from the particular scene for the rest of that shift and for the rest of that day are demobilized. Such personnel may work elsewhere but not at the scene of the incident from which they were just released. This is because the demobilization process increases one's vulnerability to severe stress reactions at the scene of the incident, but a different scene is usually viewed as not being associated with the previous incident and can normally be handled without problems.

If the incident is going to require a prolonged operation, then demobilizations should only be applied during the first 2 or 3 shifts of work after personnel would have completed their first exposure to the scene. Hence, as the operation proceeds, one-to-one interventions with obviously distressed individuals should be utilized instead.

Demobilizations are not provided after line-of-duty deaths; debriefings (and in special circumstances defusings) are done instead.

DEFUSINGS

Definition

A *defusing* is a small, structured group meeting (4-8 persons) or discussion of persons who normally work together, e.g., nurses, police, paramedics, fire-fighters, etc., and who have been exposed to a traumatic event. Occasionally, it is necessary to combine various groups of emergency response personnel together for a defusing but this is only done when all of the parties to be combined were involved together in the same incident.

Overview

A defusing is likened to a shortened debriefing. Both the defusing and the debriefing techniques were initially developed by Dr. Jeffrey T. Mitchell (1996) and they are believed to have similar mechanisms of action. The defusing is nonetheless much less organized and more immediate in its application.

Such meetings are provided as soon as possible after the traumatic event and not later than 8 hours after it. When a particularly traumatic incident occurs at the beginning of a shift and the personnel must work through the remainder of that shift, it is very helpful to bring the group together and provide a defusing. On the other hand, if a traumatic incident occurs at the end of a shift, it is better to provide a defusing before the group goes home.

Defusings last for 20-60 minutes and they are aimed at the core working group that was most seriously affected by the events.

Defusings and demobilizations can usually substitute for each other. One or the other is provided for an incident, but not both. Unlike demobilizations, defusings are never provided at the scene of the incident.

After exposure to a traumatic event, the affected persons take time to put up their emotional guards and like other persons dealing with very stressful situations, they are generally receptive to assistance. Consequently, defusings can significantly reduce the psychological impact of such events.

Follow-up services are always necessary after a defusing to ensure that the personnel are managing their stress adequately.

Contraindications

Defusings are not indicated for the following:

- Use after routine events;
- Usually not employed after large-scale events, e.g., major disasters, unless they are used as part of a larger SMID program;
- If the traumatic incident occurred more than 8 hours earlier;
- After a line-of-duty death once a debriefing team is available;
- As a substitute for a debriefing or psychotherapy.

Providers

Defusings can be provided by any trained SMID Team member, even in the absence of mental health professionals. It is best that a defusing team be made up of at least two persons.

When peer support personnel conduct a defusing in the absence of mental health professionals, they should go over what was done with one of the team's mental health professionals within 8-12 hours of the defusing.

Location

A defusing should be held in a private, quiet, comfortable environment, which is free from distractions and away from the scene of the incident. The media and other uninvolved persons must be denied access to the place where the defusing is being conducted.

Goals

1. To provide information about the incident and the reactions of the personnel;

2. To provide information about stress reactions, stress management and available support services;

3. To rapidly reduce the intensity of the reactions to the traumatic event;

4. To reinforce the social network of the group and dispel feelings of uniqueness;

5. To establish positive expectations about the future and reinforce the value of the personnel;

6. To do an assessment of the well-being of the personnel involved to determine their need for follow-up services.

Procedure

A defusing session consists of three main segments that are linked to each other in a free-flowing conversation about the traumatic event.

The *introduction phase* usually takes 5 to 10 minutes and allows for the intervention team's members to be introduced, the process to be explained and expectations to be set. The *exploration phase* takes 10 to 35 minutes and allows for the traumatic experience to be discussed through the participants' disclosure of facts, cognitive and emotional reactions and symptoms of stress related to the traumatic event. The *information phase* takes 5 to 15 minutes and seeks to cognitively normalize and educate the participants about traumatic stress.

If a defusing takes longer than 60 minutes, it is likely that a debriefing is needed in the next few days. Persons attending a defusing may speak or they may be silent and no note taking or record keeping is permitted at any time.

Because there is usually very little time to prepare for a defusing, refreshments are seldom served at the end of the procedure.

Defusing format

The ***Introduction Phase*** of a defusing includes the following steps:

- Introduce the facilitator;
- Outline the purpose of the defusing;
- Reassure participants that the procedure is not an investigation;

- Describe the process;
- Outline the main guidelines of a defusing;
- Call for strict confidentiality;
- Outline the goals;
- Encourage those present to participate;
- Encourage mutual support;
- Attempt to alleviate fears about the defusing process;
- Call for any questions before proceeding; and
- Offer additional support.

The ***Exploration Phase*** includes the following:

- Ask participants to describe what just happened;
- Ask the minimal number of clarifying questions;
- Gently encourage the participants to discuss their experiences, thoughts, feelings and reactions;
- Assess the need for follow-up services; and
- Reassure the participants as necessary.

The ***Information Phase*** of the defusing includes the following:

- Note and summarize the information provided by the group in the exploration phase;
- Answer any queries that the participants might raise;
- Normalize the experiences and/or reactions of the group;
- Teach practical stress management techniques;
- Summarize the proceedings;
- Organize a follow-up debriefing if one seems indicated; and
- Be available to the group once the defusing is over.

End of Section Quiz

Please circle the correct answer.

1.	Defusings can be done up to 48 hours after exposure to a traumatic incident.	T	F
2.	Refreshments are always served as part of a demobilization.	T	F
3.	Persons can be demobilized and returned to the same traumatic scene to work.	T	F
4.	Generous helpings of chocolate cake should be served at demobilizations.	T	F
5.	Refreshments may be served at defusings if the necessary arrangements can be made.	T	F
6.	Defusings usually last about 2 hours.	T	F
7.	Only mental health professionals can conduct demobilizations.	T	F
8.	Defusings are usually provided at the scene of the incident.	T	F
9.	A defusing consists of 7 main segments.	T	F
10.	Participation in a defusing is optional.	T	F

Note: Answers to questions are on page 128.

N O T E S

SECTION 7: DEBRIEFINGS

PAHO/WHO

A debriefing has been planned for later today at the Quayside Resort Hotel by the Vesta Human Resource Manager of A.L.D Airlines. This is for the families of the airline crew members who lost their lives 5 days ago when the A.L.D Airlines Boeing 747 jet crashed soon after takeoff from the Seajet International Airport." (See description of event on page 14.)

