Psychosocial crisis intervention – part V

Major Erik de Soir looks at the primary prevention of psychological trauma in tertiary victims, examining crisis psychological debriefing and emotional uncoupling

FOR THE PURPOSES OF THIS ARTICLE, the discussion of emotionally disturbing, shocking or traumatising interventions, in groups and according to procedures, is called 'emotional uncoupling' (EU). This is an individual or group-oriented intervention based on the commonly known 'psychological debriefing' (PD) process in which the most important elements of an emotionally disturbing experience are treated shortly after the event.

Lately psychological debriefing, mostly based on the elementary protocol of Critical Incident Stress Debriefing, has been generally advised as the best stress management technique for high-risk professions – firefighters, military, police, etc.

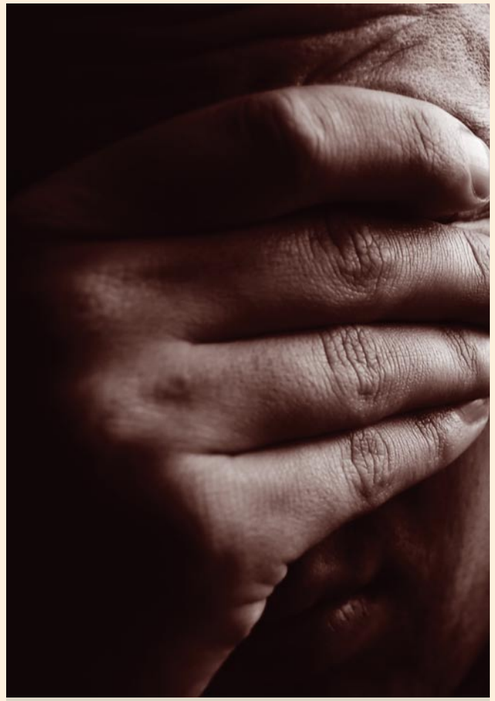
Currently, a number of variants of the original Mitchell protocol of psychological debriefing are widely used in psychological crisis intervention services. But the expected outcomes of psychological debriefing are too high and recently specialists have begun to argue about its effects.

Guided reconstruction

I do not like the term 'debriefing' because even many of its users do not fully understand its meaning or think they think they can easily carry these debriefings out (because the term 'debriefing' is familiar to them from 'operational debriefing'). I also think that the outcome criterion, ie the prevention of post-traumatic stress disorder, may be the wrong one.

Without going back on the way in which PD is applied in all its variants, and without further discussion of its utility, the guided reconstruction of an emotionally disturbing and/or traumatic event appears to be of primary importance.

It seems pointless arguing about the outcome of PD during every scientific congress. Especially when nearly all participants at these congresses – trained and supervised caregiver peers from firefighter and medical emergency stress teams who have already led more than



Shock, sorrow, pain, fear, anger and other intense emotions are useful catalysts to reach an assimilation of the emotionally disturbing and/or traumatic event with which the affected person can live

photo: Stockxpert

200 emotional uncoupling procedures – say they are "glad to have participated" and "grateful for the recognition and help provided."

One should not expect to 'prevent PTSD' when administrating PD.

As the most important purpose of EU is the lessening of the (often intense) psychological suffering caused by an emotionally disturbing or traumatic event, it is clear that accurate memories of this event are of primary importance. This, in itself, poses a problem for large-scale interventions in which different teams of emergency medical personnel, firefighters or even larger groups of caregivers take part. These individuals often have trouble working out the larger context of the intervention in which they took part as a small, but often important link. In the case of large-scale interventions, it is clear that a correct reconstruction is impossible if people are only debriefed within their own organisations. Such limitations make it impossible to gain sufficient information on a multidisciplinary intervention and to measure its success.

For example, following a very severe traffic accident in which four people died, a firefighter had to watch his colleagues and emergency medical personnel administering first aid and attempting to resuscitate a trapped victim. He was standing by, ready to intervene with the high pressure lance, at the slightest spark. Yet, after the event he felt superfluous and useless. To him this was the worst thing that had ever happened.

