Assisting in the Aftermath of Disasters (And Other Life Crises)

John D. Weaver, LCSW, BCD, ACSW

Introduction

People are almost always changed by the traumatic events they face during their lives, but they need not be damaged by those events.

That’s how I like to begin my DMH presentations to audiences that have come to learn more about crisis intervention with victims of disasters and other traumatic life events. The following is a brief summary of DMH concepts and techniques. Much of this material is drawn from the 1995 book, Disasters: Mental Health Interventions, published in Sarasota, FL by Professional Resource Press (Weaver, J., author), from subsequent chapters in three other books (Weaver, 2002, 1999, and 1996), from my Website (www.eyeofthestorminc.com), and from several journal articles. This is copyrighted material and it should not be reproduced without proper consent.

The basic tenants of DMH begin with the central principle that the target population primarily consists of normal people who have been through an abnormally stressful disaster (or other emergency situation). Victims generally will not stop functioning, but they will react in fairly predictable ways (with some differences due to age and maturity). By using various crisis intervention techniques, outreach services, and psychoeducational approaches, the victims and relief workers can be quickly triaged and briefly counseled (or referred for formal services), so as to return them to pre-disaster levels of functioning as quickly as possible. The goal of DMH is to help assure that the victims become survivors, by doing whatever can be done to prevent long-term, negative consequences of the psychological trauma.

Few mental health professionals have received training in crisis intervention, advocacy, mediation, education, psychological first aid, defusing, and debriefing—the primary skills used for DMH intervention. Social workers, for example, are mandated to provide appropriate professional services in public emergencies. The NASW Code of Ethics 6.03 Public Emergencies states that Social Workers should provide appropriate professional services in public emergencies to the greatest extent possible. Yet few social workers have the specific training/skills needed to serve as relief workers. Many undergraduate and graduate programs in social work, psychology, counseling, nursing, and psychiatry spend little time (if any at all) teaching the critical prevention and crisis intervention techniques needed for relief work.

One of the greatest challenges for traditionally trained mental health professionals who want to volunteer some of their time assisting with disaster relief is to make the shift from being focused on diagnosing and treating pathology (a damage model) to being focused on normal stress reactions, resiliency, and wellness (a challenge model). Many do not feel comfortable working with sudden grief and loss, or with the intensity of emotions stirred by DMH work. First time volunteers will quickly discover that they either love this work or they never want to do it again.

When a disaster occurs, folks look at a lot of things in a different way than they did before. Prior to the event, people have an order to their lives and they feel like they are in command. In the days and weeks following the disaster, they often feel they no
longer have control over anything—the event has caused unexpected losses and has taken away their normal routines. They will find themselves awash in a sea of paperwork and bureaucracy (relief agencies and services, insurance claims, etc.) that many refer to as the second disaster. They soon begin to realize it will be some time before they will regain their former sense of stability and control.

Literature suggests that persons/communities struck by disaster will generally pass through four distinct phases of response:

- **Herocic Phase** (may begin prior to impact and last up to a week afterwards): people struggle to prevent loss of lives and minimize property damage.
- **Honeymoon Phase** (may last two weeks to two months): massive relief efforts lift spirits of survivors and hopes for a quick recovery run high; this optimism is often short-lived.
- **Disillusionment Phase** (may last from several months to a year or more): sometimes called the second disaster, when the realities of bureaucratic paperwork and recovery delays set in; outside help leaves and folks realize they must do more themselves.
- **Reconstruction Phase** (may take several years): normal functioning is gradually reestablished.

(Farberow and Gordon, 1981, pp. 3-4; Weaver, 1995, pp. 31-32)

These are the common feelings and reactions that most victims will express and/or display:

- Basic survival concerns.
- Grief over loss of loved ones and/or prized possessions.
- Separation anxiety and fears for safety of significant others.
- Regressive behaviors such as thumb sucking and bed wetting in children.
- Relocation and isolation anxieties.
- A need to express thoughts and feelings about having experienced the disaster.
- A need to feel one is part of the community and its rebuilding efforts.
- Altruism and the desire to help others cope and rebuild their homes and their lives.

(Farberow, 1978, p. 26; Weaver, 1995, p. 32)

Disasters often cause behavioral changes and regression in children. Many react with fear and show clear signs of anxiety about recurrence of the disaster event(s). Sleep disturbances are very common among children (and adults) and can best be handled by quickly returning to (or establishing) a familiar bedtime routine. Inability to do this can be a major problem following events like an earthquake, as frequent aftershocks and displaced residences make it difficult for anyone to return to regular sleep routines. Many families find themselves sleeping together in the same bed long after the main quake.

Similarly, school avoidance may occur and it can lead to development of school phobias, if children are not quickly returned to their normal routine of school attendance. In some disasters the schools, themselves, may be damaged and inoperable. This, and the need to be bused to other, unfamiliar buildings, will further add to the stresses on children. Sometimes the aftermath of a disaster (e.g., aftershocks) results in lots of children staying home for days or even weeks, fearful to leave their parents’ sides for the length of the school day.

Adults often report mild symptoms of depression and anxiety. They can feel haunted by visual memories of the event. They may experience psychosomatic illnesses. Pre-existing physical problems such as heart trouble, diabetes, and ulcers may worsen in response to the increased level of stress. They may show anger, mood swings, suspicion, irritability, and/or apathy. Changes in appetite and sleep patterns are quite common. Adults, too, may have a period of poor performance at work or school and they may undergo some social withdrawal.

Middle-aged adults, in particular, may experience additional stress, if they lose the security of their planned (and possibly paid-off) retirement home (or financial nest-egg), and/or if they are forced to pay for extensive rebuilding. Older adults will greatly miss their daily routines and will suffer strong feelings of loss from missing friends and loved ones. They may also suffer feelings of significant loss from the absence of their home or apartment, or its sentimental objects (especially items like paintings, antiques, family Bibles, photo albums, and films or videotapes), which tied them to their past.

Adults living in group residential rehabilitation settings (mental health, mental retardation, and substance abuse facilities) and institutions (prisons, hospitals, boarding homes, and nursing facilities) may react in the same ways others in the community react to the disaster. For these groups there is often an overriding sense of isolation and dependence, which they may have felt before the disaster. These negative feelings can worsen during the recovery period, when family members and friends are lost, as casualties of the event, or as captives of the cleanup effort. Either way, the persons in these residential settings generally receive less social contact and will tend to feel more forgotten and alone.
Timing of the onset of these changes varies with each person, as does duration. Some symptoms occur immediately, while others may not show until weeks later. Just about all of these things are considered normal reactions, as long as they do not last more than several weeks to a few months.

**Here are some other “Key Concepts” that DMH workers must keep in mind:**

1. Mental health labels should be avoided.
2. People do not disintegrate.
3. Victims (and relief workers) respond to DMH workers who show active interest and concern.
4. Workers need to abandon traditional office-based approaches.
5. Be sensitive to cultural, ethnic, racial, and socioeconomic diversity.
6. The disaster climate has a way of generating lots of rumors.
7. Disasters bring out the best and the worst in people.
8. Helpers are subject to a vast array of physical and emotional responses to crises, including burnout.
9. Workers can find strength (and peer support) in numbers.
10. One DMH experience is enough to get you hooked—the work is highly addictive for many who volunteer.

(Weaver, 1995, pp. 41-45)

Lots of DMH work is done while “hanging out” with victims and other relief workers. Most interventions will be very brief contacts, many being 15 minutes or less in length. Those persons who are having more serious difficulties will need more careful attention and longer, more formal interviews.

The following material should help clarify some types of information that must be gathered while screening persons with more significant, negative reactions:

1. What drew special attention to this person?
2. What are the person’s presenting problems?
3. How long have the problems existed?
4. What help (support, education, and/or treatment services) has the person received and from whom?
5. What prescription and nonprescription (over-the-counter) medications are being used by the person for physical problems?
6. What psychotropic medication, if any, is the person taking for any psychiatric condition(s) for which he or she is receiving treatment?
7. Is the person self-medicating (abusing street drugs, prescription or non-prescription medications, or alcohol)?
8. Has the person had a good, recent physical exam to rule out any physical problems that might be causing (or adding to) the current problems?
9. Is there a family history of mental illness?
10. What changes in mood, behavior, sleep, appetite, ability to concentrate, motivation, etc. are present?
11. If depression is mentioned (or seems obvious), ask about current and previous suicidal thoughts and attempts.
12. If anger and/or poor impulse control are issues, explore thoughts (and history of actions) involving harm to others.
13. If the person is hearing voices, displays suspiciousness of others, sees things, feels odd sensations, believes he or she is being controlled by others (or the media), etc., these are often good indicators of serious mental illness.

(Weaver, 1995, pp. 86-89)

It is always a good idea to conclude any screening interview with a general, open-ended question that will allow the individual to fill in any gaps. Say something like, *is there anything I did not ask you that might be important for me to know about how things are going with you since the disaster?* Keep the possibility of abusive behavior in mind. Physical and/or psychological child abuse, spouse abuse, elder abuse, and other abusive relationships may worsen under the stress. Substance abuse also tends to rise, adding to tensions and further fueling abuse issues.

DMH workers need to get people talking, keep people busy, and begin problem solving. DMH contacts can be made at work locations such as disaster sites, staging areas, shelters, feeding locations, service centers, and so on. Workers need to work the crowds at congregate relief points, visit remote sites, do home visits, and make condolence calls. Watch out for people who engage in “defense oriented” responses to traumatic situations (e.g. excess crying and social withdrawal) as they will generally have less positive outcomes than people who use “task oriented” forms of coping (e.g. begin to clean up and salvage, fill out needed paperwork for relief assistance/insurance claims, etc.).
Outreach services and public education are essential because only a small portion of those persons emotionally touched by a disaster may seek direct-care services. Workers need to utilize print and broadcast media to broadly distribute timely information about the normal reactions people experience during the recovery (a period of time that will take far longer than most people realize). Several excellent brochures are available (with many also printed in Spanish) to help spread the critical messages.