Definition

Debriefings are structured group meetings or discussions about a traumatic event involving persons who normally work together. Occasionally, it may be necessary to combine various groups of emergency response personnel together for a debriefing but this should only be done when all of the parties were involved together in the same incident. Debriefings are designed to mitigate the impact of such an event and to assist persons to recover as quickly as possible from the stress arousal associated with the particular event.

Overview

A Critical Incident Stress Debriefing (CISD) is one type of debriefing which integrates crisis intervention strategies with educational techniques. It was originally developed by Dr. Jeffrey T. Mitchell. CISD is the debriefing protocol most widely used today and it is the technique which will be outlined in this workbook.

CSID was designed to be applied among public safety, disaster response, military and emergency response personnel but it can be used with virtually any population, including children, when it is employed by a skilled intervention team.

A debriefing is not psychotherapy, nor is it a substitute for psychotherapy. Instead, it is meant to provide an opportunity for ventilation in a structured and supportive environment. The core focus of a debriefing is the relief of stress in normal, emotionally healthy people who have been exposed to a traumatic event. The debriefing is not intended to resolve psychopathologies or personal problems that existed before the traumatic incident being debriefed.

Debriefings usually take 2 to 3 hours; marathon debriefings indicate one or more of the following problems:

1. That the incident was a very traumatic one;
2. That too much time was spent on the fact and thought phases;
3. The team was inexperienced or unfamiliar with the debriefing process;
4. The quality of team leadership was poor.

When a debriefing has been planned, the senior personnel of the involved organizations need to be informed and their assistance, participation and cooperation solicited. Only in very unusual circumstances are senior personnel split off from junior personnel for debriefings. Sometimes, it may be necessary for the SMID Team to hold an additional meeting with senior personnel who may have special needs that they would like to discuss with the SMID Team members without having their junior personnel listening in.

Persons attending debriefings must be relieved of all other duties. It is potentially dangerous for them to leave a debriefing in the middle to handle emergency calls. The debriefing lessens one's cognitive defenses, and having to deal with an emergency during the process could jeopardize their safety because they would be functioning more at the emotional level than at the cognitive level.

Whenever possible, refreshments should be served after the debriefing. This helps to keep those who attended the debriefing together for a bit longer and affords the SMID Team members the opportunity to meet each participant on an individual basis.

Contraindications

Debriefings are not indicated in the following situations:

- For use after routine events;
- For a debriefing to be conducted in the absence of a mental health professional;
- For a debriefing to be conducted if too much time has passed since the traumatic incident;
- For use in mediating management-employee conflicts;
- For use as a substitute for psychotherapy.

Timing

Debriefings must be held when the participants are emotionally "ready" to accept and benefit from them. This often occurs within 24 to 72 hours after exposure to a traumatic incident. However, some traumatic incidents, especially disasters or line-of-duty deaths require a much longer waiting period since the shock, numbing or denial mechanisms may last for weeks after the traumatic event.

Emergency response personnel work very hard to suppress their emotions. Any attempt to force them to bring those emotions to the surface for examination will meet with significant resistance because too close a realization of how many emotions are a part of their lives may jeopardize their ability to work efficiently under field conditions. The average non-emergency trained individual tends to be less well cognitively defended and is usually ready much earlier to let their emotions and other reactions come to the surface.

If too much time has passed since the incident (3 to 4 months) one might consider not holding a debriefing, but rather meeting with people on an individual basis and assessing whether or not they have residual reactions to the incident and what type of intervention would be most appropriate. Victims' psychological defenses are often reintegrated within a few months and a debriefing might only serve to break down those natural defenses and result in re-traumatization.

Group size

The ideal debriefing group size is between 4 and 20 persons, with 4 to 12 persons comprising a small group and more than 12 persons a large group. Groups of between 20 and 40 persons are possible but they are much more time-consuming and difficult to work with. Groups of more than 40 persons should ideally be broken down into sub-groups.

When there are too many people who need a debriefing, persons most affected by the

incident must be dealt with first and groups can be broken down according to logical categories, e.g., usual working group, profession, etc.

Location

A debriefing should be held in a private, quiet, comfortable environment which is free from distractions and away from the scene of the incident. The media and other uninvolved persons must be denied access to the place where the debriefing is being conducted.

The chairs should be arranged in a circle large enough to accommodate the group and the SMID Team members and should be spaced more or less equally among the participants.

Reasons for the therapeutic effects of debriefings

1. **Early intervention**: Prevents the concretization of traumatic memories.
2. **Opportunity for catharsis**: This ventilation of emotions leads to reduced stress arousal.
3. **Opportunity to verbalize the trauma**: The opportunity to verbally reconstruct and express specific traumas, fears and regrets leads to reduced stress arousal.
4. **Structure**: Superimposes an orderly process with a finite beginning and a finite end upon the chaos of a traumatic event.
5. **Group support**: The group experience provides numerous healing factors which are intrinsic to the group process.
6. **Peer support**: Peers can most effectively eradicate the myth of uniqueness and can suggest more appropriate stress management techniques.
7. S**tress education**: Allows for a better understanding of available skills to cope with stressful situations.
8. **Allows for follow-up**: Persons in need of further care can be more readily identified.

Providers

The debriefing process is a team effort which is conducted by a group of two to four SMID Team members. A mental health professional must be present to lead the debriefing. If the debriefing has been organized for emergency response personnel then peer support personnel must also be part of the debriefing team and one of them must be the co-leader of the team. Usually that person is the most experienced peer debriefer.

A SMID trained member of the clergy may also be present at some debriefings. But, because not all participants will share similar religious beliefs, preaching and praying are excluded from the actual debriefing process.

Do not serve as a member of a debriefing team if:

1. You have played a significant role in the actual event;
2. You have direct command or supervising responsibility for the personnel involved in the incident even if you were not there;
3. You are working with the group involved on a regular basis, even if you were not with them during the incident;
4. You are a close relative of one of the affected persons;
5. You are very close friends with the members of the group involved in the debriefing event;
6. You are presently or may be eventually involved in the investigation of the event.

Roles of Debriefing Team Members

The Team Leader (mental health professional):

- Encourages participation;
- Clarifies and summarizes;
- Maintains order;
- Assesses psychological well-being;
- Instills a positive outlook;
- Teaches;
- Arranges appropriate follow-up.

The Team Co-Leader (peer/mental health professional):

- Shares leadership with the team leader;
- Plays a significant role in arranging follow-up contact.

