Psychosocial crisis intervention

"What makes you, breaks you and what breaks you, makes you." Major **Erik De Soir** begins a series on psychosocial crisis intervention with military and emergency services

ACUTELY STRESSFUL OPERATIONS are an unavoidable element of military and civilian emergency services' duties. Nevertheless, these potentially traumatic experiences constitute a major occupational hazard that needs to be recognised and responded to. Crisis intervention can prevent or reduce long term psychosocial impairment and maintain the effectiveness of these workers.

This series will address the conditions that raise psychosocial risk among military and emergency services personnel, along with the principles of effective and timely interventions. Examples of both preventative and healing interventions will illustrate how these principles can be converted into effective actions. The author draws conclusions on the most effective elements of these interventions and offers recommendations for implementing similar solutions in emerging crises.

In the last ten years more attention has been paid to the psychosocial consequences of long term deployment in conflict areas and the multiple effects of large-scale accidents and disasters. The domains of victimology, crisis psychology and psychotraumatology have received more attention from mental health professionals, authorities and top-level management. In many cases, this has been the direct result of campaigning by military operatives or emergency responders who have injured themselves, or who have seen their fellow soldiers or colleagues injured in the course of their duties.

Meanwhile, in most basic training courses for fire, rescue, emergency, police and military services personnel, a considerable amount of effort has been made to introduce the various concepts of stress and trauma specific to the fields of crisis intervention and disaster response.

There is still confusion with regard to the potentially traumatising effects of crisis response operations or emergency response, and the necessary help and support the different categories of victims should receive.

In Europe, multi-disciplinary co-ordination and co-operation has only become more organised in a broader operational framework since the region's armed forces became involved in a risky new type of peace support operation in post modern conflicts; and after several large scale accidents and disasters in the early 1990s.

The objective of these new psychosocial disaster plans and/or support models was to ensure vital psychosocial support, both as an immediate response to crisis, and as a long term follow-up.

A great leap forward was the creation of postgraduate courses in Disaster Medicine and Disaster Response, in which key personnel from several disciplines that worked together at grassroots level were trained in the same psychosocial framework, allowing them to use the same concepts in times of crisis. The next step was the development of joint regional psychosocial disaster plans for hospitals, industrial plants and high risk areas, and the organisation of follow-up training for disaster response networks comprising doctors, nurses, fire and rescue personnel, psychologists, psychiatrists, social workers, clergy, etc. The same evolution took place in the armed forces where a raft of support measures was developed for soldiers and their families prior to, during and after long term deployment.

Intervention

Successful psychosocial intervention in military operations, crisis situations and disasters also requires successful integration of all the disciplines involved, to give a common conceptual basis with respect to the immediate and post-immediate psychosocial needs of stricken trauma victims. Many organisations (eg fire, rescue, police, hospitals, army) introduced Critical Incident Stress Management (CISM) with the naïve expectation that it would prevent the development of Post-Traumatic Stress Disorder, but they only offered short and superficial training to their personnel who started to apply – with or without the creation of a peer support structure – the common principles of CISM, but often without even asking whether or not early intervention strategies have to be different according to the type of critical incident a stricken individual or group has been confronted with.

This series aims to provide a refreshing, divergent and non-standardised European view on trauma, rather than repeating predictable and widespread theories.

In my experience working as both a crisis psychologist and a voluntary firefighter/paramedic, and having provided numerous workshops for peer support officers and trauma practitioners all around the world (including the US, Canada, Latin America, Australia and New Zealand) – I have been impressed by the

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work carried out by people working in remote areas. Lots of guidelines and best practice lists are published, but in remote areas such as the outback towns of Australia, during military or war operations, or under disaster conditions, these guidelines can be impossible to follow because of the lack of resources and difficult conditions.

I have seen extensive knowledge on crisis intervention, but mostly from a one-sided view and based on a mechanistic flowchart or written policy. It seems that there is still confusion with respect to early psychological intervention after military operations, large accidents or disasters.

Most peers and clinicians are very familiar with the different concepts of CISM – such as demobilisation, defusing, psychological debriefing or Critical Incident Stress Debriefing (CISD). However, they appear to lack the historical and theoretical context of debriefing and are unfamiliar with the core of the ongoing debate on the efficacy of psychological debriefing, which appears extensively in the current literature and divides the trauma field.