In major disasters, working conditions are sometimes poor and hours are long. Relief workers often put in 12-14 hour days and sometimes do so for weeks at a time. DMH team members and other volunteers need to be mindful of stress management and self-care. Burnout is a serious hazard for disaster workers. Use of peer support is the best method that can be used to cope with the stresses—make friends and watch out for each other. Appropriate use of breaks, scheduled time off, humor, maintenance of proper diet, exercise, and getting proper amounts of restful sleep, are other critical elements in each worker’s plan of care. Keeping a personal journal (a log of what was seen, thought, and felt), and writing a narrative at the end of the assignment, can be of help, too. Disaster work is not for everyone—workers need to recognize and admit their limitations.

Once a disaster operation ends, workers need to make the transition back into their pre-disaster lives and responsibilities. This can be a challenging time for the worker, his/her family, and those with whom he/she works. It is often wise to try to schedule some time off before returning to normal duties. Workers and volunteers often appreciate a defusing/debriefing session once their relief roles end.

Disaster service often changes relief workers in a variety of ways. One common outcome is a unique perspective on life. For instance, when someone works as many major disasters as I have, some of the pettiness of day-to-day activities of living can be more easily ignored and it’s easier to keep focused on what’s important. During times of tragedy, one thing that is very important is support—support from family members, support from friends, support from communities of faith, and support from others who care enough to share something of themselves when people are in need.

### Less Is More (Keep It Simple)

Begin with this fundamental premise:

*There is nothing you can say or do that will quickly end the shock, ease the pain, or make survivors feel better…But there are lots of things you can say or do that can make them feel (or act) worse!*

Examples: *I know what you’re going through…or…Everything is going to be fine.* (Either comment may seem innocent enough, yet often results in an angry response.)

Many times **Passive Listening** is the best approach—use attentive silence and keep responses to a minimum. Overreaction is counterproductive to cathartic ventilation. There is a concept in communication known as **Rehearsal Drop**—basically a point in conversation where the listener’s listening ends and his or her formation of a question or response begins. By speaking too much, responding too quickly, or falling into any of the other nervous interviewing patterns he or she displayed at the beginning of his/her counseling career, the novice or nervous DMH worker often shoots himself or herself in the foot. The next section gives you an idea about one such pattern of helper behavior that is often counterproductive.

### How Do You Feel? (Don’t Ask!)

When the survivors are ready to talk, there is no way to avoid getting their feelings. Still, I frequently see well-meaning, novice DMH people try to begin their conversations with the quintessential question, **HOW DO YOU FEEL?** (or some similarly intrusive variant that goes straight for victims’/survivors’ gut feelings). Following the TWA 800 crash, the governor of NY sent in hundreds of well meaning, untrained volunteers, many of whom kept approaching survivors with that same question. Someone who is only available to serve for a short time is often impatient—wanting to make something meaningful happen during his or her short time on the job. Then they can feel good about what they did, write an article, etc.

**How do you feel?** is often perceived to be the stereotypic psychobabble that TV and movies use as shorthand for all MH counseling. It is also the same bluntly intrusive question many media representatives use to get their 15-30 second sound bites of traumatized people in pain. Avoid it! There is no need to go directly after the feelings in any counseling situation, let alone one as sensitive as sudden death scenarios. Once you begin opening up a dialogue about the facts, the feelings will follow, without you ever needing to ask for them.

This may initially strike some of you as a ridiculous notion, but your mom has probably already taught you many of the main skills you will need in order to be effective in the early stages of DMH intervention. There are many parallels to what moms must do when their children get a boo boo and what we do in defusing and debriefing. For instance, think back to one of those many times you fell from your bike (or somehow had gotten other bumps and bruises) and you sought help from mom (or dad, grandma, grandpa, etc.). Whoever was doing it, his or her intervention probably began with two simple steps—a hug and a simple question: **What happened?**
As you got yourself composed and began to tell the dramatic details (the defusing or debriefing), mom would be working with you to clean out the wounds. In many cases, what she was doing was actually making it hurt a little more, in the short run, as soap and water, peroxide, iodine, or Bactine were used to get the messy stuff out and set the stage for proper healing. After the first time or two, you knew it would hurt worse while being cleaned yet you trusted the process. At some level you probably began to realize it needed to be done as soon as possible and it needed to be done right the first time, or there would be worse problems and pain later on.

Mom’s work was serious stuff done in simple ways. The key elements of her role were:

1. To listen and get the story out (What were you trying to do?), which served as a nice distraction for her work in step #2).
2. To be sure the wound was properly cleaned and to patch it up.
3. To offer perspective (You could have gotten yourself killed!) and teach valuable lessons about how to avoid similar scrapes in the future (Next time, stop and look both ways!).
4. To consider whether or not you needed a time-out (or rest period).
5. To relieve the emotional pain and offer the support and guidance needed to get you safely back into play (or your other normal routines).

What she said during this encounter was not as important as her manner (calmness), her ability to listen, and her reassurance. Once it was over, mom was probably an emotional wreck, especially if the potential had been there for a worse outcome. She probably called a friend or went outside and chatted with a neighbor—her peer support (to get her own defusing or debriefing session).

But, mom’s work was never done. She had to remain alert and be watchful at all times. Is he climbing in that tree again? Did she look both ways? Is the gate locked? She was your protector—a guardian angel. She could stay out of the way, in the background of your life, but be available for you to check-in. She needed to be there, especially in the early years, for times of danger that may require her to step in. Charles Bruder (1995) presented a paper at the APA Annual Convention in New York on a very similar DMH concept that he dubbed the psychological lifeguard.

Bruder’s presentation grew out of his work with recovery efforts following the Flight 427 Crash. There he discovered the value of being able to hang back and let emergency personnel do their jobs while keeping a keen and watchful eye open for signs that some are experiencing difficulties considerable enough to compromise their abilities... (p. 17). Then, as needs arise, DMH workers can step in with the needed crisis intervention and support services.

Everly and Mitchell (1999) offer this list of communication techniques that are essential to developing an effective approach to crisis interviews:

- Silence: avoid intrusion and facilitate uninterrupted catharsis.
- Nonverbal Attending: monitor body language;
- Restatement: check and clarify terms and listening accuracy.
- Paraphrasing: summarize main points of conversation.
- Reflection of Emotion: mirror and acknowledge emotional reactions.
- Open-ended Questions: what, why, how, describe, tell me.
- Closed-ended Questions: where, when, did, can, should, could (pp. 41-43).

With these ideas in mind, let’s take a more detailed look at defusing and debriefing.

**Defusing**

Defusing is the term given to the process of talking it out. It works like taking the fuse out of a bomb (or an explosive situation), by allowing victims and workers the opportunity to ventilate about their disaster related memories, stresses, losses, and methods of coping, and allowing them to do so in a safe and supportive atmosphere. The defusing process usually involves informal and impromptu sessions. A DMH worker might witness an emotional interchange between a victim and another staff member and, soon afterward, approach one or both of them to open a dialogue. This will, in turn, help them release thoughts and feelings that might not otherwise be appropriately expressed. Suppression or repression of this kind of highly charged material can lead to troubled relationships and development of any number of stress related physical and/or mental illnesses.

Greeting a victim who is waiting in line at a disaster service center and offering a snack or a drink, or playing a game with a child in an emergency shelter, or making a purchase from a clerk at a store in the disaster area, or even ordering a meal while in the field, can be enough of an opportunity to begin a healing process for someone who is anxious to tell his/her story. Running into a coworker at the copy machine offers the same chance. So does going out to eat with other staff members. Although informal and immediate, the defusing often becomes a mini-debriefing and can follow one of the formats discussed below. Because the allotted time is often too
brief, it is simply a starting point. Further intervention is often required and this can be anything from offering ongoing support (e.g., briefly touching base with the persons/groups in the coming days/weeks) to scheduling and providing formal debriefing sessions.

### Debriefing

The psychological debriefing is a formal meeting, done individually or in small groups. It is generally held shortly after an unusually stressful incident, strictly for the purpose of dealing with the emotional residuals of the event. Any location that is large enough to accommodate the group, and can be secured so as to assure privacy, is appropriate for use. This session may require a block of time that is several hours in length, particularly if a process such as Mitchell’s (1983) Critical Incident Stress Debriefing (CISD) model is used.

Whenever possible, everyone involved in the crisis should attend the debriefing(s). Many organizations recommend or even require attending defusing and debriefing sessions, whenever certain types of incidents occur. The American Red Cross (ARC), for instance, used to offer defusing as necessary, throughout a person’s tour of duty at a disaster scene. ARC also recommended (but did not require) having a debriefing before leaving for home. Once ARC workers got home, their local ARC chapter usually offered them a formal debriefing. At the morgue following the 1994 crash of Flight 427 near Pittsburgh, volunteer trackers and scribes (persons who escorted the remains of the 132 victims through the I.D. process) were offered graphic pre-briefings to provide stress inoculation. They were required to attend debriefings at the end of their shifts. Many expressed their gratitude and all seemed to value the opportunity to be debriefed. ARC now prefers to offer psychological first aid, a more evidence-based practice. More will be said about that later in this document.

The original Mitchell process was designed for first responders (police, fire fighters, emergency medical technicians, etc.), to help them overcome the emotional aftereffects of critical incidents (e.g., line-of-duty deaths). Sessions were usually held within the first 24-72 hours after the traumatic event, with follow-up sessions as needed. Given the nature of disasters, we do not always identify all of the victims that quickly. Fortunately, the debriefing process is still beneficial, even when the sessions are held long after the event. Local, single family fires and other small scale disasters often cause the same traumatic responses as do the larger events and victims respond well to these interventions. Most mental health professionals have not been taught about defusing or debriefing and report being amazed at how helpful these simple but powerful tools can then become in their day-to-day practices in helping clients cope with various life crises.