The Peer Support Personnel:

- Observes for evidence of distress;
- Teaches;
- Assists other team members as may be necessary.

The Door Keeper (usually peer support personnel):

- Denies entry to the debriefing room of unauthorized persons;
- Encourages persons attending the debriefing not to leave prematurely.

Debriefing goals

1. To provide information about stress, stress reactions and stress management techniques;
2. To facilitate a speedier recovery in persons who are experiencing features of a stress reaction;
3. To provide reassurance that the stress response is controllable and that recovery is likely;
4. To dispel the fallacies of abnormality and uniqueness;
5. To establish positive contact with a mental health professional;
6. To provide a sense of post-crisis psychological closure if possible;
7. To do an assessment of the persons involved to determine their need for further intervention.

Rules or guidelines of a debriefing

- No unauthorized persons are allowed to attend a debriefing;
- Confidentiality must not be breached;
- Participants should only speak for themselves;
- Judgement and operational critiques are not permitted;
- Participants are encouraged not to leave the debriefing prematurely since it is important that they complete the entire process;
- Participants are also advised that no breaks will be taken but that persons will be allowed to leave the meeting to take care of their personal needs and return as soon as possible after;
- All distracting devices should be turned off during a debriefing;
- No recording or note taking of any kind is ever allowed;
- In debriefings, participants have no rank;
- SMID Team members must make themselves available to the participants after the debriefing process is complete.

Preparation of the debriefing team for a debriefing

Debriefing team members should:

1. Arrive at the site of the debriefing at least an hour before the debriefing is scheduled to start;
2. Familiarize themselves with as much information as possible about the event that is to be addressed in the debriefing;

3. Circulate among, meet and converse with the participants who are attending the debriefing. This helps to relieve tension and to provide the debriefing team members with potentially useful information;
4. Excuse themselves and meet privately to discuss their approach to the debriefing and for their specific roles to be assigned, once they have had enough time to circulate among the participants (10-45 minutes).

Format of a debriefing

The Mitchell model of debriefing (CISD) is a 7-stage intervention with the following stages:

1. Introduction
2. Fact
3. Thought
4. Reaction
5. Symptom
6. Teaching
7. Re-entry

Introduction Phase: (Cognitive, 10-15 minutes, provides participants with the ground rules and a chance to be introduced to everyone present)

- This phase is crucial and if it is not handled properly it is likely that the remainder of the debriefing will be difficult.
- During this stage the team leader:

    (a) Introduces the team members,

    (b) Explains the process,

    (c) Highlights that the debriefing is not an investigation,

    (d) Allays fears,

    (e) Goes through the rules of the debriefing,

    (f) Encourages participation,

    (g) Answers questions,

    (h) Announces the commencement of the fact stage.

- Throughout the introductory stage, the team needs to speak with confidence and concern. Any resistance expressed by the participants at this stage also needs to be addressed.

Fact Phase: (Cognitive, 5-25 minutes, establishes what happened)

- The goal of this phase is to get the participants to describe the traumatic event from their perspective.
- This phase proceeds in an orderly fashion from participant to participant to try and give everyone an opportunity to make a contribution. Some persons may refuse to speak or, because of time constraints, some may not be afforded the opportunity to speak.
- This is the most logical way to start a discussion about a traumatic incident with emergency response personnel because discussions of facts are not as distressing as attempting to talk about feelings.
- When participants in a debriefing are asked to describe the facts of the situation and they begin to express their emotions, it is a sign of how badly they have been affected by the incident. If this happens during this phase the team should not probe, instead the emotion should be acknowledged and validated, the person and the group reassured, and another person moved on to unless the person indicates that they wish to continue speaking.
- Such an early show of emotion may be unnerving for emergency response personnel—this is where peers on the team can be very helpful.

Thought Phase: (Cognitive → Affective, 5-25 minutes, discusses the thoughts that were associated with the event)

- This phase represents a transitional phase from the cognitive domain to the affective (emotional) domain and it is intended to allow participants to shift from a description of the facts to one of their emotional reactions.
- This phase begins when the team leader asks the participants to state their first thoughts or their most prominent thought once their auto-pilot mode of operation had ceased.
- Once again, one proceeds in an orderly fashion to try and give everyone a chance to make a contribution.
- If the emotional content becomes too emotional too quickly, the participants may experience anxiety and a desire to resist any efforts to bring them closer to their emotions.
- The team needs to be prepared for the possible repercussions. If the emotions become too intense, they may need to be acknowledged and validated and the participants reassured by the team. Also, if diffuse anger is expressed, it may need to be redirected.

Reaction Phase: (Affective, 10-40 minutes, discusses the feelings that were associated with the event):

- This phase sets out to allow participants to identify the most traumatic aspect of the

incident for them and the associated emotional reactions to the trauma.

- During this phase most of the talking is done by the participants and the discussion is free-form, with persons being given the opportunity to speak if and when they choose.
- It is typically the most emotionally charged phase of all and it is triggered by a question like, "What part of this event bothered you the most?"
- Initially the discussion will be slow. There may be bouts of silence, moments of intense verbal expression and evidence of anxiety, but persons will usually participate.
- When the discussion drops off and several attempts by the team to elicit more discussion from the group fails, it is a signal to proceed to the next phase.

Symptoms Phase: (Affective → Cognitive , 5-10 minutes, reviews signs and symptoms of distress that have been experienced since the event)

- This is another transitional phase where the group moves from the affective (emotional) domain back to the cognitive domain.
- The goal of this phase is to identify personal symptoms of stress and to move back from the emotional to the cognitive domains.
- The phase is initiated when the team asks the participants to describe any cognitive, physical, emotional or behavioral experiences which they have encountered and to delineate when these symptoms occurred, i.e., at the scene of the incident, after the incident and before the debriefing, and/or after the incident and are still present at the time of the debriefing.
- On occasion, the participants are reluctant to admit to having experienced any symptoms for fear that they would stand out as abnormal. If the team suspects this, then they may encourage the discussion initially by asking for a show of hands for various symptoms.
- Once the number of persons admitting to having experienced symptoms decreases significantly it is time to proceed to the next phase.

Teaching Phase: (Cognitive, 10-20 minutes, provides information about ways to cope with stress and emphasizes "normality")

- This phase tends to flow naturally after the symptoms phase and its goal is to educate the participants about critical incident stress and its management and to concretize a return to the cognitive domain.
- All of the team members participate in the teaching process but care needs to be taken not to prolong this phase with irrelevancies since by this time the participants are likely to be quite tired. Only topics relevant to the group being debriefed should be discussed.
- At the end of the teaching phase, a team member may enquire from the group if there is anything that happened during the incident which makes them feel in any way positive even though the overall incident might have been a very horrible one.
- The teaching phase leads quite naturally into the re-entry phase.

