Psychosocial intervention – part II

Major **Erik de Soir** continues his series on psychosocial crisis intervention with military and emergency services by examining typical responses to emotionally distressing, shocking and potentially traumatic events

Life-threatening events and large-scale accidents, calamities or disaster situations are not only potentially traumatic for direct victims and their significant others but also for the caregivers involved. Even military troops deployed as peacekeepers in a crisis response operation in which the core business is humanitarian assistance or war relief activities, can be confronted by the same type of problems. Instead of acting as fighting troops, they behave as military caregivers and frequently suffer from what one could call 'vicarious traumatisation'.

Emotional distress

Everyone who starts out as an emergency responder expects to be confronted sooner or later with emotionally distressing, shocking and potentially traumatic events. As in all high-risk and vocational professions (military or police personnel, money couriers, prison guards, emergency medical personnel), it is to be expected that staff – as well as their employers – are well equipped to deal with these impacts.

In fact it is generally assumed that the consciousness of having to work with living, injured or dead victims of fire or serious accidents, natural disasters, violent crimes, hostage situations and shootings automatically leads to good psychological assimilation. This is absolutely untrue.

The author has led several field studies based upon semi-structured clinical interviews with military personnel, firefighters and paramedics, which have shown that one in ten firefighters or ambulance personnel have not come to grips with earlier traumatic experiences incurred during an intervention. The short and long-term effects of intense and sudden stress, as well as slowly accumulating stresses, can have a destructive effect on the rescuers' and caregivers' well-being.

The world of firefighters and emergency medical personnel is often a closed one to which an outsider is only admitted reluctantly. The same thing is true for highly trained military units. Many earlier efforts at mending the detrimental effects of PTSD in firefighters, emergency medical services, police departments or military

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units have failed because the projects had little ecological validity or because the initiators approached their potential victims on the wrong assumption that they would ask for and accept psychological support. Nowadays, it is common knowledge that non-embedded psychologists, trying to work with rescuers, emergency personnel, law enforcement or the military, as specialists do with their patients, are rather seen as a 'spy' instead of 'psy'.

All emergency personnel want to be heard, supported and helped by someone who is as alike to them as possible, who lives in a similar world. Traumatic stress is not easy to calculate or to express in a mathematical model.

A fault line in many organisations like fire or rescue departments, for instance, is the one between young and old: rank or experience does not necessarily equal knowledge. Many young firefighters or ambulance personnel have obtained degrees or qualifications that they use against older colleagues.

Emotionally disturbing or traumatic interventions can cause many physical or psychological complaints. Possible symptoms are: Withdrawal from social life; avoiding difficult situations; agitation and nervousness; heightened irritability or downright aggression (sometimes also within the family); backaches, headaches, stomach aches, chest pain; re-living the incidents in various forms (nightmares, flashbacks, etc); concentration problems; and jumpiness. These are manifest symptoms of post-traumatic stress.

Many studies indicate that there is a marked cardiovascular pathology in firefighters and paramedics, disciplines which experience noticeably more victims than in the average population. Firefighters and paramedics appear to have more cardiovascular risk factors such as cardiovascular hypertension, obesity and hypercholesterolaemia. These medical risk factors are further enhanced by the virile and macho culture that usually reigns – albeit sometimes as a flimsy varnish – within fire brigades and emergency medical services.

Firefighters, police officers, soldiers and/or masculine emergency medical personnel usually consist of men who have been educated to believe that crying is a sign of weakness. They have become experts in stifling pain and hiding emotions with black humour and cynicism as an outlet. This is the safety valve that allows these men and women to maintain a psychological distance from the victims.

During their work, often in gruelling circumstances, they have learned to concentrate on technical or operational manipulations and to suppress their emotions. This behaviour has often been described as insensitivity in the past, but the way in which firefighters deal with their feelings appears to be very functional. Yet after the excitement of the intervention is over, the armour is dropped and firefighters/paramedics wake from their functional tunnel vision, leading to a host of problems.

Prototypical male

Prototypical male and extrovert behaviour like smoking, drinking, loud bar-room discussions, taking up a lot of space in the group, telling (dirty) jokes and bragging about their deeds seems to be reinforced by the specific profile of firefighters, police officers, soldiers and paramedics. In fact, psychologically speaking, they are all asking for a lot of attention.