This debriefing controversy is partly due to the lack of good sense and field experience of many trauma researchers, who seem surprised that organising single session debriefings does not prevent psychological trauma, especially when one is working with primary victims for which these CISM interventions do not seem the right support intervention. Practitioners working at incidents understand that immediate or early support, acute intervention and first psychological aid are very different, depending on the type of victim – they would not debrief disaster victims, burn injury patients or rape victims, for example.

The series will provide illustrations from the point of view of the trauma counsellor and therapist, and from field experience in military, police, fire and emergency medical services. The aim is not to criticise existing models or to point the finger at people who tried to do their best in given situations, but to generate ideas and questions that should allow us to elaborate appropriate guidelines for good practice in coping with human crash situations, in times of war and peace, and which should enhance our way of understanding the noxious impact of traumatogenic events.

I hope that this series will contribute to an increase of quality in both the immediate and post immediate stage of trauma intervention, so that both trauma practitioners and peers start to invest more energy in analysing emotionally disturbing events and their impact, instead of just considering themselves and their practice as part of a policy based on 'one size fits all'.

Acute reactions

First, we must inject clarity into the variety of effects of emotionally disturbing and potentially traumatic events. We must put aside widespread and overgeneralised concepts of traumatic event and traumatic stress, and reserve these terms for events which are really traumatising.

The term 'trauma' is too widely used, both in the literature and in spoken language and a conceptual lack of clarity influences the practice of psychosocial crisis intervention and early intervention. The best illustration of this is a psychological debriefing controversy over whether or not CISM techniques are effective. While the techniques of psychological defusing and debriefing were originally developed to support professional (or professionally trained) caregivers – such as troops, firefighters, rescue workers and police or emergency medical services personnel – they have also been widely used (and researched) to support all kinds of victims of critical events.

The problem is that the definition of a critical incident has always been very vague and that these CISM techniques have conquered the whole trauma field. Both CISD – being an integral part of CISM – and the latter concept of early intervention have become a 'catch-all' concept covering various kinds of interventions for various kinds of victims. In the meantime, a whole 'disaster business' has developed and professional caregivers or high-risk organisations (eg banks, petrochemical industry, rescue services, army, police) are being urged or legally forced to 'do something' to support any personnel exposed to various kinds of emotionally disturbing and potentially traumatising events.

An event is emotionally disturbing when it is abrupt and shocking and involves disturbing feelings of anxiety and/or depression, followed by guilt and/or shame and/or sadness and/or rage. By its sudden impact, the event temporarily (and more or less severely) disrupts the emotional and/or physical and/or cognitive equilibrium of the individual and their significant others, who are struck by the secondary impacts of the event. Examples are the painful or sudden death of a friend or a relative, seeing severely injured or dead people and other important losses. These events are considerd to be shocking, rather than being directly traumatising.

Secondary victims

On New Year's Eve 1995, a hotel fire in Antwerp, Belgium, killed more than 10 people and injured more than 150. I tend to consider this event as emotionally disturbing (ie it had a temporarily disruptive impact) for people living in the neighbourhood, as well as for the firefighters, police personnel and emergency medical services involved.

If secondary or tertiary stricken victims (significant others and involved professional caregivers or police) were not personally involved during the aforementioned hotel fire, or if they did not go through a mental process in which they identified themselves with the stricken victims, we do not consider this event to be potentially traumatising for these categories. However, traumatisation can occur due to a process of identification with victims or through the on-scene contact with friends or relatives. In other cases, such an event can also trigger earlier trauma and thus lead (again) to post-traumatic sequelae, aggravating the already damaged mental structure of the stricken individual.

An emotionally disturbing event is traumatic if it is: Sudden, abrupt and unexpected; involves feelings of extreme powerlessness, horror and/or terror, disruption, anguish, and/or shock; leads to vehement emotions of anxiety and fear of death, due to; the subjective (feelings) or objective (real, direct) confrontation with death. Central to this definition is the confrontation with death; the traumatic event confronts an individual with an unknown world of cruelty and horror, the world of death in which certainties, norms and values no longer appear to exist.