There are now several newer debriefing models, some of which are presented in the table below. While they differ in the number and type of phases (or stages), they all get at the same basic elements that Mitchell’s original process sought to examine, in order to help people cope with the sights, sounds, smells, thoughts, feelings (replaced by thoughts and reactions in revised Mitchell Model), symptoms, and memories that are all part of a normal stress reaction to a traumatic event. ARC was using the Multiple Stressor Debriefing Model. The National Organization for Victim Assistance (NOVA) has its own model and has specialized crisis response training programs.

### Multiple Stressor Debriefing Model

- **Introductions**
  - Stage 1: Introductions
  - Stage 2: Fact Phase
  - Stage 3: Feeling Phase
  - Stage 4: Symptom Phase
  - Stage 5: Teaching Phase
  - Stage 6: Reentry Phase

- **Phase 1:** Introduction of Events
- **Phase 2:** Feelings and Reactions
- **Phase 3:** Coping Strategies
- **Phase 4:** Termination

*Armstrong, Lund, McWright, & Tichenor (1995), p. 85*

### Mitchell CISD Model (original version)

- **Stage 1:** Introductions
- **Stage 2:** Fact Phase
- **Stage 3:** Feeling Phase
- **Stage 4:** Symptom Phase
- **Stage 5:** Teaching Phase
- **Stage 6:** Reentry Phase

*Mitchell (1983), pp. 36-39*

### Mass Disaster/Community Response Variation of CISD

- **Stage 1:** Introductions
- **Stage 2:** Fact Phase
- **Stage 3:** Thought Reaction Phase
- **Stage 4:** Emotional Reaction Phase
- **Stage 5:** Reaffirming Phase
- **Stage 6:** Teaching Phase
- **Stage 7:** Reentry phase

*Everly (1995), pp. 288-289*

Whatever model you decide to use, allow lots of time for folks to ventilate, especially during the initial phases/stages of the process, when facts, thoughts, and feelings are being discussed. Encourage detailed expression of the most vivid or graphic, negative images and memories. Think of it as cleaning out an emotional wound before allowing it to heal with foreign material still on the inside. Improper procedure with a bad cut promotes infection. Improper procedure here will mean the emotional wounds can be too easily reopened by future stressful events and it will increase the possibility of developing PTSD. Facilitators should not, however, push people to reveal anything that is still too upsetting for them to discuss. Forcing things may cause additional harm by making people re-experience the traumatic event at a time when healthy denial may be a better approach.

Normalize their experiences. Teach them about stress reactions. Provide stress inoculation about anniversary reactions and other issues they will eventually face. Offer lots of support and try to anchor a positive image and outlook for their successful recovery.
End by thanking them for coming and taking part in the debriefing process; shake their hands and/or give a hug as each person leaves the session.

Bear in mind that the personal impact of disasters tends to be much worse whenever the disaster events are caused by intentionally destructive human acts than by natural causes (or pure accidents). Whenever inhumanity plays a major role in causality, survivors seem to need extra time to resolve their losses and move forward with their lives. This relates directly to the greater amount of anger involved, overexposure from repetitive media coverage, and the fact that any true sense of closure may not come until the perpetrator(s) are found and prosecuted.

### Guidelines for Organizing Community Debriefings

The following material was designed to help Lehigh Valley ARC DMH workers facilitate formal community debriefing sessions that are often held in the days and weeks following a disaster event. Remember that the Red Cross DMH team, county and/or state mental health offices, the area’s CISD or CISM (Critical Incident Stress Management) team, and other agencies may also be available to help when mutual aid is needed.

1. Try to find a site that allows separate breakout rooms, so that a large group can be divided into smaller ones. Churches, schools, and other similar buildings are good meeting places.
2. When working with several groups, try to locate a neutral spot in the building where the group that finishes first can go to await the arrival of the other group(s). This same spot is a good place to use for offering simple snacks and drinks, before and after the session.
3. Try to get someone from the group of persons who have requested the debriefing to help with preparations by having that person invite the appropriate participants and select the logical meeting place. This screening will help assure confidentiality.
4. As the invitations are being made, try to get a fix on how many persons may attend and how many small groups may be needed. A good rule of thumb is to try to have no more than 12 persons in each small group, and have two facilitators per group.
5. To maintain confidentiality and eliminate interruptions, it is helpful to take along an extra person to watch the door. This person can stop anyone who is late (or uninvited) from disrupting the process. He or she can also intervene with anyone who becomes upset and tries to leave early.
6. Take along some appropriate educational handouts.
7. When entering a large room and taking seats, folks will often form logical subgroups. Use this phenomena to your advantage, to help in allocating space and assigning participants and facilitators to the smaller working groups.
8. It is important to separate participants into groups by trauma-exposure level. If folks had low levels of exposure to the nastiest sights, sounds, smells, etc., you will need to avoid exposing them to that new stress via the debriefing session.
9. Facilitators should try to sit on opposite sides of the small group’s circle, to allow the maximum ability to monitor group dynamics and each other.
10. While participants are not required to speak, it is generally a good idea to try to draw everyone into the conversation and do so as quickly as possible. Try to have folks begin by going around in a circle with introductions. Then, go around again for each person to respond to the fact phase and the feeling phase (or whatever format you are using). After a few times around, a more natural, free-flowing process can be allowed to take place. By structuring it in this way initially, shy people are more likely to participate and overbearing personalities are less likely to take over the session.

While the focus here has been on disaster events, DMH techniques work equally well in day-to-day practice situations. Clients who have experienced the loss of a loved one, crime victimization, or any traumatic events can be helped with this approach. Defusing and debriefing can also help prevent burnout when used to support coworkers who find themselves in highly stressful situations.

On page 27 of this FOCUS CE Course you can find a sample Debriefing Session Handout, based upon the current Mitchell CISD model that has been used to help conduct community debriefing sessions. It can serve as a road map for the meeting, helping guide the participants and the facilitators (some of whom may be first-timers, new to the process) through the session. A similar handout can be developed around any of the debriefing models. Use of this kind of handout helps demystify the process and instills an adult-learning atmosphere for those who might otherwise be somewhat apprehensive.

### The Controversy about Debriefing

Debriefing has certainly had its share of detractors. Gist and Woodall (1998), for example, view debriefing (and its many supporters) as a social movement rather than true social science. They cite many studies that found a lack of efficacy and question whether debriefing may actually exacerbate distress. Nevertheless, debriefing programs and related support services have indeed become the standard of care for the initial assessment and management of stress reactions resulting from traumatic events.
Everly and Mitchell (1999) have noted that the critical research done up to that time had often been sloppy in its design. Some studies mixed apples and oranges by blending results obtained from interventions offered by practitioners with varied levels of skill and training, and possibly using different debriefing models. Other studies involved improper application of debriefing, using it as a freestanding intervention rather than as one component of a complete Critical Incident Stress Management (CISM) program. They noted that similar difficulties commonly arise whenever researchers attempt to study the efficacy of psychotherapy using randomized experimental designs. Everly and Mitchell (1999) suggest that the only way to get an accurate picture of the effectiveness of these interventions is to allow a broader research approach, including the use of nonrandomized designs and survey research.

A National Institute of Mental Health (NIMH) workshop on mass violence concluded that early intervention in the form of single one-on-one recitals of events and emotions evoked by a traumatic event do not consistently reduce risks of later post-traumatic stress disorder or related adjustment difficulties (NIMH, 2002, p. 2). Beyond that comment on the potential failings of one-shot debriefing with no follow-up, though, the same workshop concluded that early, brief, and focused psychotherapeutic intervention can reduce stress in bereaved spouses, parents, and children and selected cognitive behavioral approaches may help reduce incidence, duration, and severity of acute stress disorder, post-traumatic stress disorder, and depression in survivors (p. 2). Thus, do no harm. A good rule of thumb is to use debriefing carefully and do so as part of a broader crisis intervention program that includes options for ongoing education, social support and, when necessary, ongoing psychotherapy.

For those interested in more on this debate, Litz, Gray, Bryant, & Adler (2003) offer one of the most complete overviews and critiques of the debriefing controversy and the current state of research to better address whether debriefing is helpful or harmful. Another review has been written by McNally, R. J., Bryant, R. A., & Ehlers, A. (2003). Remember that debriefing is not meant for use as a single, stand-alone intervention. While it is a very good way to structure the initial crisis intervention, psychological first aid, and triage efforts in the aftermath of traumatic events, many victims and helpers may benefit from short-term cognitive-behavioral therapy (CBT) sessions. For one example of such programs, see Stein, Jaycox, Kataoka, Wong, Tu, Elliott, and Fink (2003). Some people may need to receive even more comprehensive and ongoing treatment.

Because of the controversy, the American Red Cross has revised its DMH training class and has stopped teaching/using defusing and debriefing. Instead, emphasis is being placed on offering psychological first aid for emotional support.

### Psychological First Aid

As early as 1993, the Danish Red Cross supplemented its regular first aid training programs with psychological first aid (PFA). In 2006 the American Red Cross began offering its own Psychological First Aid: Helping Others in Times of Stress course. The twelve principles of its PFA program are:

- Making a connection
- Helping people be safe
- Being kind, calm, and compassionate
- Meeting people’s basic needs
- Listening
- Giving realistic assurance
- Encouraging good coping
- Helping people connect
- Giving accurate and timely information
- Making referrals
- Ending the conversation
- Taking care of yourself

PFA is an evidence-based practice tool. These principles allow all responders to focus their “awareness, attitudes, and actions” on supporting survivors and fellow helpers in ways that will help avoid long-term problems.

### Sudden Death

Some disasters and other traumatic life events end in the deaths of loved ones. Crisis counselors can use these questions to help guide conversations with surviving family members and friends:

1. When did you and your family get the news of the death(s)? (awakened; called while away from home; was support available)
2. How were you notified? (who told them)
3. Who else did you have to notify? (especially check for children and grandchildren)
4. What have you learned about the circumstances of the death(s)? (gory details; fears person suffered; body fragmentation)
5. What must you do next? (prepare to travel; gather records to help with ID; etc.)
6. What was the nature of your relationship with the deceased? (close or distant; friendly or quarrelsome)
7. What happened during your last contact with lost loved one(s)?
If the last contact was not a positive one, take them back to another one that was positive and work with them on thought-stopping and substitution, to establish a more positive memory.