During the EU procedure at which his colleagues, emergency medical personnel, the police, tow service and other caregivers were present, this firefighter exploded with anger and started to cry. Then a nurse said that she would not have taken such a risk to help the patient – there had been petrol dripping from the car on the other side – if the firefighter had not been there, ready to intervene. The eye contact she had kept going with him during the intervention, and which he had read as reproach, had – on the contrary – meant a lot to her and she was grateful to this firefighter for his presence. She also said something else which was very important – that even while they were driving to the scene of the accident, she had heard which fire brigade would assist them. She thought: "If it's those guys, everything is going to be all right."

This meant more to the firefighter (and his colleagues) than any therapeutic intervention could have. In general, these kind of remarks by 'outsiders' – witnesses, medical staff, police – all mean a lot; it makes people feel useful in their jobs, which can sometimes appears to be very passive and frustrating.

This is a good example to use when a colleague insists that psychological debriefing – what we call EU in this text – should only take place in small groups and within only one discipline or organisation at any one time.

In some cases even the testimonies of witnesses or direct victims can be essential in this reconstruction process.

Further and equally important goals of EU are: ventilating tensions and frustrations (in many cases based upon the behaviour of the press and 'disaster tourists'); normalisation, comprehension and legitimisation of occurring reactions and feelings; creating a cognitive restructure (we hope to replace negative cognitions with positive ones) creating an almost mythical bond among fellow caregivers; and the identification of those participants who may be at high risk of problematic assimilation.

Emotional uncoupling

Emotional Uncoupling Procedures (EUPs) appear to be an effective means of handling direct and delayed post-event emotional collapse in caregivers. One should not expect elimination or extreme reduction of the risk of long-term dysfunction after a traumatic crisis, but this kind of support, which has to take place at the right time and by the right people, will always be very much appreciated by the stricken caregivers and will allow them to uncouple emotionally more easily from disturbing and/or traumatic interventions.

The Big Five of Victimology, as we call the five following factors, will be essential to ensure a person can cope healthily with emotionally disturbing events: Providing correct and honest information; mobilising the available natural support systems; ensuring the right rituals; avoiding secondary victimisation (by avoiding bad reactions from outsiders); and providing the necessary recognition to the concerned caregivers.

From Table 1, it is clear that the main goals of EUPs aim to help the afflicted gain insight into the fact that both the initial on-scene coping mechanisms and their post-fact psychological suffering are the engine behind the assimilation of the trauma, but that they can let this engine work for them instead of letting themselves be flattened by it. In fire and rescue services, these EUPs will usually be extremely well received, since most of their effects are depressogenic (initiating a potentially depressing impact, following the confrontation with grief and bereavement) instead of traumatogenic (meaning the typical high anxiety and high arousal type of event). Our practical experience teaches us that the more events are depressing, the more they need early emotional ventilation.

Shock, sorrow, pain, fear, anger and other intense emotions are useful catalysts to reach an assimilation of the emotionally disturbing and/or traumatic event with which the affected person can live. We use the term assimilation, not digestion because a minute stimulus is enough for the victim to relive the whole scene. Emotional uncoupling should not be used to confirm feelings or to quash them, but to recognise feelings that surface during the session as normal and legitimate reactions to an abnormal situation.