Survivors of terrible events must try to emerge from an underworld

This is the (under)world from which the survivors of terrible accidents, wars, fires, explosions, earthquakes and floods, macro- or micro-social interpersonal terrorism or severe threat, must try to emerge. They must try to awaken and leave the empty silence, feelings of complete abandonment and loneliness.

The deep emotional and psychological consequences of a close encounter with death are evident in the testimonies of trauma survivors of the Switel hotel fire in the ballroom during the New Year's Eve party in 1994/1995: "I was playing trumpet on the podium when suddenly a fireball appeared in the rear of the ballroom. In just a few seconds the fireball rolled through the whole ballroom. The lights switched off, I heard the loud sounds of explosions and I heard people screaming and running in search of rescue. Then it seemed as if I heard nothing anymore. The only sensation I still remember is the enormous pulse I felt in my chest and the overwhelming black smoke which made it nearly impossible to breathe. The new year's party suddenly became like hell: smoke, screaming and the smell of burnt meat. Herds of people running to find an escape which seemed impossible to find. These sensations would later be the gist of my nightmares. I don't know why, but I was running in the opposite direction to all the other people. I would never know why. The heat in the ballroom seemed to become unbearable. The only thing I wanted, was to survive. And I kept saying to myself: 'you will survive'. On pure intuition, I ran through a door and arrived in a small kitchen in the rear of the ballroom. On hands and knees, I tried to find a way out. It seemed hopeless. Completely exhausted and in total desperation, I decided not to fight any longer against fate and prepared myself to die. But, sitting down against a wall, I suddenly felt a last rush of energy which made me jump up and run, like being out of myself, hitting a wall, then a door, and ... there I stood, outside the building, in the pouring rain. At first, it seemed as if everything around me happened in slow motion, and like a movie just playing in front of my eyes. Then, reality and sound came back to me and I realised that I just escaped from death. In these first moments, I didn't realise that I was hurt, but after a few moments I started to feel the pain from my burn injuries. My hair was gone and my skin was hanging down from head and hands. It felt as if thousands of needles were penetrating my body. I was severely burned and started to feel more and more pain as the time went by. At that moment, I did not realise that this would be the start of a recovering and rehabilitation period stealing several years of my life ..."

Total submission: The moment at which the victim experiences such overwhelming power and violence, that it appears to understand that fighting death no longer makes sense

Powerlessness

Another Switel survivor expressed her feelings: "We were sitting at a very pleasant table and having a great time. Suddenly somebody shouted: 'My God, look what a flame'. That same flame would soon become a real fireball leaving no time and space for escape. I saw everything happen in just a few seconds and thought that it was an illusion. It just could NOT happen during such a fantastic evening. Not here. Not now. But it soon became very serious. Somebody grasped me by the arm and pulled me away from the table. From then on, I acted like an animal. I was running without seeing in the black ballroom, and without even knowing where I was running to. While running, I felt the desperate attempts of people lying on the floor and desperately trying to get up. I really did not fully realise that I was actually running on top of other people. After a while, I passed out, I lost consciousness. I was wearing a nylon dress that evening; a very short dress with open shoulders. That is why I was severely burned. When I came back to consciousness, I did not feel the pain. I did not realise that I was wounded. I remember that we were evacuated with military helicopters to a military hospital. I thought that I was in the middle of a war. Or that there had been a terrorist attack. Or that there had been an explosion in our hotel. The whole military context justified these impressions. It would have made sense. Once in the hospital, the nurses started to undress me and to cut my long hair. I was very angry because it took years to grow my hair so long and the hairdressing had cost me a small fortune. But, they told me that I was severely burned and that they would have to put me to sleep for at least a couple of weeks. Three weeks later, I woke up with a tube in my throat, which would stay there another two weeks. Impossible to express what you feel during such moments. A psychologist was sitting on my bed when I woke up. Immediately I wanted to know how my husband had survived the hotel fire, but the psychologist took my hand, looked me right in the eyes and said: 'I'm sorry, both your mother and your husband died'. My whole world collapsed. It would become even worse when I heard from the doctors that my left hand, ears and nose, burned to the third degree, had been amputated and that I would have to go through a lot of other surgical operations. I went to the Switel hotel to celebrate New Year's Eve as a young, successful and beautiful woman, but several weeks later, I would wake up as a monster, mutilated for life."