In our contacts with coroners, government agencies, relief organizations, etc., we often get more information than may initially be made public. Sometimes you may be able to add factual information to what survivors have been told by others, before they hear it (or read it) from the media. This can be often be comforting to them.

Coming to terms with the loss(es) and restructuring lives in the wake of sudden death(s) involves major changes. The next few pages contain the text of a handout that is available on my website that may help with educating survivors to the rough road that is ahead.

**Sudden Death in Disasters and Transportation Accidents:**
* A Guide to Survival for Family Members and Friends

Someone you love has died. It is an understatement to say that your life has been changed forever. Your pain and perhaps anger are deep and it will be a very long time until you can resolve the strong mix of feelings you are now experiencing. Getting from where you are now to a point of resolution about your loss will take a great deal of hard work and determination on your part, as well as the support of one or more caring listeners.

Right now, there are a flood of thoughts, emotions, and reminders of the person(s) you lost. You should expect to have crying spells, mood swings, sleep difficulties, and troubling memories and dreams. This painful array of feelings and reactions is often so intense that people may wonder whether they are losing their minds. All of this is actually a normal part of coming to terms with a traumatic event like this one.

You may have had a previous experience something like this earlier in your life, having lost someone close to you suddenly. If so, you will be able to use that experience to help you handle this one. Each of us must ultimately resolve these horrendous life experiences in our own way.

### The Most Common Feelings of Grief

The process of mourning the loss and healing the emotional wounds from such an event generally takes at least one year and, in most cases, it will continue for several more years. It can require even more time if mourning is complicated and delayed by the stress associated with any related issues (e.g., lawsuits or criminal trials). The following information is offered to help you better understand some reactions you may be having now and learn a bit about the reactions you may face in the future. Much of this may not make much sense to you right now, but keep it handy and refer to it whenever times are tough. The messages will gradually become clearer as you experience typical stages in the healing process.

**Shock**

In the beginning, most people feel a profound numbness. Some liken it to *being in a fog*. It may be this fog that allows you to accomplish making the necessary arrangements for the funeral and handling other immediate duties.

**Memories, Turmoil, and Denial**

When the fog clears, most people’s emotions fall into a state of turmoil. You may have flashbacks of the moment you were notified of the death, or of the last time you saw your loved one alive. Little things like everyday sights, sounds, and smells will occasionally trigger both good and bad memories of the lost loved one(s). This may continue to occur months or even years after the death. You may dream of your loved one, or believe that he or she will soon *walk through that door*. Part of you will deny that your loved one is dead.

At first, you may experience spasms of grief and find yourself crying as if you cannot stop. The spasms gradually will become farther apart. You may have panic attacks and feel afraid for your own life or the lives of other family members and friends. You may be filled with restlessness and unable to concentrate on anything. You may also be unable to sleep at night or you may have a hard time getting out of bed in the morning to face another day.

**Depression**

As the reality of the death sinks in, depression usually is not far behind. The world may seem to lose meaning for you. Activities that you once enjoyed may now seem like a burden. You may feel as if there is little point in going on, or you may want to avoid contact with others.

During all of these phases of mourning you will need to keep talking with someone you can trust, a person who is non-judgmental and has a listening ear. This may be the only way to keep from getting stuck in one phase. Don’t be afraid to go get some counseling, if you feel more support is needed.
Guilt

Each survivor lives with What-ifs and has questions like: Why did I let them go?; What if I had been with them?; and Why didn’t I act differently at our last moment together? This is a normal reaction. Please remember that no one can predict the future or recreate things into what might have been. Adults know that we cannot change events that happen. Children often feel, instead, that they themselves have actually caused the terrible event by their actions and thoughts, regardless of how irrational that thought might be. Adults stressed by traumatic events often dip back into childhood thought patterns. It is likely that your guilt feelings are based here.

Anger

Anger can be both frightening and motivating. Sometimes it may feel as if anger will overwhelm you. It may be directed at the system, an agency, a carrier (e.g., airlines), or even close family members and friends. It is also common to be angry with God. Once people recognize and admit their anger, they may feel guilty about it. The anger is another completely normal feeling experienced by survivors.

Be careful to avoid letting this event become an excuse for child abuse, spouse abuse, or other forms of harmful behavior to others. Anger may immobilize you or move you to relentless activity. Either way, it is a natural reaction to sudden, severe loss. Your anger probably will never completely go away but, with time and support, you will learn to manage the anger. You may even find that it is helping you take back control of your life.

Revenge

For the first time in their lives, many survivors find themselves thinking of ways to get back at _____ for their loss. Understandably, some people are deeply disturbed by this emotion. This is another thing that can cause you to worry that you are losing it (going crazy). This is generally a normal reaction. Counselors of survivors find that almost every person they work with thinks about revenge. Having these feelings does not mean you are going to act on them.

Some people will tell you that wanting revenge is unhealthy and that the only way you can find peace is to forgive. If forgiveness is in your heart, fine, but do not allow people to place unnecessary guilt on you if you are not feeling forgiving. Chances are they have never been through what you are experiencing.

Seeking Information

Factual information is a critical need for family members and close friends following a fatal event. You will likely want to know the specific details surrounding the death of your loved one. You will likely not find answers to all of your questions. While you will initially find yourself focusing on the most minute details, as you begin accepting your loss, this obsession will diminish.

Look to the agencies responding to the disaster as sources of factual information. For example, the transportation carrier (e.g., an airline) and the lead government agencies that are involved in a transportation accident (e.g., the National Transportation Safety Board) will provide the facts as they become available. The coroner can provide information in other situations.

Searching for Meaning and Understanding

You will probably experience a great need to understand why this tragedy happened. In your search for understanding, you may feel the need to know everything there is to know about what happened, where it happened, etc. Visiting the area where the disaster event occurred helps many survivors process the event. After some time has passed, you may decide to become an advocate, working to prevent similar tragedies from happening in the future.

Media Issues

There may be lots of media coverage. The best approach for you is generally to avoid paying much attention to it—the media reports many things that are sensational, but are not always factual. The media may invite you to talk about how you are feeling to educate others about trauma.

You may be tempted to take part in radio or TV interviews during an early stage of your coping. Be aware that some others who have done so in similar situations have later regretted having participated in this way.

Coping with the Reactions of Others

You are now painfully aware that most people in our society struggle to insulate themselves from the ways in which we all remain vulnerable to injury and death. Know that it will be very difficult for acquaintances and strangers in your daily life to be comfortable putting themselves in your shoes now. Many individuals struggle to deal with bad things that happen to others, often using humor as a defense. You may become aware (in a new way), of the tasteless jokes that often circulate after a tragedy.
Another common reaction of acquaintances and even friends is to try to manage or criticize your manner of reacting to this event. The fact is that each of us is an individual. We like different foods, wear different clothing, and choose unique lifestyles. It stands to reason that, at the most painful times in our lives, each of us will grieve in our own way. How we choose to grieve is determined by things like our heritage (including religious, cultural, and family issues that we have learned), our society’s views of death, and our individual personalities and beliefs.

**Family**

When a tragedy happens to a family, you might expect it to pull the family together. This is not always the case. It is not unusual for counselors to see families separate, both physically and emotionally, following a major stress like this kind of sudden loss. At a time like this, communication is very important. Work hard to express your feelings within your family and with your supportive friends.

**Friends**

When you hurt, you often turn to people outside your family who have always been there for you—your friends. But, where are they a month, six months, or a year after the death? Often, they have gone back to focusing more on their own lives, even though you still need to talk.

If you bring up the death (or the circumstances surrounding it), they may change the subject. Many people do not want to listen to the details of the tragedy, although it is very important for survivors to continue to talk about those details. It is tough for many people who have not been through it, to talk about something this frightening. They may fear they will not say the right things or they will not be good listeners on a subject that it so emotionally charged. They may also feel hopelessly inadequate. Remember that the loss of your loved one(s) probably hit them with the stark reality that, if this happened to you, it can just as easily happen to them, turning their world upside down, just as it has done to you.

You may notice that people you have known for years now avoid you on the street or in a store. Your coworkers may avert their eyes and not see you, as though you have suddenly become invisible. This is because they usually have no idea what to say and they do not realize that, for you, this feels like rejection. This, in turn, adds to your grief because now you are losing your closest circle of friends, in addition to the person(s) who died.

This new problem can be faced in a variety of ways. You can write these friends off and stop seeing them altogether. You can continue to have contact with them but avoid the subject that you most need to discuss. You can raise the issue directly with your friends and try to deal with it openly and honestly with them. You can also add to your circle of friends by spending more time with those whom you find ready to respond in the ways that are most helpful to you. Support from others who have been through similar events (e.g., talking with survivors from a previous accident) can be extremely valuable because they know how important it is to talk about the experience rather than avoid it.

### Coping with Birthdays, Holidays and Other Special Times

Holidays and other special days like anniversaries, birthdays, etc. can be very difficult. This is especially true during the first year following the death. These days usually are steeped in traditions and customs created by families and meant to be shared. When a member of the family is no longer there to share a cherished tradition, the special day often becomes a painful reminder of the loss, rather than a time of joy.

The first time you experience holidays or other memorable occasions after the death, it may seem to be a nightmare. Gifts that once were ripped open immediately may sit for days. Thanksgiving will seem to be a hollow sentiment as you find yourself asking What do I have to be thankful for? New Year’s Days and birthdays, which formerly were times to celebrate another year of life, are now disturbing reminders of death.

It will be helpful to plan to include your lost love one(s) in each occasion in a very deliberate way. You may evoke their memory, for example, by creating a toast to them, or a prayer in their honor; imagining for the group what they would be saying or doing were they still among you; and acknowledging their ongoing presence among you but in a different way now.

You may find the need to develop new traditions. For some, a trip out of town or going to someone else’s home at holiday time can be very helpful. For others, buying a gift for someone less fortunate and doing so in the name of the lost loved one(s) provides some relief. Making birthday donations to charitable organizations, in their name, or creating some similar, new traditions, is often a meaningful way to channel some of the feelings at these difficult points in the year.