Re-entry Phase: (Cognitive, 5-10 minutes, a "wind-down" phase which seeks to bring about closure to the meeting)

- This is the final stage of the debriefing and its goal is to clarify ambiguities, prepare for termination and bring closure to the discussions which just ensued.
- This is the last chance to clarify issues, answer questions, make summary statements and return the group to its normal mode of functioning.
- Every team member needs to make a summary comment. These comments tend to be words of respect, encouragement, appreciation, hope, support, gratitude and direction.
- Once the debriefing is over, the team comes to its feet and begins to make post-debriefing contact with the participants.

Mass disaster debriefings

The formal CISD model has been slightly modified for mass disasters/community response applications and consists of the following stages:

1. Introduction
2. Fact
3. Thought reaction
4. Emotional reaction
5. Reframing
6. Teaching
7. Re-entry

This variation of the debriefing process places slightly more emphasis on direct ventilation of emotions and it also places greater emphasis on the importance of the constructive aspects of the experience. Its goals are centered around rebuilding and moving on. To facilitate this, Phases 3, 4 and 5 of the two types of debriefings are conducted somewhat differently and the debriefing team is much more overt in a mass disaster CISD.

Phase 3 (Thought Reaction *vs* Thought) in the mass disaster CISD involves more direct questioning about the participants' thoughts about the situation, e.g., "What aspect of the situation had the most negative impact on you?" In a similar vein, Phase 4 (Emotional Reaction *vs* Reaction) also involves more direct questioning about emotional aspects of the situation. Finally, Phase 5 (Reframing *vs* Symptoms) departs from the discussion of symptoms to one of getting the participants to see the experience in a much more positive light.

The mass disaster CISD was designed to be utilized when disaster workers have been exposed to numerous disaster situations over time, to multiple traumatic incidents in a single disaster or to a single disaster for a prolonged period of time.

Before emergency response personnel participate in a mass disaster CISD they

should have been released from working at the scene of that disaster for at least the next 1 - 3 weeks and should have had time to reunite with their families and friends.

Post-debriefing meetings

The post-debriefing meeting is a necessity and during this meeting the following tasks must be performed:

1. Explore what happened and what was done during the debriefing so that team members can learn from the experience;
2. Assign specific follow-up tasks to individual debriefing team members;
3. Make sure that team members are not psychologically distressed.

Post-action report

The post-action report is ***optional*** but it may be kept so that the incident can be discussed at the next team meeting. It should be brief and not contain any information that could identify an individual who was at the debriefing. This report should contain the following:

1. The names of the debriefing team members;
2. Date, time and place of the debriefing;
3. The number of persons debriefed;
4. A brief description of the incident that was debriefed;
5. General themes discussed in the debriefing;
6. A summary of the advice given to participants by the debriefing team.

Possible follow-up services

1. Telephone calls
2. Station visits
3. Chaplain visits
4. Individual consultations
5. Referrals for therapy
6. Additional meetings with sub-groups
7. Follow-up meetings with entire groups one week after the debriefing

8. Family sessions
9. Ride-along programs
10. Any other service deemed necessary

Difficult debriefings

Multiple incident debriefings are used when the same personnel in an organization were exposed to several traumatic stressors in a brief period of time (less than 14 days). A maximum of four events can be debriefed simultaneously. If there are more than 4 events, then the four worst should be addressed. ***A line-of-duty death should never be dealt with as part of a multiple incident debriefing.***

When events are being debriefed simultaneously, the various events are blended into the discussion randomly and no attempt is made to organize the discussion into blocks.

Symbolic debriefings refer to debriefings in which old memories of past traumatic events are triggered. If many old significant events are being brought to the fore, then the debriefing team needs to listen carefully and attempt to find any common themes. If, on the other hand, the old events have no significant emotional power and the group just seems to be avoiding the current, more painful incident, then the drift into old topics needs to be resisted. In either case, the team needs to gently reintroduce the current event.

Line-of-duty death debriefings are very difficult since they produce intense levels of shock, denial, anxiety and grief for the participants. Great tact and sensitivity must be displayed to the individuals in the group and the need for one-to-one services before and after the debriefing tends to be very high. ***It must also be borne in mind that after a line-of-duty death, the entire organization is affected and all members of the organization are invited to a debriefing, not only those at the scene.***

Reasons why debriefings may fail

- Poorly trained, inexperienced or inappropriate service providers;
- Inflexible adherence to debriefing guidelines with no sensitivity for unique situational, personal, cultural or social circumstances;
- Failure to comply with basic debriefing protocols and techniques;
- Overzealous application of the intervention;
- Team counter-transferences because of over-identification with the persons being debriefed;
- Bringing up irrelevancies or information from other debriefings;
- Breaches of confidentiality;
- Insufficient use of peers;

- Failure to use mental health professionals in the debriefing;
- Inadequate preparation for the debriefing;
- Provision of debriefing services to close relatives, friends or work colleagues;
- Use of debriefers who were directly involved in the incident;
- Interrupting a person who is expressing their emotions during a debriefing;
- Inadequate introductory remarks;
- Insensitivity of participants or team members;
- Inadequate teaching and summary remarks;
- Failure to meet after a debriefing;
- Not providing appropriate follow-up services.

Community interventions

When a community has been seriously affected by a traumatic situation, its reactions and needs are usually quite different from those of emergency response organizations. The services to be offered to such a community must be carefully tailored to suit that particular community. For example, if a large group of persons have been affected by a disaster situation it is much more productive to bring large groups of persons together for a brief presentation on the possible effects of critical incident stress and its management than to attempt expensive, time-consuming debriefings of smaller groups.

Community interventions may be provided by emergency-based or community-based SMID teams and they need to be prompt, age-appropriate, carefully coordinated with local resources and provide for adequate follow-up services.

End of Section Quiz

Please circle the correct answer.

1.	A line-of-duty death should never be dealt with as part of a multiple incident debriefing.	T	F
2.	The Re-entry Phase is the third phase of a debriefing.	T	F
3.	The chair arrangement for a debriefing is not important.	T	F
4.	Inadequate preparation for a debriefing can cause it to fail.	T	F
5.	A post-debriefing meeting is optional.	T	F
6.	The debriefing team leader is always a mental health professional.	T	F
7.	The CISD protocol was originally developed by Dr. Jeffrey T. Mitchell.	T	F
8.	The ideal group size for a debriefing is 2 to 8 persons.	T	F
9.	Debriefers need to arrive at least 1 hour before the debriefing.	T	F
10.	The Reaction Phase of a debriefing is a cognitive phase.	T	F

Note: Answers to questions are on page 128.