Traumatic events like the above experiences shake the very foundations of a human being: you cannot expect anybody to cope with this kind of event without suffering long term psychological damage. As well as the feelings of extreme powerlessness and helplessness, and the overwhelming impression of deep penetration into one's own physical and psychological integrity, trauma survivors have to cope with the potentially ego-destructive emotions of permanent uncertainty, (survivor) guilt, anxiety, shame and loss of control. The more severe the physical injury, the longer the recovery and working-through process will last, and the more pessimistic we are about the prognosis in the long term. There is also the loss of connection with surrounding significant others and a person's environment in general.

Combat survivors

The above accounts are very similar to the accounts of combat survivors. During the traumatogenic (potentially traumatic) event – in what we will call the peritraumatic stage – the direct victims act in a way which is very significant for their survival and comparable to the way animals react when threatened by a predator. The stages are:

- **Immobility:** In nature this sometimes means 'survival', 'escape from death' and 'total inhibition'. This freezing occurs during a state of apprehension of danger and an attempt to find the right or most adequate survival response;
- **Flight:** If there is enough time and space for escape, otherwise numbness and freezing might return, or even the opposite reaction, ie pattern, panic and senseless activation;
- **Fight:** For as long as the fight to survive makes sense and offers a chance of survival;
- **Total submission:** The moment at which the victim experiences such overwhelming power and violence, that it appears to understand that fighting death no longer makes sense. In humans, it is at this moment that dissociative behaviour – alienation, depersonalisation, anaesthesia, analgesia, narrowing of attention, tunnel vision, out-of-body experiences, derealisation, etc, set in, as if to allow the victims to die without feeling pain or being conscious of the fact that they are dying; and
- **Recovery, recuperation and return of pain:** If the danger or threat of death disappears, this is the last stage in the traumatisation sequence. This involves return of sensitivity, partial consciousness of what happened, widening of attention, ie behaviour typical for a return to reality. But this reality will never be the same again if one has looked 'death' in the eye and has been confronted with the unknown, wordless and unspeakable world of death.

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After the return from death, as described by the above trauma survivors and the numerous trauma victims I have encountered in therapy (survivors of wars, RTAs, rape, assault, fires, hostage taking, etc), the fragmentary and wordless trauma sensations and experiences must be put into words in order to recover. Trauma survivors must go back into the trauma labyrinth to search for a way to express what they have lived through, to seek a meaning which could reconnect them to the world of the living.

In the first stage – which we will call the acute (or immediate) trauma stage – in the immediate aftermath of trauma, right after living through the destructive and potentially traumatic impact, trauma survivors are confronted by a confusing mix of feelings of disbelief, denial, relief and despair. These moments, during which survivors yearn for rest, recuperation and safety, will be quickly disturbed and/or alternated by sudden and intrusive recollections and re-experiences of the traumatogenic event, during which the victim acts as if the event itself was recurring and the death threat is once again present.

Intrusion

The brain does not seem to make a difference between the original event and these intrusive recollections. The trauma survivors keep asking the same questions: What happened? How did this happen? Who else is injured (or dead)? Why did this happen (to me, or to us)?

They are in a desperate need of information. They are feeling the sequelae of the hyperarousal they needed in order to survive, still disoriented and heavily impressed by their close encounter with death. During this stage, trauma survivors experience predominantly material and practical needs. They ask themselves: How will I eat? Where will I sleep? Who will pay for this? How can I tell to my relatives what just happened to me? These are all problems for which a quick solution is needed.

Normally, this stage will take a minimum of a couple of hours to a few days during which the physical recuperation from the event and the neuro-biological storm it provoked inside the body might be more important than the psychological recovery which will take months or years.

This will be followed by the stage of working through the trauma – the post-immediate or post-acute stage – during which the trauma survivors will have to: accept what happened to them; confront the negative emotions which are associated with this kind of event; regain a daily life balance, or try to return to normal activities; work through their experiences; search for a way to express and put their experience into words; and find a meaning and a narrative, to integrate what happened in their personal story. Numerous models are offered in the current trauma literature, but most of them take more or less these different stages into account. And in most models, recovery seems to mean only less PTSD (Post-Traumatic Stress Disorder) symptoms; leaving no place for the other areas of life that may have been affected. CRJ

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