There is no simple rule to follow on how to get through these especially rough times. You will grieve and you must allow yourself enough time to do so, in order to heal.
Epilogue

The rest of your life is the epilogue. Your life has been permanently changed by the untimely loss you have suffered, but you need not be psychologically damaged by this trauma. It is OK to question who you are and what is to become of you. You will see things differently than before. You will sometimes be more irritated by little things in life. Other times, you’ll be amazed by things that formerly would have seemed catastrophic and now seem insignificant, in comparison to your loss. You’ll have a much clearer notion of what your priorities are. You’ll feel you’ve been through and survived the worst that could happen.

Most survivors slowly heal and return to living their lives to the fullest. As we’ve mentioned, this is a process that can take several years. Meaning gradually returns to the daily activities of their lives. Some day, when you look back, you will find that most people did stand by you and support you. You may find that you’ve become more sensitive to the pain of others struggling with similar issues. Many survivors join others in doing volunteer work and offering support to those with similar burdens. You will continue to find joy in treasured memories of your loved one(s).

On the other hand, your faith and your view of humanity may be shaken. You may find it impossible to trust strangers, even those who may genuinely be trying to offer help. You may feel that nothing having to do with the survivorship paperwork (e.g., insurance claims, damage settlements or other legal issues, etc.) is working out in your favor. You may also question your rights and who can best advocate for you.

Try to keep a positive attitude. Keep yourself as busy as possible. Do some fun things and be good to yourself. Take part in events with family members and/or friends. Become involved with group activities with others that share your interests (e.g., singing in a choir, taking bus trips, or doing some volunteer work). Spend some time and energy arranging these kinds of activities. Getting out and doing things will help the time pass. Many report it allows them to begin to experience some happiness they would otherwise miss.

Pre-Briefing

Whenever assigning staff who will be assisting others after a disaster, be sure to provide a thorough orientation to the work. Knowledge is power and, in the case of workers who are about to begin a tough assignment, it provides a large measure of stress inoculation. Here are some tips:

- Encourage self-care.
- Describe the work in detail, covering setting, duties, schedule, ID process, and so on.
- Prepare everyone for the sights, sounds, and smells they will encounter (and that these will form memories that may come back to them from time to time).
- Be graphic in your explanations.
- Allow an opportunity for graceful exit. It is OK to stop at any time.
- Tell everyone about the availability of support services and any requirements that they attend defusing/debriefing sessions. Try to make it a requirement!
- Encourage use of a buddy system and group meetings, for peer support.
- Journaling helps, too.

Postvention

Once there has been a traumatic event, crisis counselors often step in to provide support services to the people who are attempting to find meaning in what has happened and taking small steps to move forward. School or workplace violence, crime victimization, transportation accidents, deaths of students or teachers in a school (or coworkers in an office), and natural disasters all might prompt a need for formal intervention and support services. Here are some tips:

1. Establish a mutual-aid, multidisciplinary team approach.
2. Develop event specific plans and protocols (e.g., when and how to mobilize teams, notify staff and students, etc.).
3. Try to stick to regular routines, as much as possible.
4. Call for extra help. Too many responders is better than too few.
5. Identify space for private interventions with individuals and small groups.
6. Target at-risk students/staff for special attention.
7. Confidential, outside resources are best for supporting employees.
8. Work with the family of the victim(s) and those others at-risk. This is the ideal time for public education/prevention.
9. Facilitate events on the day of the funeral (some schools/organizations even make buses available to provide extra margin of safety).
10. Designate a media spokesperson (e.g., central office staff).
11. Remember to address needs at feeder schools.
12. Crisis team members will need daily defusing and a longer, more formal debriefing session at the end of the crisis period.
13. Carefully document all actions taken.
14. Plan a review/critique session about a month later to refine plans for next time.
Practical Tips for Working with the Media

Be sure to weigh your words before you deliver your message. You can always add to a statement you have made to the media, but you cannot easily take part of it back. You are never really off-the-record when talking to a reporter.

Be positive and upbeat—convey a message of hope. Tell people about the availability of relief programs and where to find whatever services you may describe. Squelch any rumors and try to correct any previously circulated misinformation. Victims need to know that help has arrived and that order is being restored. This will help them regain a sense of control over their lives.

Use prepared materials. There is no need to generate new information on the spot—you will have enough work to do as it is. Instead, rely upon the prepackaged materials and the wealth of available resources from previous, similar disasters and tailor them to fit your needs.

Stress the normal reactions to disasters. It is very reassuring to people to hear that it is okay to feel bad in the wake of a disaster. Allay fears about the rush of strange thoughts, feelings, and emotions that people are suddenly experiencing. Let them know they are not becoming mentally ill on top of everything else they have been through.

Inoculate the public to the stress of predictable future events. Teach them, via the media, about the phases of recovery, anniversary reactions, and so on. The more they are able to understand the process, the less scary it will be.

Work with supervisory staff and with the Public Affairs component of your organization. ARC, for instance, has a large and very active public affairs department that can provide guidelines for your media contacts. The Public Affairs people will also have the statistical information (How many deaths? Number of people fed? Sheltered? etc.) that the media likes to include as part of any story.

The media craves sensational stories. Reporters will press you for detailed case examples. Be careful to protect the confidentiality and privacy of those victims and helpers whose stories you may be tempted to share. Avoid accidental breaches of confidentiality or the inadvertent sharing of inaccurate information by having all interviews be handled through a designated spokesperson.

Consider making media sacrifices of one or two victims and helpers. This sounds nasty but it really works very well. Find one or two victims who are interested in having their 15-minutes-of-fame and make them the spokespersons for everyone else (the people who want their privacy). Select people who are fairly articulate and who will speak kindly of the relief programs and the services they are receiving. Send along one or two experienced DMH workers who are comfortable with the media to support them and to answer media questions. Be sure that all are offered debriefing once it is finished. This technique often gets the media out of everyone else’s way.

It can’t hurt to ask. Remember, too, that once you have the spotlight, it never hurts to do a little bit of public relations work. Ask for more donations and more volunteers. Recent disasters have been so large that it seems there can never be enough of either one. Requesting and receiving needed in-kind gift items (such as crayons, toys, bug spray, etc.), cash donations, and fresh, new recruits can really help at most disaster scenes.

Defuse and debrief the media people. Believe it or not, they have thoughts, feelings, and reactions, too. Some seemingly tough characters will react strongly to the stories they are hearing, especially if aspects of the story come too close to aspects of their own personal lives.

Consider the ethical implications of your media activities. When dealing with the media, it is always a good practice to give some advanced thought to the ethical issues inherent in entering the interview process.

Working with the media is an extremely important form of DMH intervention, but it is often fraught with unexpected challenges. Anything that can possibly go wrong will go wrong. The media will invariably pick up the least eloquent and/or least intellectual statement you make and turn it into the headline (or the 30-second sound bite) that will be repeated over and over again. Once you accept that fact and learn to exercise caution, you will do well when in the spotlight. Be careful.

Avoiding Communications Mistakes

(Top 10 Tips for the Savvy Communicator)

1. First do no harm. Your words have consequences—be sure they’re the right ones.
2. Don’t babble. Know what you want to say. Say it…then say it again.
3. If you don’t know what you’re talking about, stop talking.
4. Focus more on informing people than impressing them. Use everyday language.
5. Never say anything you are not willing to see printed on tomorrow’s front page.
7. Don’t make promises you can’t keep.
8. Don’t use “No Comment.” You’ll look like you have something to hide.
9. Don’t get angry. When you argue with the media, you always lose…and lose publicly.
10. Don’t speculate, guess, or assume. When you don’t know something, say so.

Survivor humor is defined by Sandy Ritz (August 25, 1999, personal communication) as the spontaneous and situationally relevant humor that is actively produced by disaster survivors and workers. She explains that this method of coping and hoping involves laughing with, not at the survivors. It generally has a you had to be there style that makes fun of the situation, relieves stress, boosts survivor morale, and promotes social bonding. Used as a defense mechanism, it also serves as a safety valve for letting out aggression and tension—it helps survivors master their anxiety.

Disaster survivors in the United States use humor in innovative ways to maintain communication and social bonds. Survivor humor is fueled by the incongruities of trying to get on with life while living in a chaotic environment. As a psychological weapon, humor can be a powerful means of displaying self-reliance and strength, maintaining dignity, and providing a palatable method of communication and conflict resolution. While survivor humor does not change the facts of the disaster, it is a survival mechanism to help reframe perspective and enhance positive adaptation to enforced change. Humorous material generated by disaster survivors is often aimed at the common circumstances of their disaster situation. Disaster jokes, on the other hand, tend to involve sick humor that is generated by outsiders and is often aimed at the victims of a tragedy. Such jokes laugh at the disaster survivors and function as a means of catharsis for the fears and anxieties of outsiders who are not directly affected by the disaster.

Only those with a physical, emotional, or temporal distance from a disaster may be able to appreciate humor like disaster jokes. Survivors generally perceive disaster jokes [e.g. the rash of alligator and airline food jokes that circulated following the ValuJet crash in the Everglades] as hostile, degrading, and insensitive to their plight. In contrast, the survivor humor generated from the in-group of survivors laughs at their shared situation and perceptions, acknowledges the disaster culture, provides social support, and increases survivor group morale and social bonding. Outside humor is especially bothersome to survivors during the Disillusionment Phase. Survivors want to be taken seriously. Any smiling, laughter, or joking observed in perceived outsiders may be easily misinterpreted. They can laugh with each other but cannot tolerate a perception of being laughed at, especially by someone who is not part of their disaster culture. These are times when active listening, sincere interest, and renewed efforts to provide caring interventions that promote culturally appropriate humor are most appreciated.