N O T E S

SECTION 8: THE SMID TEAM

PAHO/WHO

***S**triving together as a team, to*

***M**ake that needed difference,*

***I**n the lives of those persons who*

***D**evote their lives to the care of others.*

***T**aking time out to listen,*

***E**ncouraging those who have lost faith,*

***A**ssisting those who need a helping hand to*

***M**ake it back to a state of psychological well-being.*

Overview

SMID Teams provide peer-oriented crisis intervention programs that depend on guidance and assistance from mental health professionals and which emphasize prevention over treatment.

An absence of mental health professionals from SMID Teams could easily result in significant psychological problems being overlooked. The absence of peers, on the other hand, may result in dysfunctional behavior of emergency response workers going unrecognized. Community-based stress management teams, in contrast, may be comprised of mental health professionals only.

SMID Team membership is strictly voluntary (unpaid). Teams work to provide services to any emergency response personnel who may need them but under special circumstances they may also serve community groups. Each SMID Team must have a well publicized call-out procedure. There also needs to be a 24-hour center to which requests for SMID Team services can be directed (e.g., the telephone operator of the Accident and Emergency Department of a general hospital).

To maintain a healthy SMID Team there must be regular team meetings, quality education and cross-familiarization where peer support personnel are trained in issues which are usually the domain of mental health professionals and vice versa.

The goals of such teams are to:

1. Enhance the overall psychological health of the emergency response worker,
2. Reduce the impact of traumatic stress on emergency response personnel and disaster workers, and
3. Accelerate recovery from exposure to stressful events.

Senior personnel of the various emergency organizations served by SMID Teams need to know about the nature of the team, its functions, the type of events it responds to and the manner in which it may be called into action. It would be wise to bring the leaders of these various organizations together in the early stages of the team's development and periodically after it has been established.

Administrative and supervisory personnel must be assured of the following:

1. SMID is primarily a prevention program which encourages recovery from stress and not from disability;
2. SMID services are relatively inexpensive to provide and the benefits are tremendous although difficult to measure;
3. The SMID Team can make suggestions or express its concerns regarding staffing or operational procedures but it cannot over-rule a commanding officer, especially when the team is working at the scene of an incident;

4. The SMID Team will keep the administrative and senior personnel informed about the general nature of the team's activities and about developments in the field of critical incident stress management;
5. The SMID Team will coordinate relevant educational programs for all those organizations utilizing its services;
6. The SMID Team will actively participate in disaster drills or in any other activities that will enhance the quality of the services which it provides.

Regional SMID Coordinating Body in the Caribbean

It is hoped that eventually a Regional SMID Coordinating Body can be set up to oversee SMID Services provided in the Caribbean. Each Caribbean territory or country with at least one SMID Team would then be required to nominate a single representative to serve on such a coordinating body. This body will be headed by the Regional SMID Coordinator and have a Secretariat in one of the member Caribbean territories and countries.

Both representatives and executive officers of such a coordinating body should serve two-year terms with a maximum of four consecutive years. Its success will depend heavily on the cooperation of and feedback from member countries and territories throughout the region.

The proposed duties of the Regional SMID Coordinating Body in the Caribbean will be to:

1. Decide on policies, protocols and procedures for the operations of SMID Teams throughout the region;
2. Coordinate training and serve as the certifying body for training;
3. Keep member organizations up to date with recent clinical developments in the field of critical incident stress management;
4. Evaluate the quality of SMID services provided by member countries or territories;
5. Attract funding to assist member countries or territories;
6. Foster information flow between members;
7. Be the final disciplinary arbitrator.

Lead Agency

The Lead Agency serves to establish the environment in which the SMID Team(s) can be developed and supported initially in any given country or territory. The actual services provided by the agency may vary from agency to agency.

Such an agency may be the Government, an emergency response agency, a disaster preparedness agency, a hospital or the psychology department of a college or university.

The Lead Agency may dissolve its role once the team(s) have been established and their Management Committees begin to function effectively. In countries or territories with more than one SMID Team the Lead Agency may continue to function as the local coordinating body for such teams.

The basic functions of the Lead Agency are to:

1. Provide funding and resources during the time of the team's development;
2. Develop a Mission Statement;
3. Establish a management committee;
4. Establish a team membership committee;
5. Assist in the drawing up of rules, standards, protocols and procedures for the team's operation;
6. Develop and coordinate the work of the team(s);
7. Put protocols in place to allow for cooperation with teams headed by other Lead Agencies;
8. Secure release time for staff members to manage and serve the team;
9. Maintain an up-to-date background file and call-out number for all team members;
10. Assist in the development of research and evaluation methods as well as quality assurance.

Management Committee of a SMID Team

The Management Committee is an administrative body which coordinates the work of the SMID Team. Its headquarters will initially be located at the Lead Agency but may eventually be relocated. In some jurisdictions, the Management Committee may perform the role of Lead Agency during the initial development of the team(s). The committee should meet weekly during the setting up phase of the team and monthly once the team has been established.

The Management Committee should comprise:

1. An Administrator
2. An Assistant Administrator
3. A Secretary / Treasurer
4. A Public Relations Officer
5. The Team Coordinator
6. The Team Clinical Director and
7. Support Clerical Staff (1 or 2 persons) who should hold full-time, paid posts.

The Management Committee should have access to the services of a Legal Advisor and an Education Advisor.

The duties of the Management Committee include:

1. The duties of a Lead Agency (if none exists);
2. The establishment of written policies, protocols, rules, regulations and procedures to govern the operations of the SMID Team;
3. Coordination of the initial and on-going training of team members;
4. Initial and on-going recruitment of team members;
5. Selection of appropriate team leadership;
6. Provision of general support for the activities of the SMID Team;
7. Evaluation of team performance;
8. Record keeping, data collection and research.

Team member selection

Persons to serve on a SMID Team will be selected by a Membership Committee which should comprise:

1. The Team Clinical Director,
2. The Team Coordinator,
3. One other mental health professional,
4. Two other peer counselors.