Beside these main goals there are a number of smaller individually-oriented goals. First is cognitive restructuring through a clear notion of the traumatic event and the reaction to it. The world of the victim can be turned upside down, but it does not have to remain like that forever. Next, individual and group tensions must be diminished. Also one has to ensure that any feelings of abnormality are

Table 1: Goals of Emotional Uncoupling Procedures

- **First:** *Together with everyone who took part in the event, establishing a correct reconstruction of what really happened by putting the pieces of the puzzle of each concerned person together;*
- **Second:** *To give these people ample occasion to ventilate their emotional reactions concerning the events and to establish the intensity of these reactions;*
- **Third:** *Offer recognition, support, information and comfort to the stricken, by offering a detailed discussion, legitimisation and normalisation of the symptoms;*
- **Fourth:** *Initiate, stimulate and catalyse the proper assimilation capacities in each participant in order to help him restore the feeling of safety and trust (and their feeling of predictability and control) in the environment in which they live and work;*
- **Fifth:** *Take away the feeling of being uprooted by stressing and stimulating the togetherness and the connection among partners in adversity.*

lessened by sharing them and being told that these are normal reactions to an abnormal situation. Further, an attempt has to be made to increase the support, cohesion and solidarity of the group. The afflicted have to be prepared for symptoms or reactions that can occur later. And last, but not least, EU can help identify people who may need help later.

Conclusions

With this series, I have tried to create the full picture of a framework – the psychosocial matrix of psychosocial crisis intervention – for immediate and post-immediate support after potentially traumatising events. The examples are drawn both from my own experience in the field as a firefighter and paramedic, as well as from my clinical practice as a trauma counsellor in risky military operations and large scale accidents and disasters.

In my interpretation of psychological trauma, I have tried to go beyond the superficial trauma descriptions found in the *DSM-IV* and have minimised the use of the concept of Post-Traumatic Stress Disorder (PTSD), which is still 'the reference' with respect to psychological trauma in most Anglo Saxon countries. Still convinced that PTSD is not the absolute scientific truth when talking about early trauma intervention or support, I also wanted to provide some extra insights with respect to first psychological support and early trauma intervention instead of using the 'one-size-fits-all' or 'cure-all' techniques of widespread CISM-protocols for all kinds of trauma victims.

An essential point in this discussion has been the difference made between directly life-threatening (traumatogenic) events, and depressogenic (depressing and grief inducing or sad events and bereavement situations) events.

Standardised models of how victims respond to extreme stress, and standardised interventions for early trauma support, never seem to differentiate between these various kinds of events and often allow a culturally blind and ideological use of intervention techniques which – in my opinion – will not prevent people from developing chronified trauma and/or complicated grief.

Pre-formatted and standardised techniques used in too broad a variety of situations, and the uncritical attitude towards these techniques, sometimes implemented on a commercial basis, aimed at post-trauma support of burn injury patients, traffic accident survivors, raped victims, hurricane victims, firefighters and military personnel in or after wartime experience, without even making the difference between all the situations in which these victims were involved, made both scientists and clinicians doubt about the effectiveness of their interventions.

In the meantime, trauma support and critical incident stress management seems to become an ideology: this ideology of acute trauma management has conquered large parts of the whole world, often paralysing the minds of many practitioners, until the scientific debate and controversy on the effectiveness of psychological debriefing and early intervention exploded less than a decade ago. But the damage was already done.

We must have the moral strength and courage to fully and independently develop our own practice-based trauma concepts which we gain from our own experience at the coal-face, instead of undergoing the tyranny of concepts imposed by high profile trauma doctors, bio-psychiatrists and neuroscientists, being heavily sponsored for their laboratory research. We should not let them make us prove what we know already – that what a nurturing mother does for her scared child is right. CRJ