The timely use of humor allows the disaster survivor to neutralize the horror of the trauma and even makes it possible to rise above it. The bitter reality of the disaster cannot be altered. What can be altered, though, is ones attitude toward it. Although outsiders may not find their comments and/or behaviors funny, laughter (and even occasional obscene comments) can serve the survivors’ needs to cover embarrassment and humiliation.

(Sandy Ritz, August 25, 1999, personal communication)

Just as survivors may surprise you with their ability to maintain a sense of humor, they also can handle sadness and very appropriately shed tears. Workers need to become comfortable witnessing expressions of sadness and encourage letting the survivors’ tears flow. In fact, it is okay if you end up crying with them, in response to some touching aspect of their story. Sometimes having a good, cleansing cry is the best move for everyone.

Always be careful about where you are, and what you are saying and doing, when you are having a good time. Victims do retain their sense of humor and many will poke fun of themselves and the messes they find themselves facing. Still, they may take offense if they are coming into a relief center in order to get help with their serious problems and they find the staff there having what appears to be too good a time.

Surviving the Stress of Helping Others

There is a cost to caring (Charles Figley, 1995). Hearing the troubled life stories of our clients and feeling their pain has always been an occupational hazard for people in the helping professions. Add to this the stress of the many other disturbing life events we have experienced over the past few years, including incidents of school and workplace violence, mass murder, disasters, terrorism, and war. Sadly, the result is an ever more co-traumatized workforce, as staff members are increasingly experiencing compassion fatigue, secondary victimization (vicarious traumatization), and possibly even burnout.

It is important to remember that no matter how effective someone’s coping skills may be, there are events that can easily overwhelm those skills. This is true for each of us as individuals and each of us as members of our larger relief organization’s teams. Stress reactions are common, normal reactions to any unusual and highly stressful situations.

People can experience several types of stress:

- Anticipatory stress: concerns over the future (“What if…?”, “Am I ready for this?”, and “Here we go!”).
- Situational stress: the concerns of the moment (newness, uniqueness, and magnitude).
- Chronic stress: worry over time (“I thought this would end sooner!” and “I miss my family”).
- Residual stress: unresolved issues from previous incidents.
The intensity of each person’s reaction to stress can be modified by several factors:

- **Duration:** longer exposure to any stressful event usually makes it more severe.
- **Multiplicty:** the more stresses there are, the greater the potential reaction.
- **Situational importance:** greater importance of the event means greater reaction.
- **Individual’s evaluation of the stress:** how threatening is the situation and how prepared am I to cope with the consequences (we each have our own psychological Achilles’ heel).
- **Reminders that trigger vivid memories** (press coverage, trials/law suits, and similar incidents).
- **Stress tolerance:** general ability to tolerate plus benefits of stress inoculation.

There are three categories of reactions to traumatic stress: thoughts, feelings, and behaviors.

Here are a few examples of each:

### Thoughts
- Recurring dreams or nightmares about the disaster.
- Reconstructing the events surrounding the disaster in your mind, in an effort to make it come out differently.
- Difficulty concentrating or remembering things.
- Questioning your spiritual or religious beliefs.
- Repeated thoughts or memories of the disaster, or of loved ones who died in the disaster, which are hard to stop.

### Feelings
- Feeling numb, withdrawn, or disconnected.
- Experiencing fear and anxiety when things remind you of the disaster, particularly sights, sounds, and smells.
- Feeling a lack of involvement or enjoyment in everyday activities.
- Feeling depressed, blue, or down much of the time.
- Feeling bursts of anger, or intense irritability.
- Feeling a sense of emptiness or hopelessness about the future.

### Behaviors
- Being overprotective of your and your family’s safety.
- Isolating yourself from others.
- Becoming very alert at times and startling easily.
- Having problems getting to sleep or staying asleep.
- Avoiding activities that remind you of the disaster, avoiding places or people that bring back memories.
- Having increased conflict with family members.
- Keeping excessively busy to avoid thinking about the disaster and what has happened to you.
- Being tearful or crying for no apparent reason.

---

**Basic Self-Care**

No matter how good your coping skills or how many disasters you have worked or experienced, there will come times when some aspect of an operation breaks through your defenses and makes you vulnerable to the traumatic stress. It is clear in the research literature that there are relatively simple things that can be done to improve your resilience to stress. While this is true in any disaster, it is especially true in aviation disaster, and a higher level of self-care is required.

- **Shifts (stick to them):** With the exception of the first day or two, be certain that you stick to the shift assigned hours.
- **Breaks (take them):** A reasonable time frame is 10-15 minutes every two hours. More may be needed. Get away from the maelstrom for a few moments.
- **Diet:** A healthy and balanced diet can significantly improve your ability to cope with high levels of stress. Drink lots of water and stay hydrated. Beware of caffeine and alcohol. Both can significantly impair your ability to function. If you need caffeine to continue to function in this supercharged environment, you just aren’t getting enough sleep. Beware of too much junk food. Too much sugar can cause sugar lows in addition to the famous sugar highs.
- **Support:** Be sure you don’t isolate yourself. Talk about things other than the operation with colleagues on your team. Talk with your family back home. Call colleagues that understand what you’re going through.
- **Days off:** Common practice for relief operations is one day off in every seven. The high intensity and stress of aviation disasters may create a need for more frequent time off. This should be considered on a case-by-case basis and not held against any individual requesting additional time off.
But you probably knew all of that—it seems almost too basic. Self-care and stress management cannot possibly be that simple, can they? The answer is a resounding “YES”—these basic elements are consistently found to be the most effective components of effective self-care. With that in mind, let’s now go into a bit more detail.

### Who is At-Risk for Stress Reactions?

When multiple and prolonged exposures to traumatic stress are present, as they are for relief workers in the aftermath of every major disaster, everyone is at risk—everyone will need to work at stress management and self-care. Some of us, however, may be at even greater risk, especially in the early stages of our involvement.

**Here is a list of persons to consider as being at higher risk for stronger reactions:**

- The young and/or the newest among us.
- Those who are most caring / empathetic.
- Those who are the least well defended.
- Those who tend to become overly involved.
- Those in the most emotionally charged settings (e.g., childcare).
- Those with unresolved personal issues (e.g., rescue fantasies).
- Those who have recently experienced other loss(es) and are grieving.
- Those who are least trained, supervised, and/or supported.
- Those who do not practice good self-care and stress management.
- The trauma specialists, especially those who may think they are immune.

We will all have some reactions to the stressful situations we face during our assignments and this is perfectly normal. In fact, we all tend to be “changed” by the uniqueness and the intensity of our experiences in mass-casualty assignments, but we need not be “damaged” by these experiences.

### How Do Serious Stress Reactions Come About?

If only there was one simple answer to that question. Then, perhaps we could fully inoculate everyone to the stress and protect relief workers as they serve others. Unfortunately, there is not always a pure, cause and effect relationship between exposure to traumatic situations and development of long-term problems. Most people now realize that one easily definable traumatic event can result in development of stress reaction (and possibly lead to development of PTSD).

For relief workers, though, there are multiple exposures to traumatic material that has been experienced by others. Hearing the stories and feeling the pain of others can easily make us secondary victims. As we are working very hard at serving others, we often do not realize how much exposure we have had. That is because our exposure is often a more insidious process, slowly building over time. A good way to think about it is that it is similar to secondhand smoke—it very often hard to measure and it is even harder to predict what effect it may have on us in the future.

### What is it that Determines Our Susceptibility to Traumatic Stress?

**Several factors play a role in determining how each of us manages stress:**

- Prior trauma experiences and stress inoculation.
- Gradation of exposure.
- Identification with the victim—reactions like “that could have been my child” and “survival guilt.”
- Our own physical and psychological health status.
- Other “routine” stresses (work, family, etc.).

How should we try to avoid these problems? We can begin by learning what it is that pushes our buttons and triggers our personal reactions to trauma. Most factors involve associations and similarities to our lives. These can be triggered by sights, sounds, and smells (e.g., children who are the same age as our children/grandchildren). Other triggers may be recent life events (still resolving death of a family member or friend) and reflections on our own fears/mortality (that could have been…). These situations should not be mistakenly viewed as opportunities to escape stresses/issues at home or to resolve prior life events.

We need to be able to recognize and “manage” our anticipatory reactions. Many experience a strange (and sudden), heightened awareness of everything that can go wrong in life (a loss of innocence). There can be over-identification with the victims and/or the survivors (everything starts to seem personal). There can also be a sense of déjà vu as people have “Here we go again?” reactions whenever similar cues are present.
We also need to be able to accept the problems presented by our own frustrated desires and the frequent desire for closure. There can be a sense of helplessness and lack of control over traumatic events. Working with people for short periods of time as they begin the process of grieving, we seldom have a chance to see very much progress and it is too early to gauge outcomes.

We must avoid the natural tendency to beat up our own egos when things are not running as smoothly as we would like. This is especially true when things actually go wrong. It is easy to become incapacitated by guilt, self-pity, fears of next time, and/or trouble letting-go.

We must also keep in mind that crisis work is not for everyone. For some volunteers, even routine disaster assignments are too stressful and mass-casualty events are anything but routine. The process of taking care of oneself can begin even prior to acceptance of these difficult assignments, during the recruitment call. Think seriously about whether or not you need this amount of stress in your life right now (or if you ever need it).

If you are already grieving another loss or if you have recently been on another mass-casualty operation (or any rough assignment), put your own health first and say “NO” this time. If you have more general doubts about your ability to handle this kind of work, avoid it altogether and stick with other, less-stressful assignments.

