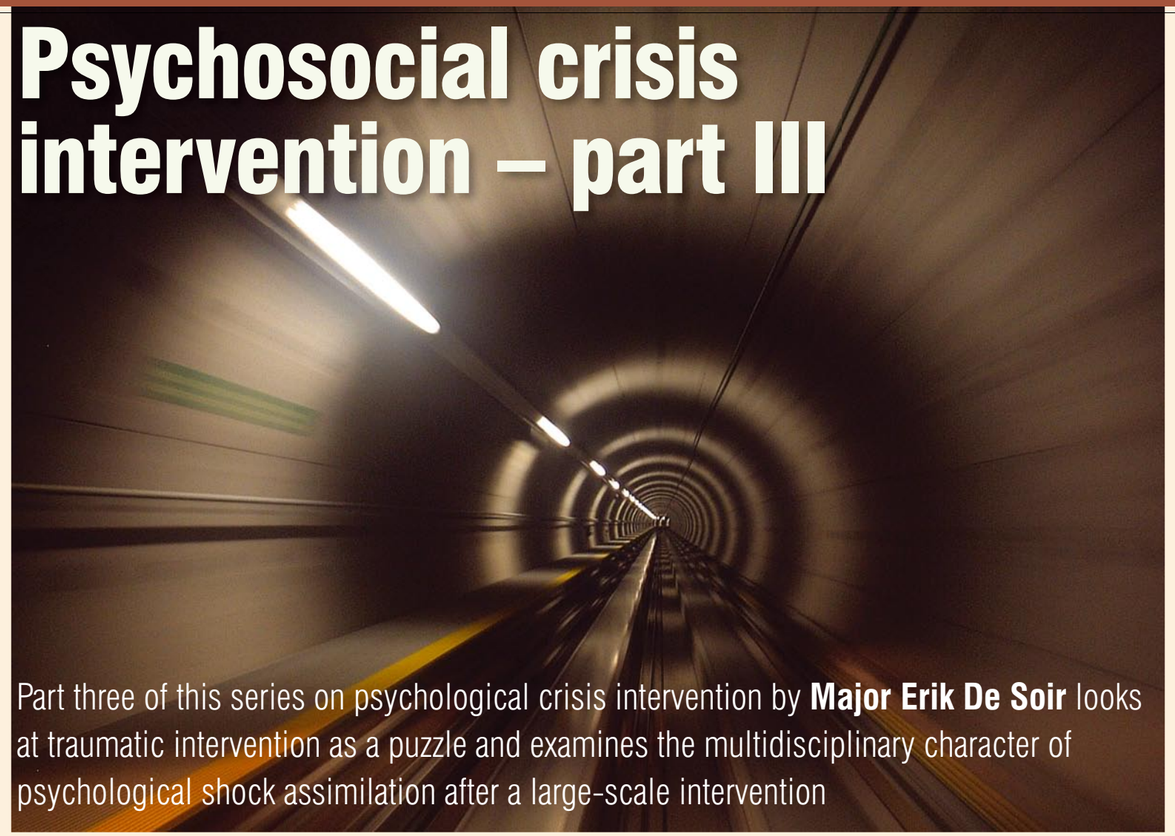
Psychosocial crisis intervention – part III



Part three of this series on psychological crisis intervention by **Major Erik De Soir** looks at traumatic intervention as a puzzle and examines the multidisciplinary character of psychological shock assimilation after a large-scale intervention

As already mentioned in previous articles in this series, the acute psychological experience of an emotionally – potentially traumatising – disturbing event is one of extreme powerlessness and loss of control. The victim feels as if his or her willpower is eliminated and simultaneously experiences a sudden and unexpected dislocation of work and/or living conditions. They feel as if nothing will ever be the same and that there is a constant threat of death or serious damage to their psychological and physical integrity, or that of others.

Compromised

The illusion of invulnerability – 'accidents only happen to careless or unknown people' – is seriously compromised; they experience intense feelings of guilt, shame, fear, anger.