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Sources

- *American Psychiatric Association:* Diagnostic and Statistical Manual for Mental Disorders III *(1980);* Diagnostic and Statistical Manual for Mental Disorders III-R *(1987); and* Diagnostic and Statistical Manual for Mental Disorders IV *(1994). Washington DC.*
- *Bergman LH, Queen T:* Critical Incident stress. Part 1. Fire Command*, 1986.*
- *Christianson SA, Loftus EF:* Some characteristics of people's traumatic memories*. Bull Psychonom Society, 1990.*
- *Cutler B, Penrod S, Martens T:* The reliability of eyewitness identification*.* Law Hum Behav*, 1987.*
- *Crocq L:* Le retour des enfers et son message, Revue Francophone du Stress et du Trauma*, 2000.*
- *De Clercq M, Lebigot F:* Les traumatismes psychiques*, Paris, Masson, 2001.*
- *De Soir E:* Non published research reports on stress & trauma in fire & rescue services*, Leopoldsburg, 1995, 1996,1997;* Traumatische Stress en Politie*, Antwerpen/ Apeldoorn, Maklu Uitgevers, 1997;* Handleiding voor de Emotionele Doorwerking van Schokervaringen*, Antwerpen/ Apeldoorn, Maklu Uitgevers, 1997;* Op het netvlies gebrand …! Traumatische stress bij hulpverleners*, Antwerpen/Apeldoorn, Garant Uitgevers, 2000; and De Soir E, Vermeiren E (Eds.):* Les debriefings psychologiques en question*, Antwerpen-Apeldoorn, Garant Uitgevers, 2002.*
- *Dunning C, Silva M:* Disaster-induced trauma in rescue workers, Victimology*, 1980.*
- *Easterbrook JA:* The effect of emotion on cue utilization and the organisation of behavior, Psychol Rev*, 1959.*
- *Eysenck MW:* Attention and Arousal: Cognition and Performance, Berlin*: Springer-Verlag, 1982.*
- *Figley CR:* Compassion Fatigue: Coping with Secondary Traumatic Stress in those who treat the traumatised*, New York, Brunner/Mazel Inc, 1995.*
- *Griffin CA:* Community disasters and post traumatic stress disorder: a debriefing model for response*. In: Williams T. (Ed).* Post-traumatic stress disorders: a handbook for clinicians*. Cincinnati: American Disabled Veterans Publication, 1987.*
- *Kassin SM, Ellisworth PC, Smith VL:* The "general acceptance" of psychological research on eyewitness testimony: a survey of experts*.* Am Psychol*, 1989.*
- *Kramer TH, Buckhout R, Fox P, Widman E, Tushe B:* Effects of emotional arousal on free recall: anterograde amnesia*. Paper presented at the Eastern Psychological Association Convention. Boston, 1985.*
- *Lebigot, F:* La clinique de la névrose traumatique dans son rapport à l'événement*,* Revue Francophone du Stress et du Trauma*, 2000.*
- *Loftus EF, Loftus OR, Messo J:* Some facts about "weapon focus". Law Hum Behav*, 1987.*
- *Maass A, Kohnken O:* Eyewitness identification: Stimulating the "weapon effect". Law Hum Behav*, 1989.*
- *Mitchell JT:* Emergency response to crisis: a crisis intervention guidebook of emergency service personnel*. Bowie, MD: RIBrady Co, 1981; and Mitchell JT, Everly GE:* Critical Incident Stress Debriefing: an Operations Manual for the Prevention of Traumatic Stress Among Emergency Services and Disaster Workers*. Ellicott City: Chevron Publishing Corporation, 1993*
- *Nijenhuis, ERS:* Somatoform Dissociation. Phenomena, Measurement, and Theoretical Issues.*, Assen, Van Gorcum, 1999.*
- *Nijenhuis ERS, Van der Hart O:* Forgetting and Reexperiencing Trauma: From Anesthesia to Pain*.* In Goodwin J, Attias R, Splintered Reflections. Images of the Body in Trauma*, New York: Basic Books, 1999.*
- *Raphaël B:* When disaster strikes*, New York: Basic Books, 1986.*
- *Van der Hart O, Brown P, Graafland M:* Trauma-induced dissociative amnesia in World War I combat soldiers*,* Austral NZ Journal of Psychiatry*, 1999.*
- *Wagner M,* Airline Disaster: a stress debriefing program for police*,* Police Stress*, 1979.*
- *Yarmey M, Jones DR.* Secondary disaster victims: the emotional impact of recovering and identifying human remains*,* Am J Psychiatry*, 1985.*