**Strategies for Improving Coping While On-the-Job**

<table>
<thead>
<tr>
<th>Carefully consider how these issues fit into your personal and organizational stress management plans:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pre-briefing is essential. Convey the magnitude and the gory details—convince workers about the need for treating the big ones a bit differently than their day-to-day tasks.</td>
</tr>
<tr>
<td>• Tasks-at-hand should be the immediate and central focus. Break up the work and start to do the little jobs well. At first, the big picture may just be too overwhelming.</td>
</tr>
<tr>
<td>• Reality must be respected. Be realistic with both personal and organizational objectives. We can only do so much work and we can only handle so much pressure/stress.</td>
</tr>
<tr>
<td>• Peer Support is critically important. Develop and encourage use of a buddy system. Balance the workload. Share the tough cases. Meet regularly (e.g. beginning and end of each day) to tell the stories and vent the stress.</td>
</tr>
<tr>
<td>• Self-Talk is a good thing. Encourage use of that same inner voice mentioned above for developing and reinforcing a positive outlook. Self-defusing by keeping a journal is also possible. It can be combined with cognitive-behavioral techniques to help rid yourself of troubling, negative thoughts.</td>
</tr>
<tr>
<td>• Dangers-of-downtime are often unexpected challenges to all. With rest there is the accompanying time, energy, and peaceful environment, all of which are conducive for reflection. Some will begin to process their thoughts and feelings. Others may try to escape with hectic entertainment or a premature return to their relief setting and role.</td>
</tr>
</tbody>
</table>

**PTSR or PTSD?** We expect normal stress reactions and know that they will run their natural course in the first days, weeks, and months following the disaster. Through self-care, peer support, and diligent use of DMH interventions like psychological first aid, defusing and debriefing, we hope to prevent the long-term negative outcomes that may lead to PTSD.

**What Else Can Be Done?**

| • When you have the opportunity, allow yourself to feel sadness and grief over what has happened. Talking to others about how you are feeling is useful. |
| • Try to keep in place routines such as regular meal times and other rituals. These will help you to feel some sense of order. |
| • Upsetting times can cause people to drink alcohol or to use drugs in a way that causes other problems. Recognize that potential in yourself and your team. |
| • Forgive yourself and others when you act out because you are stressed. This is a difficult time, and everyone’s emotions are closer to the surface. But also be certain that your stress does not become an excuse for abusive management styles. |
| • Don’t let yourself become isolated. Maintain connections with your team, but also with friends and family. Try to keep a sense that there is a real world outside the relief operation. |
| • Maintain boundaries between your life and your assignment. Having some measure of healthy emotional distance from your work is very useful. For instance, it is not a good idea to read all the news reports or watch all of the media broadcasts that detail the lives of those who were lost. This tends to make things too personal and workers will begin to over-identify themselves with the situation. |
| • Set aside time to maintain your spirituality. Attending memorial services and engaging in contemplative prayer are helpful to many relief workers. |
Caring for the Spirit

Spiritual care providers are familiar with the traditional pastoral care role of chaplains serving in health care and military settings. Using a *ministry of presence*, they offer genuine warmth, unconditional love, authentic concern, and emotional support. In addition to the offering of *presence*, the chaplain’s role involves spiritual support services.

September 11, 2001 began as just another day for most Americans. Things quickly changed though as the hideous terrorist plot began to unfold. As a Disaster Mental Health (DMH) member of the American Red Cross (ARC) Aviation Incident Response (AIR) Team, I was called up immediately and for the next 12 days I served as the Coordinator of the Family Assistance Center (FAC). The FAC is a “safe haven” spot where family members can come together and share their thoughts, feelings, and memories with one another. There they can also talk to mental health workers and members of the clergy, doing so in a secured place designed to protect their privacy. Many prefer to avoid the media, lawyers, and any others who might further victimize them at a time when they are quite vulnerable.

Part of our DMH role is to organize family member visits to the crash site. Most surviving family members need to visit the site—a visit that helps them accept their loss and begin to move forward with their suddenly altered lives. These visits were followed by multi-faith memorial services. There participants are given a chance to formally honor those lost souls by mourning their deaths but also celebrating their lives. About 500 family members and close friends of those lost on Flight 93 were served by our ARC team. Helping us serve them were the warm wishes and prayers of people all over the world. We received a marvelous array of flowers, cards, banners, gift baskets, comfort kits, and letters of support. Especially helpful were the touching messages from innocent children, some of whom attended a school that was near the crash site. These things all gave great comfort to the families and, when we closed the FAC, these items became part of the permanent memorial to those brave souls who lost their lives while protecting the lives of others.

My experiences with mass casualty incidents always sadden me (something that generally hits us as we end our work) and this was no exception. In fact, this one was worse for me than usual. I cried off and on, all the way home from western PA. For several days thereafter, I found myself having what I’ve jokingly dubbed *random acts of crying* triggered by certain songs, pictures, or news reports. That ran its course but two weeks later as I wrote a letter to my niece, I found myself tearing up again. I had chosen to write the letter as a way to pass my time while on a bus ride to New York City. I’d had two weeks rest and I was on my way there to join the larger, ongoing ARC World Trade Center (WTC) relief operation. There the workers were helping in very similar ways, including the offering of site visits and memorial services.

During times of tragedy, one thing that is very important is support—support from family members, support from friends, support from others who care enough to share something of themselves when people are in need, and support from communities of faith. Spirituality becomes a major concern for both the victims and the helpers. For some, it will be spirituality centered in formal religious beliefs and activities such as the offering of prayers, attending church services, giving last rights, etc. For others, it may simply be allowing time reflect on issues of their own life journey (and mortality) while communing with nature, preparing and sharing comfort foods, and/or feeding their souls in other ways that they might most their needs at that moment.

The grief that does not “speak” in some way—through crying, talking, rituals, tributes, or creative expression—remains unresolved. (Sarah York, 2000)

I find that the longer I am involved in crisis intervention and disaster relief, the more I value resources to help address the spiritual issues that so closely relate to the mental health issues we face in this work. Grieving victims and helpers need to find suitable means and opportunities for expressing their losses. Part of this comes out through our typical DMH interventions, especially defusing and debriefing, but these brief encounters can only do so much. Expressions of grief can and should also be drawn out through encouragement of participation in well-planned, carefully timed memorial services. Sarah York has written an excellent book designed to help family members, clergy, funeral home staff members, hospice workers, and mental health professionals plan services and rituals that will help them say goodbye and begin to move forward with their lives.

*Here is the reference:*


It is full of real-life stories and practical examples of ways to sensitively address all sorts of issues that arise as families begin to face the difficult decisions that arise when they lose someone they love.
One section of York’s book contains suggested readings, prayers, and blessings. On pages 203-204 there is *A Litany of Remembrance* by Roland B. Gittelsohn that I’ve found to be especially helpful. Adapted from a modern Jewish liturgy, this has been used as a responsive reading at several memorial services that have followed aviation incidents. The service leader will read the first lines and the participants will reply by saying *we remember them*. Following some incidents, we have also had this printed on small memorial cards (lavender card stock with deep purple print—2 1/2” x 4”) that can be given to family members, friends, and all support staff who attend the site visits/memorial services. I never knew the original source till reading York’s book.

*Read more inspirational stories and poetry on page28 of this CE course.*

---

### DMH Team Auto-Kit

(*Preparedness Pack*)

Everyone who serves as a DMH team member or volunteer should keep these items handy in case a rapid response is needed:

1. DMH handbook and/or plan
2. Photo I.D.
3. Educational handouts (a starter supply)
4. One set of comfortable slacks/jeans and the rest of an outfit suitable for a disaster setting
5. Strong comfortable shoes (closed toe, low heel, and hard sole model works best)
6. A hat and a coat
7. An umbrella and a rain slicker
8. A blanket
9. A crank flashlight / radio (for news/weather info), (or regular one with fresh batteries)
10. Spare glasses, contact lens solutions, etc.
11. Medications (required prescriptions and commonly used non-prescription items)
12. A tablet, pencils/pens, crayons/markers, and drawing paper or newsprint.
13. Healthy foods/snacks and gum
14. A few copies of the most needed DMH forms (leaders may need to pack a larger supply)
15. A local map
16. Sunscreen, bug spray, etc.
17. Pure bottled drinking water—dehydration can be a serious problem
18. FRS radios (the 2-mile range walkie talkies we wish we’d had as kids)

In some communities, the local Red Cross unit’s DMH team coordinators all carry a *black bag* (a nylon briefcase) with forms, supplies, and temporary I.D. material, in the trunks of their cars. Each of these bags has enough supplies to handle a disaster with up to 50 victims. When several coordinators get together for a larger incident, their combined bags allow them to cover much larger populations.

Team members and volunteers should consider making both a preparedness pack (to keep in their vehicles) and a ready-to-go bag (for perishable needs like snack foods and medications). For those who are not willing to be quite this prepared, consider at least having a handy checklist of needed items, to make the last minute hunting and packing frenzy somewhat more efficient. Some other preparedness information and a checklist to help manage a larger DMH relief operation can be found on this website:

[www.eyeofthestorminc.com](http://www.eyeofthestorminc.com)

---

*Post Test on page 25*
**About the Author**

**John D. Weaver, LCSW, BCD, ACSW** is a Founding Partner of Eye of the Storm, Inc., a private consultation and education group practice specializing in disaster mental health, crisis intervention, and risk management related training and support. He is also a part-time therapist for Concern Counseling Services. He worked for many years as a Casework Supervisor for Northampton County Mental Health and has served as a member of the Adjunct Faculty for the ACCESS Program at DeSales University, Marywood University’s Graduate School of Social Work, and Northampton Community College’s Psychology Department.

He received his undergraduate degree in Psychology from Moravian College, Bethlehem, PA and his Masters Degree in Social Work from the University of Pennsylvania, Philadelphia, PA. Throughout his career he has written many articles, several chapters, and three books. He has served as an expert reviewer for a crisis management guide for schools. He has presented seminars and papers at state and national conferences in social work, psychology, counseling, and nursing.

Weaver has been an active volunteer with several organizations including the Mental Health Association and the American Red Cross (ARC). He has assisted at several local and national disasters including service during the Great Mississippi River/Midwest Floods of 1993, coordinating DMH activities with morgue volunteers following the 1994 airline crash in Pittsburgh, and service with the ARC team at the 1996 plane crash in the Everglades, near Miami. More recently, he served as Coordinator of the ARC AIR Team’s Family Assistance Center following the 9/11/01 terrorist incident that led to the crash of United Flight 93 in Shanksville, PA and then served as an Assistant Officer helping manage the larger World Trade Center relief operation in NY City. He is also a volunteer instructor for ARC. In recognition of his service to the organization, ARC has presented him the Clara Barton Honor Award for Meritorious Volunteer Leadership. Weaver donated half of his royalties from one of his books - *Disasters: Mental Health Interventions* (1995, Sarasota, FL, Professional Resource Press; phone 1-800-443-3364) - to the American Red Cross National Disaster Relief Fund and his publisher, Larry Ritt of Professional Resource Press, matched his donation.