The stricken caregiver – whether police, medical, fire or other – can, in many instances, no longer maintain his or her image of the world and basic assumptions and expectations about life are no longer valid. Everything, even in firefighting operations, becomes dishonest, unjust, unpredictable and dangerous. Danger lurks behind every corner. Training no longer stands for controllability. Every intervention means danger.

It becomes increasingly difficult for modern firefighters or paramedics to recognise and understand each other with the special highly technological and protective clothing they are wearing. Participation in any intervention becomes more anonymous.

Let us first examine the case of firefighters working on a disaster or accident scene. For the firefighter, it is even difficult to hear or recognise his/her colleagues. Modern firefighting gear protects them from mechanical impacts, deafening noise and radiation or contact heat. In reality, this makes a firefighter more or less sensorially deprived or 'contact-dead'. Older and more experienced firefighters have more problems with this situation. They used to 'feel' their work; fire was a living thing and they could operate using warmth and hearing. Now the firefighter is partly isolated.

This does not just affect operational sensitivities, like feeling or smelling the risk of a backdraft, or correctly evaluating the chances of a flash-over during a fire. Firefighters are socially involved people whose firefighter training emphasises strong reliance on direct contact with colleagues and teamwork.

The intervention of the shock mechanism – sometimes referred to as tunnel vision – helps to protect victims or the caregiver from (emotional) collapse during a traumatic event

photo: Heinrich Jakob/Morguefile

Our hypothesis with regard to this problem is that this working in isolation while still in a group situation will considerably increase the stress during an intervention and affect firefighters' coping skills.

If emergency workers anticipate that the psychological burden of an intervention will be beyond their means, their physical arousal in the initial phase is considerable. It will be in large part due to this arousal that the firefighter, nurse, emergency doctor or police officer will only be able to recollect part of the events afterwards. This same heightened arousal will cause them to make more errors, think incoherently and, sometimes, make the wrong decisions.

While this physical arousal is necessary to stay operational and alert, too much arousal during traumatic interventions may cause diminished attention and increased human failure.

This phenomenon of narrowed attention – which could be compared to the victims' peri-traumatic dissociative responses – is known in literature as the Easterbrook-claim, which says the physiological arousal of emotionally disturbing events leads to a narrowing of attention. This, in turn, leads to a diminished capacity to take cues or information from the environment in which an event takes place. It is therefore very difficult for the caregiver in question to come to a meaningful reconstruction of the whole event. It becomes like a giant puzzle for which they only have a limited number of pieces, making it very difficult to build a complete picture, which is indispensable to work through the event in a healthy way.

Shocking

If we couple the insight that information from emotionally disturbing or shocking events is usually badly encoded to the individual's perceptions after the event, we have reached the very core of the problem: the fantasy built around emotionally disturbing and/or traumatic events, and the lack of real event-based information, are often worse than the reality. This is true for victims and even for their caregivers. This is one of the (theoretically based) reasons that direct trauma victims and their caregivers can mean a lot to each other when it comes to the working through process which follows traumatic events.

But there is a problem: on the one hand scientists claim that the high emotional content of events can undermine memories of them. On the other hand some researchers assert the opposite: that the high emotional content of events would make memories more exact and detailed. For example some studies on weapon focusing have determined that certain stress-inducing objects such as firearms or knives used in crime may focus the attention of people and thus improve the accuracy of the memories of some details to the detriment of others.

Given these scientific insights, it appears as if direct victims' reactions are different to the reactions of their caregivers. Mutual contacts on these differences in reactions and behaviour patterns can be very useful in both directions. It is also a very human way of counselling, with caregivers meeting the victims they rescued, or attempted to rescue, and both returning to the distressing event, talking it through to support each other and search for meaning.

Often, during psychological debriefings with caregivers or psychological first aid activities with victims, the traumatic event is described as being similar to a movie or a video clip – unreal and riddled with signs of denial.

Again this is the intervention of the shock mechanism – sometimes referred to as tunnel vision – that must protect the victims or the caregiver from (emotional) collapse during a traumatic event.