The uniformed man/woman is typically very action and goal oriented, dedicated, very motivated, ambitious and prepared to take calculated risks. For caregivers and rescuers, deceased victims equal failure. The often overwhelming powerlessness, coupled with the inability to reflect on emotions, turn many firefighters into prospective burnout victims.

Burnout was first described by Freudenberger (1987) as a specific form of depression found in all types of practitioners of social medicine. But in many elder firefighters, emergency medical nurses and paramedics, the symptoms of burnout can be traced one by one. Unwillingness or inability to talk about impressions and accumulating emotions inevitably leads to problems in the long run.

Scarred

Some leave emergency medicine or rescue work after a few years, startled and scarred by what they had to go through. Five years of service in firefighting or emergency medicine – certainly for volunteers – seems to be a critical period. If they succeed in finding a balance with regard to traumatising interventions and the time they invest in voluntary aid within those five years, the chances of remaining with the service for a longer period increase. One of the first important hurdles is learning to deal with feelings of guilt and impotence.

Emergency responders must learn to accept that they should not be too harsh on themselves because there just is no coping with some situations. This is reality.

Others leave their jobs with a bitter feeling of failure after a long and strenuous grapple with a passion got-out-of hand for violence and loss. Many firefighters and caregivers are, in fact, 'trauma junkies' who do not like periods of inactivity. The escape valve appears to be yet again – not surprisingly – black humour, irony and cynicism.

Within these firefighters and caregivers we can imagine the physical, mental and emotional exhaustion as an ever-increasing chaos. The person concerned has to invest more and more energy to avoid experiencing past traumatic intervention properly.

Alcohol and hyperactivity (often in occupations that increase social isolation) are well-used ways of escape. Those affected may spend a lot of time in the fire department, occupy themselves with odd jobs, play cards and drink together, go through past interventions in bars, and keep outsiders at a safe distance. In this way they share

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an important amount of time together. There is a strong mutual bond among firefighters and paramedics of this kind. They remain, albeit from the sideline, and even when retired, very involved with everything the service organises. In the first, crisis responders are doers rather than thinkers and talkers. But once they start talking…

Firefighters and paramedics do not want to feel like victims themselves. In this environment it seems as if the counsellor him or herself needs to have 'a little cancer' to be able to deal with cancer. Counselling by a psychiatrist, psychologist, therapist, social worker or mental health worker in general from a viewpoint of power and degree-based knowledge does not work with firefighters and crisis responders.

As stated before, it will be important to treat the firefighting and emergency medical personnel as equals to obtain a mandate of equality and from there on to start a discussion about an emotionally disturbing (potentially traumatising) intervention. This insight recently led to the creation of the European Association of Fire Psychologists, an association reuniting mental health professionals being both a trained and experienced firefighter and/or paramedic, and a clinical psychologist or psychiatrist.

Emergency responders realise that the line between saving and not being able to save, and therefore between being a hero or a victim, is very thin indeed. First-line counselling will therefore have to be oriented towards creating an atmosphere of confidentiality and mutual understanding to be able to discuss everybody's feelings about the intervention, followed by legitimising and normalising possible reactions.

In the group the following emotions usually surface: often overpowering impotence; a feeling of helplessness; paralysing grief about the human (and very recognisable) suffering of the victims; the intense guilt of not having been able to do more; and the anger generated by all this.

Depressing

But it is important to note that such an emotional intervention-based experience should, usually, be viewed as depressing rather than being classified as life-threatening or traumatic.

It is quite obvious that different kinds of interventions need different kinds of post-intervention support, an element which seems to be underestimated in current trauma research in which no difference is made between emotionally shocking and depressing events, in which grief about the losses suffered is an essential part of the working through process, and the life-threatening, high anxiety and high arousal events, in which immediate arousal reduction and physical recuperation seem to be much more important than immediate emotional coping.

Before treating the sequences of crisis psychological assistance and going into the details of what the psychosocial matrix of crisis psychological assistance, it is important to consider the emotionally disturbing intervention as a difficult puzzle, from which the pieces have to be put back together, to allow the stricken emergency responder to fully understand the context in which the intervention took place. It is this context that determines the shape the group counselling is to take; the so-called 'supervised peer debriefing', as used by the European Fire-Fighter & Emergency Medical Stress Teams and instructed by the trainers belonging to European Association of Fire Psychologists. CRJ

■ *Next issue, Major Erik de Soir will be looking at the multidisciplinary character of psychological shock assimilation after a large scale intervention.*

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