**Contact information:**

John Weaver  
Eye of the Storm, Inc.  
4635 Hillview Drive  
Nazareth, PA 18064-8531

Email: [johndweaver@eyeofthestorminc.com](mailto:johndweaver@eyeofthestorminc.com)  
Phone: (610) 614-1860

To view more information about DMH and disaster preparedness, see Weaver’s Internet site and the American Red Cross website:  

[www.eyeofthestorminc.com](http://www.eyeofthestorminc.com)  
[www.redcross.org](http://www.redcross.org)
References


Litz, B., Gray, M., Bryant, R., & Adler, A. (In press). *Early Intervention for Trauma: Current Status and Future Directions*. *Clinical Psychology: Science and Practice*. Also web posted with permission by the National Center for PTSD. [http://www.ncptsd.org/facts/disasters/fs_earlyint_disaster.html]


Weaver, J. D. (2001). *A Report from Ground Zero.* Audiotape produced by Barbara Alexander, *On-Good-Authority* series, *Grief: A Collection,* Tape #1. The *Disasters* (1995) tape was also re-mastered and is included as part of Tape #4 in this series. For information or to order, please phone: 1-800-835-9636.

1. Which of these is not one of Farberow and Gordon’s phases of recovery from disaster:
   a. Heroic
   b. Honeymoon
   c. Guilt
   d. Recovery

2. The most typical victim reactions to disasters involve basic survival concerns and grief over lost loved ones and prized possessions.
   True or False

3. Psychological first aid involves or includes all of these except:
   a. helping people be safe
   b. gathering third party billing information
   c. listening
   d. giving accurate and timely information

4. “There is a cost to caring” is a quote by one of the foremost researchers on compassion fatigue among those who treat trauma victims. The researcher is:
   a. Charles Figley
   b. George Everly
   c. Robert Ursano
   d. Ann Norwood

5. The best approach to handling traumatic events and high stress jobs is to:
   a. speak to your mate/family about the experiences
   b. seek professional counseling
   c. use peer support
   d. see your supervisor

6. People who engage in “defense oriented” responses to disaster will generally have more positive outcomes.
   True or False

7. Many skilled mental health professionals find they are uncomfortable with DMH crisis counseling because:
   a. it requires learning many new diagnostic terms
   b. the work involves a heavy emphasis on loss and bereavement
   c. working with persons with such serious problems almost guarantees that the victims will eventually develop PTSD
   d. working with persons with such serious problems almost guarantees that the helpers will eventually develop PTSD

8. One of the greatest challenges for traditionally trained mental health professionals who want to volunteer some of their time assisting with disaster relief is to make the shift from being focused on diagnosing and treating pathology to being focused on normal stress reactions and a wellness orientation.
   True or False

9. Disaster relief work can be highly addictive.
   True or False

10. Weaver’s concept for getting back to the basics when helping trauma victims is:
    a. less is more
    b. KISS
    c. back to reality
    d. none of these

11. The Critical Incident Stress Debriefing (CISD) model is a result of the work of:
    a. Charles Figley
    b. Frank Ochberg
    c. Diane Myers
    d. Jeff Mitchell

12. In the CISD model, traumatic events like police shootings, line-of-duty deaths, fires in which children perish, and similar occurrences faced by emergency workers are called:
    a. traumatic stressors
    b. distress events
    c. critical incidents
    d. good reasons to leave their chosen profession

13. Anniversary reactions are quite common following traumatic events.
    True or False

14. The informal process of talking out disaster related problems is called defusing.
    True or False

15. The more formal, highly structured and lengthier process for exploring traumatic material is called debriefing.
    True or False

16. Pre-briefing can be used as a form of stress inoculation.
    True or False

17. One especially troubling aspect of helper exposure to the traumatic events described by victims is that there is not generally a pure, cause and effect relationship with co-traumatization situations, as there generally is with the traumatic events that result in PTSD. This injury is often more insidious, slowly building over time in a manner that is similar to the damage done to physical health by secondhand smoke.
    True or False
18. Those at greatest risk for problems include all of the following except:
   a. the newest among us
   b. the most caring and empathetic
   c. those who are well defended
   d. those with unresolved personal issues (e.g., rescue fantasies)

19. Types of stress that were mentioned in this program included all of the following except:
   a. anticipatory stress—concerns over the future
   b. situational stress—pressures of the moment
   c. tension stress—being too tightly wound
   d. residual stress—unresolved issues

20. While many critics fault debriefing for a lack of efficacy, psychological first aid is considered to be an evidence-based intervention. True or False

---

FOCUS CE Course Evaluation

Circle the most appropriate number below to indicate the extent to which the course’s learning objectives were achieved.

(5 = Achieved in full / 1 = Not Achieved)

1. Identify key DMH concepts including the origins of DMH, typical “normal” victim and relief worker reactions, and the timeframes/phases of recovery.
   (Achieved in full)  5  4  3  2  1  (Not Achieved)

2. Understand typical reactions of adults and children that may result from exposure to disasters or other traumatic life events.
   (Achieved in full)  5  4  3  2  1  (Not Achieved)

3. Learn the psychological risks of helping others (and the resulting transfer of trauma), while living and working in an increasingly troubled world.
   (Achieved in full)  5  4  3  2  1  (Not Achieved)

4. Respect the critical need for helpers to practice self-care and peer support.
   (Achieved in full)  5  4  3  2  1  (Not Achieved)

5. Please provide comments on current course and suggestions for future courses:

___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

---


A score of 80% or better is passing and we will send a certificate of completion to you, for 2 CEs.

Please enclose a check payable to “NASW”. (Sorry, credit cards not accepted for this offer.)

Send to:
NASW, 14 Beacon Street #409
Boston, MA 02108

Name ______________________________
Address ______________________________
City ___________________ State _______ Zip _______
Day Phone ______________________________

☐ NASW Member, $15  ☐ Non NASW Member, $25
Debriefing Session Handout

This session has been scheduled to help everyone come to terms with the thoughts and feelings that arose out of the recent tragic situation that you all faced. The format for the session is based upon the Critical Incident Stress Debriefing (CISD) model put forth by Jeffrey Mitchell (1983).

(Fill in the name of the sponsoring organization) has provided the workers who will serve as facilitators for today’s debriefing. The session will probably last from one to two hours and it will cover these six areas:

1. **Initial Phase** — Introductions, a discussion about confidentiality, an explanation of the purpose of the session, and a review of some other guidelines for the session. Some general rules in addition to the need to maintain confidentiality are:
   - Please speak only for yourself.
   - There is no rank during the session.
   - No press and no outsiders are allowed in the session.
     - (If anyone feels he or she does not belong in the session, please speak up about it right away).
   - Once we begin, there will be no break until we end the session.
   - No beepers and no phone calls, or other interruptions are allowed.
   - This will not be a time of investigation or critique.
   - Feel free to ask questions any time.
   - Please plan to stick around for the whole session.
   - No one has to talk, if they do not want to do so.

2. **Fact Phase** — Review of what actually happened during and after the incident (e.g., What each person heard, saw, smelled, touched, thought, and did).

3. **Thought Phase** — Review of the thoughts each person had at the time of the incident and in the time since the incident.

4. **Reaction Phase** — Review of the reactions each person had at the time of the incident and in the time since the incident.

5. **Symptom Phase** — Examination of the physical and psychological aftereffects of the incident.

6. **Teaching Phase** — Used to remind everyone that the symptoms they are experiencing are normal responses to the abnormally stressful situation they have faced.

7. **Re-entry Phase** — This is the time to wrap-up, answer any questions, and develop a plan for any future action that may be needed.

We hope this debriefing will be helpful to you, as you continue with the normal recovery process. The facilitators welcome your questions and/or feedback about the session.
Caring For The Spirit

Spiritual care providers are familiar with the traditional pastoral care role of chaplains serving in health care and military settings. Using a ministry of presence, they offer genuine warmth, unconditional love, authentic concern, and emotional support. In addition to the offering of presence, the chaplain's role involves spiritual support services.

Lord, take me where you want me to go;
let me meet who you want me to meet;
tell me what you want me to say;
and keep me out of your way.

Father Mychal Judge, OFM
NYFD Chaplain
R.I.P. September 11, 2001

Father Mychal will probably not be remembered as the first officially recorded fatality following the attacks on the World Trade Center in New York City on September 11th. His legacy as a caring Franciscan priest, mentor and friend, will solidify his memory in the hearts of all those he touched in the 68 years that he was alive. Becoming a fire chaplain in 1992 was a dream-come-true for Father Mychal. I always wanted to be a priest or a fireman; now I'm both, he once said. His dedication to New York firefighters would be tested on the 11th of September. According to Cassian Miles, O.F.M., communications director for the Holy Name Province, Father Mychal was anointing a firefighter and office worker at the site. He removed his helmet in prayer and was fatally struck in the back of the head by falling debris.

St. Anthony Messenger, AmericanCatholic.org, 10/19/01

A Litany of Remembrance

Roland B. Gittelsohn

In the rising of the sun and in its going down,
we remember them.
In the blowing of the wind and in the chill of winter,
we remember them.
In the opening of buds and in the rebirth of spring,
we remember them.
In the blueness of the sky and in the warmth of summer,
we remember them.
In the rustling of leaves and in the beauty of autumn,
we remember them.
In the beginning of the year and when it ends,
we remember them.
When we are weary and in need of strength,
we remember them.
When we are lost and sick at heart,
we remember them.
When we have joys we yearn to share,
we remember them.
So long as we live, they too shall live, for they are now a part of us,
as we remember them.