The caregivers in question often call this working on auto-pilot and most actions during the immediate first stage of an intervention are conducted by instinct and falling back on training, without speaking. The scene loses its reality and rescuers report that children can be perceived as dolls, acquaintances become anonymous and injured or dead victims can be dehumanised, possibly through black humour, to maintain a distance.

Thus it seems clear that sooner or later, caregivers and rescuers, firefighters, paramedics and emergency medical nurses will definitely pay the emotional price for their work

But the moment does come when the auto-pilot is switched off. After the intervention we know this phenomenon as the emotional post-fact collapse. During long interventions one precise stimulus may be enough to stop the auto-pilot; a stimulus will pierce the caregiver's armour and, from that moment onwards, he or she will start to function as a vulnerable individual. And this cannot be sustained for long; once the intense experience is over and the danger averted, the caregiver in question obtains an insight – albeit partly – into what has really happened. From that moment the trauma-video-merry-go-round begins. Because of the fragmented experience during the intervention, every caregiver starts to reconsider or ruminate upon events, wondering if they, or their colleagues, should or could have done more. The more holes there are in the experience, the longer the questioning process takes and the longer the mind ruminates.

This causes the person concerned to end up in the dialectics of a psychological trauma: continuous and intrusive re-experiencing, alternated by periods of negation/avoidance and, as a consequence, heightened arousal remains unchanged. And if arousal becomes too high during the moments of intrusive re-experience, integration of the traumatising experience will not take place. The person can become mired in either intrusive re-experience or avoidance/denial, which leads to increasing social dysfunctional. From this moment on and if the necessary DSM-criteria are met, Anglo-Saxon literature speaks of post-traumatic stress disorder.

Thus it seems clear that sooner or later, caregivers and rescuers, firefighters, paramedics and emergency medical nurses will definitely pay the emotional price for their work. This often occurs at the moment during which they are confronted with personal losses in their life, just as in the next example.

Peter, an extremely experienced firefighter aged around 50, had been involved in the rescue operations for the Switelfire (see CRJ Vol 2 Issue 4) from the first moments, helping dozens of shocked and burnt victims. After the rescue operations, he was convinced of his good work. He did not feel the need to discuss his experiences nor to participate in the post-intervention debriefing sessions. He did not want to dwell on this one big intervention.

A few years later he was confronted with a series of emotional disturbing experiences in his own private life, in just a three month period: he lost his mother and father, his wife was diagnosed with breast cancer and his oldest daughter attempted suicide. Peter was unable to cope with both the regular disturbing nature of his firefighting work and his personal experiences. He asked for help – contacting me by e-mail, and recounted how he started to have nightmares. In each nightmare he saw his own family sitting at a table in the Switel hotel fire and suddenly being engulfed by flames. While his relatives were screaming for help he was looking for them with his full fire equipment and oxygen mask, being completely lost and disoriented by the heat and the smoke.

This example clearly demonstrates that potentially traumatic events which have not been worked through or integrated, and which have been blunted in the post-immediate stage, can accumulate in the psyche and cause trouble – unexpectedly – much later on.

Debriefing

All this demonstrates clearly that psychological group debriefing with all the participants in a major intervention is a must, even if nobody takes part in psychosocial crisis intervention on a mandatory basis, so that the minds of the caregivers concerned can be put at rest as quickly as possible. In some cases, support activities will have to include both the victims and their caregivers. Caregivers should start on the site of the accident with first psychological support for the dazed and shocked trauma victims. They will be supported themselves, on-scene, by their own well-trained peers. And in many cases, after the intervention, when suffering their own post-fact collapse, they will make contact again with the stricken victims (or the victims' families), invite them in the emergency department or fire brigade, to talk about their experiences and to work through the event together.

■ *In the next part of this series, we will shed light on the support activities aiming at psychological first aid and emotional uncoupling sessions, after introducing the core concepts of the CRASH-model for psychosocial crisis intervention. The type of support can vary as a function of the type of (potentially traumatic) impact, or victims involved.* CRJ

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