It will be the responsibility of this Committee to ensure that only the most suitable persons serve on the SMID Team. This is crucial for a team's survival and efficient functioning. ***There should be no "political" appointments to the Team, since the wrong kind of help may be more destructive than no help at all.***

Team structure

The SMID Team needs to comprise as many persons as are necessary to provide a 24-hour service, but 15 to 40 persons will usually be adequate. At least one third of the membership of a SMID Team needs to be professional support personnel and the remainder peer counselors. In any given country or territory, there may be the need for more than one SMID Team.

The persons who make up SMID Teams are:

(a) Professional Support Personnel

- Clergy
- Mental health professionals

(b) Peer Support Personnel

- Fire fighters
- Paramedics
- Police officers
- Life guards
- Nurses
- Physicians
- Search and rescue personnel
- Disaster workers
- Prison officers
- Any other first response personnel

For a 30-member team, the following organizational structure is suggested:

1. Team Coordinator (1)
2. Assistant Team Coordinators (4)
3. Clinical Director (1)
4. Other mental health professionals (9)
5. Other peer support personnel (15)

The Team Coordinator, Assistant Team Coordinators and the Clinical Director are elected by the team for a two-year period and they should not hold office for more than four consecutive years.

Team Clinical Director

The Team Clinical Director is a mental health professional who oversees the intervention activities of the team and should hold office for no longer than four consecutive years.

The duties of the Team Clinical Director are to:

1. Work closely with the Team Coordinator to ensure that the appropriate services are provided and that all of the team members work within the limits of their training and experience;
2. Put measures in place to ensure quality services;
3. Represent the SMID Team before the public and before organizations served by the team;
4. Assist with the writing of policies, protocols and procedures;
5. Co-lead team meetings with the Team Coordinator;
6. Assist with the recruitment, selection and training of team members;
7. Liaise with the Team Coordinator to ensure that the necessary support services are available and provided;
8. Conduct periodic reviews of team records and services;
9. Develop cross-familiarization programs for mental health professionals and emergency response personnel;
10. Maintain contact with other organizations in the field of critical incident stress management and keep current with recent developments in the field.

Team Coordinator

Team Coordinators should also be peer counselors since they better understand the normal operations of emergency organizations. The Team Coordinator is in charge of the day-to-day operations of the team and should hold office for no longer than four consecutive years.

The duties of the Team Coordinator are to:

1. Assess and coordinate requests for SMID services along with the Team Clinical Director;
2. Represent the team at emergency and community meetings;
3. Put measures in place to ensure quality services;
4. Provide general management of the team;
5. Assist with the writing of policies, protocols and procedures;
6. Co-lead team meetings with the Clinical Director;
7. Coordinate with the Clinical Director to ensure that the necessary support services are available and provided;
8. Assist with the recruitment, selection and training of the team's members;
9. Keep current with recent developments and maintain contact with other organizations in the field of critical incident stress management;

10. Develop positive relationships with agencies and community groups;
11. Maintain an up-to-date call-out list of all team members and an up-to-date referral list of mental health professionals;
12. Ensure that distressed debriefers are given appropriate assistance;
13. Keep a written record of all team activities.

Peer support personnel

Peer support personnel on a team are drawn from all of the organizations that may be served by the team. In community situations and education programs it is not necessary to utilize peer support personnel, but in the emergency services the use of peers is absolutely essential. It is important to note that in these organizations peer support personnel often make the first contact with persons who are showing signs of distress after exposure to a traumatic event.

Peer support personnel on SMID Teams need to be trained to provide SMID services. They should be mature, caring, dedicated, possess good interpersonal and social skills, be able to keep information in confidence and be able to work as part of a team.

The duties of peer support personnel are to:

1. Assist with assessing the need for SMID services and make recommendations to the Team Coordinator;
2. Provide peer counseling services;
3. Perform and participate in the delivery of various SMID services under the guidance of mental health professionals;
4. Assist the SMID Team to provide educational programs for their fellow emergency personnel;
5. Participate in peer review sessions;
6. Assist with any other team projects or activities as necessary.

Mental health professionals

Mental health professionals are persons who have the minimal qualifications required in their territories for their various professions, who work as providers of mental health services and who have received the necessary SMID training. Mental health professionals include psychiatric nurses, social workers, mental health occupational therapists, trained counselors, psychologists, psychotherapists and psychiatrists.

Duties of mental health professionals are to:

1. Assist with education of the team;
2. Provide psychological leadership during a debriefing;
3. Assist in the development and provision of follow-up and referral services;
4. Represent the SMID Team before the public and before organizations served by the team;
5. Provide clinical guidance to team members who have intervened in traumatic events;
6. Assist with the collection and interpretation of team data.

Clergy

It would be advisable for each team to have at least one person who is a member of the clergy. Members of the clergy serving on SMID Teams must be trained in the delivery of SMID services. They will serve the team by providing spontaneous support to team members and distressed persons as necessary. However, clergy must be careful not to impose a given religious perspective on persons with whom they come into contact.

Team training

All SMID Team members need to undergo initial and on-going training, since properly trained team members are the key to the success of any SMID Team.

Below is a list of suggested areas of initial and on-going training:

1. SMID training,
2. SMID Team policies, protocols and procedures,
3. SMID services,
4. General stress and its management,
5. Occupational stress and its management,
6. Critical incident stress and its management,
7. Post-traumatic stress syndromes,
8. Anxiety states,
9. Understanding emotion,
10. Basic and advanced counseling skills,
11. Peer support and counseling,

12. Medico-legal considerations of counseling,
13. Crisis intervention skills,
14. Significant other support,
15. Follow-up services and making referrals,
16. Understanding the aftermath of disasters,
17. Grief and bereavement,
18. Effective communication and public speaking,
19. Guidelines about making effective presentations,
20. Interpersonal and social skills training,
21. Conflict interventions and anger management,
22. Understanding how therapeutic groups work,
23. Understanding children and adolescents under stress,
24. Data collection and research techniques.

Setting up a SMID Team

Establishment of an efficient and effective SMID Team will take time and effort. Team development requires careful study and planning, a dedicated development committee, effective leadership, clearly stated goals and objectives and a drive to provide an excellent quality of service once the team is established. Below are a set of guidelines to follow when attempting to set up a SMID Team:

1. Pre-feasibility phase:

(a) Seek approval from administration to investigate the need for and to establish, if necessary, a SMID Team.

(b) Determine whether or not there is a need for a team. Identify the number of traumatic incidents which had a serious emotional impact on emergency service personnel over the last 5 years. If it averages at least 5 incidents per year then a team is indicated. If it averages less than 5, a regional-based team would be better for such a community. Also determine whether adequate peer and mental health support is available for the establishment of a team.

(c) Gather information about the development of similar bodies in other countries.

(d) Form a task force of peer support personnel and mental health professionals to develop the SMID Team.

(e) Solicit funding for set-up and training costs.

2. ***Pre-establishment phase:***

   (a) Recruit and select potential team members.

   (b) Provide training for potential team members.

   (c) Establish written policies, protocols and procedures for team operation.

3. ***Establishment phase:***

   (a) Select team members.

   (b) Choose the necessary leaders.

   (c) Establish the necessary committees.

   (d) Coordinate and evaluate team performance.

Maintaining the health of team members

Persons who provide SMID services need to bear in mind that they are themselves vulnerable to stress reactions and that they provide services to persons with very intense emotions. Team members need to take time out when they are feeling overwhelmed or dealing with major problems of their own.

Some incidents are so powerful emotionally that the team members who were involved in debriefing such incidents may need to be debriefed themselves, preferably by members from another team. On such occasions, the debriefers must be flexible and allow team members to re-tell the entire story in chronological order so that everyone can discuss the extent of their involvement.

Disaster drills

The team needs to go through the steps of being called out, responding to the scene and setting up with the officer responsible for health and safety issues at the scene.

The team should not attempt "simulated crisis intervention" since emergency response personnel tend not to like such role playing. Instead, the team should familiarize itself with perimeter control points, command post operations, rehabilitation of personnel, the morgue set up, the media section and any other relevant aspects of a possible disaster situation.

Team members could take the opportunity to distribute informational brochures on the goals and functions of the SMID Team at the end of the drill. The handout should contain a clear outline of the team's call-out procedure and the names and telephone numbers of team contacts.

Peer review

A Peer Review Board reviews complaints (internal and external) about errors or deliberate disregard for commonly accepted SMID practices.

The Peer Review Board is made up of between three and five members of the SMID Team (including both mental health professionals and peer support personnel) who are in good standing. The Board is chosen by the Clinical Director in conjunction with the Team Coordinator. Each member is chosen for a period of two years and they may spend a maximum of four consecutive years on the Board. At least two of the Board members should have served on the previous Peer Review Board. No team members can review his or her own case, hence substitutions can be made by the Clinical Director in consultation with the Team Coordinator in such situations.

The Peer Review Board should gather the facts related to the incident as soon as possible after a complaint is lodged. The Board then meets with the member(s) in question within three days of the complaint, evaluates the information gathered and issues a written report with recommendations to the Clinical Director and Team Coordinator within two days of the meeting with the person under review by the Board.

The Clinical Director and the Team Coordinator can either act on the recommendations of the Board or resubmit the report for further review.

Team membership can be revoked by the Clinical Director, the Team Coordinator or the Peer Review Board. Possible reasons for revoking a person's membership are:

1. Breaches of confidentiality;
2. Failure to comply with policies, protocols and procedures of the team;
3. Misrepresentation of the team;
4. Providing services without the prior authorization of the team;
5. Using one's team membership to enhance one's private business concerns, one's personal social life, etc.;
6. Failure to provide a service that one had agreed to do;
7. Consistent failure to attend team meetings and team education programs;
8. Acting against the expressed directions of the Clinical Director or the Team Coordinator.

Time-out for over-extended team members:

Some team members do not recognize their need for a break. Peers on a team are more likely candidates for over-extension because of their more frequent contact with distressed colleagues. Fellow team members may need to point out the problem to such persons

so that they can have time-out to gain control of themselves before they suffer serious damage.

While the matter has to be discussed in a frank and up-front manner, every effort needs to be made to allow the person to realize that they need a break. However, because "burnt out" team members can jeopardize the smooth functioning of the team, if the persons do not gain insight into their problem they may need to be asked to take a break from the team.

Possible warning signals of over-extension:

1. Excessive preoccupation with SMID services provided or with the persons to whom such services were provided;
2. Intense irritability if fellow SMID Team members offer advice;
3. Unfounded anger;
4. Frequent unexplained loss of emotional control;
5. Excessive agitation and restlessness;
6. Disturbed sleep patterns;
7. Chronic feelings of fatigue;
8. Loss of interest in one's job;
9. Excessive withdrawal from contact with others;
10. Attempts to work independently of the team without appropriate supervision;
11. An erroneous belief that one's skills are superior to those of other team members.

Protection from legal action:

Below are some of the protective steps that can be taken to reduce the chances of legal action being taken against a SMID Team:

1. Be familiar with the laws in one's jurisdiction;
2. Provide high quality services;
3. Carefully follow international and local policies, protocols and procedures;
4. Do not participate in breaches of confidentiality, except as noted in the next item;
5. Act in the best interest of actively suicidal or homicidal persons even if it entails a "breach" of confidentiality;
6. Respect the right of persons to refuse SMID services—mandatory participation should be avoided;

7. Always tell persons up front what the services to be provided are all about;
8. Warn recipients of SMID services not to disclose any information that could jeopardize an investigation or implicate them or anyone else;
9. Have practice insurance;
10. Do not allow any type of recording in confidential proceedings;
11. Never turn a defusing or a debriefing into psychotherapy.

Evaluation of SMID services

Formal evaluation of a SMID Team's performance is extremely difficult for a number of reasons:

1. Emergency service personnel resist being evaluated by outsiders especially with respect to their inner thoughts and emotions;
2. Emergency service personnel are normally busy;
3. Emergency and disaster workers are constantly being re-exposed to traumatic events;
4. No laboratory exists in which emergency service personnel can be studied under controlled conditions.

Despite these limitations, SMID Teams must constantly strive to find ways to evaluate the effectiveness and efficiency of their interventions. One should always bear in mind other less formal methods of evaluating team performance, which include:

1. Feedback from persons and organizations which have benefited from SMID services;
2. Team meetings to review services provided; and
3. Reviews of formal complaints by the Peer Review Board.

End of Section Quiz

Please circle the correct answer.

1.	SMID Teams provide peer-oriented crisis intervention programs.	T	F
2.	The SMID Team Clinical Director does not sit on the Management Committee of the team.	T	F
3.	"Political" appointments to SMID Teams are okay.	T	F
4.	The Team Coordinator is a mental health professional.	T	F
5.	Members of the Clergy do have a potential role to play in SMID Teams.	T	F
6.	A feasibility study should precede the establishment of a SMID Team.	T	F
7.	SMID Teams need not participate in routine disaster drills.	T	F
8.	Over-extended SMID Team members may need time out from the team.	T	F
9 .	The Peer Review Board of a SMID Team reviews complaints.	T	F
10.	Frequent bouts of anger may be a sign of "burnout" of a team member.	T	F

Note: Answers to questions are on page 128.

N O T E S

APPENDIX 1

Score Interpretations

1. As a service provider, what is your level of work-related stress?

   - Scores between 26 and 50
     indicate a low level,
   - between 51 and 75
     a moderate level, and
   - between 76 and 100
     a high level of work-related stress or possible "burnout".

2. What impact did the last traumatic stressor to which you were exposed have on you?

   - Scores between 26 and 50
     indicate a low impact,
   - between 51 and 75
     a moderate impact, and
   - between 76 and 100
     a severe impact as a result of exposure to the stressor.

APPENDIX 2

Quiz Answers

	1	2	3	4	5	6	7	8	9	10
Section 1 (page 18)	F	F	F	F	T	F	T	T	T	F
Section 2 (page 41)	T	F	F	F	T	T	T	T	T	F
Section 3 (page 56)	T	F	T	F	T	F	T	T	T	T
Section 4 (page 75	T	F	T	F	T	T	T	T	T	F
Section 5 (page 83)	T	T	T	F	F	F	T	F	T	T
Section 6 (page 92)	F	T	F	F	T	F	F	F	F	T
Section 7 (page 108)	T	F	F	T	F	T	T	F	T	F
Section 8 (page 125)	T	F	F	F	T	T	F	T	T	T

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What Is SUMA?

At the beginning of the 1990s, the countries of Latin America and the Caribbean pooled their efforts, with the support of the Pan American Health Organization (PAHO), the government of the Netherlands and the Colombian Red Cross, to develop SUMA—the Humanitarian Supply Management System.

SUMA is an information management tool that helps governments improve the management of humanitarian assistance and ensure efficiency and transparency in the reception and distribution of relief supplies. SUMA also helps disaster managers to provide donors and humanitarian agencies with the information they need to guarantee accountability.

What Does SUMA Do?

- It streamlines the identification, sorting and classification of arriving humanitarian supplies.
- It helps to assign different priorities to the incoming supplies based on the needs of the affected population.
- It consolidates all the information about incoming shipments and existing stocks into a single database.
- It provides a clear picture of the circulation of donated supplies from the point of arrival until they get to the final beneficiaries.
- It eases and encourages the preparation of reports and exchange of information among all stakeholders (governments, NGOs, donors, etc.).

Who Handles SUMA?

SUMA trains national teams and promotes self-sufficiency by ensuring that countries can manage humanitarian assistance employing their own resources. The national teams comprise volunteers from health agencies, civil defense or emergency committees, the armed forces, the local Ministry of Foreign Affairs, customs, the Red Cross, NGOs and other bodies. Over 2,000 volunteers have already been trained in Latin America and the Caribbean.

SUMA—Towards a Global Standard for Humanitarian Supply Management

SUMA is accepted throughout Latin America and the Caribbean as *the* standard in the management of relief supplies. The countries of the Region are now exporting the model to other parts of the world that have requested assistance and training in the use of the SUMA System to meet their disaster management needs.

For more information please contact:

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Or visit the web site: http://www.disaster.info.desastres.net/SUMA/

Regional Disaster Information Center for Latin America and the Caribbean

Disaster management is, above all, the management of information. The goal of CRID is to provide the countries of Latin America and the Caribbean with access to the best disaster information sources and resources available so that users can make well-informed decisions when managing disasters and trying to prevent or reduce their impact.

CRID enjoys the support of six organizations and agencies[1]. Its objectives are:

- To improve the compilation, processing, and dissemination of disaster information.
- To strengthen local and national capacity in setting up and maintaining disaster information centers.
- To promote the use of information technologies.
- To support the development of the Regional Disaster Information System.

Services Provided by CRID

CRID provides the following services:

- The ability to conduct bibliographic searches over the Internet, on CD-ROMs, or by contacting the Center directly.
- The publication and distribution of specialized bibliographies and reviews of the literature *(Bibliodes)*.
- Direct access over the Internet to a wide collection of full-text documents on disasters and disaster reduction in general and in the Region.
- Distribution of publications and training material.
- Mass distribution of public and technical information.
- Technical advice and training on how to set up and manage disaster information centers.
- CRID promotes and supports the consolidation of a Regional Disaster Information System for Latin America and the Caribbean through technical support for national and local information centers, the development of a unified methodology and tools, and the establishment of uniform information services.

For more information please visit: http://www.CRID.or.cr

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CRID, the best source of disaster information in Latin America and the Caribbean

[1] The Pan-American Health Organization / Regional Office of the World Health Organization (PAHO/WHO), the United Nations International Strategy for Disaster Reduction (UNISDR), the National Risk Prevention and Emergency Response Commission of Costa Rica (CNE), the International Federation of Red Cross and Red Crescent Societies (IFRC), the Center for the Prevention of Natural Disasters in Central America (CEPREDENAC), and the Regional Office for Emergencies of Médecins Sans Frontières (MSF).

Emergency Preparedness and Disaster Relief Coordination Program
Pan American Health Organization
Regional Office of the World Health Organization

In 1976, the Pan American Health Organization created this Program in response to a call by the Member Countries to establish a technical unit to strengthen health sector disaster preparedness, response and mitigation activities.

Since then, the Program's main objective has been to support the health sector to strengthen their national disaster preparedness programs and its interaction with all the sectors involved in disaster preparedness. This support has been channeled to the countries of Latin America and the Caribbean in three principal areas:

In **disaster preparedness**, in addition to constant promotion of a strong health disaster preparedness program, PAHO regular activities include training (through hundreds of courses and workshops) and the preparation and distribution of training materials (books, slides and videos).

Disaster mitigation is just as important. An investment in disaster preparedness can be rendered useless if hospitals or health centers cannot withstand the impact of a disaster and collapse at exactly the moment they are most needed. PAHO promotes and supports including disaster mitigation in natural disaster reduction programs and legislation.

In **disaster response**, PAHO works with the affected countries to identify and assess damages and needs, carry out epidemiological surveillance and monitor drinking water, and mobilize international relief and manage humanitarian supplies. PAHO has established the Voluntary Emergency Relief Fund that collects money to support post-disaster activities.

The Program also has several special technical projects: Disaster Mitigation in Hospitals and Drinking Water Systems; Humanitarian Supply Management System; Use of the Internet for Disasters and Emergencies; and the Regional Disaster Information Center (CRID).

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