Section III – Helping The Helpers

Rescuing and aiding survivors, and the tasks of body recovery, identification, and transport are but a few of the stressors that contribute to high levels of emotional distress among disaster workers (Uranso, R.J., McCaughey, B.G., & Fullerton, C.S. 1994). The task of mitigating disaster worker stress is a vital component of emergency service operations and may be organized as an on-going process of prevention, early on-site intervention, and immediate follow-up. Interventions may be in the form of training, consultation, defusing, debriefing, or crisis counseling.

Disaster mental health work with helpers requires a broad clinical background and specific knowledge of stress reactions, post-traumatic stress disorder, crisis intervention, the nature of emergency work, stress management, and other intervention protocols appropriate to the disaster environment. Mitchell and Dyregrov (1993) suggest that the "wrong type of help provided by the wrong mental health professionals at the wrong time or under the wrong circumstances can be more damaging than no help at all."

STRESSORS ASSOCIATED WITH DISASTER WORK

Generally, disaster work is a combination of negative and positive experiences. Experiences may involve profound feelings of grief, despair, helplessness, horror and repulsion.   On the other hand, the experience of sharing common goals and purpose, of social bonding, and other experiences that renew professional and renewed personal convictions or re-evaluation of life priorities also make disaster work very rewarding.

Occupational hazards of rescue work and workers' personal situation/stressors account for the majority of stress reactions.

Occupational Hazards

- Exposure to unpredictable physical danger
- Encounter with violent death and human remains
- Encounter with suffering of others
- Negative perception of cause of the disaster
- Negative perception of assistance offered victims
- Long hours, erratic work schedules, extreme fatigue
- Cross cultural differences between workers and community
- Inter-agency/intra-organizational struggles over authority
- Equipment failure and perception of low-control
- Lack of adequate housing
- Encounter with mass death
- Encounter with death of children
- Role ambiguity
- Difficult choices
- Communication breakdowns
- Low funding/allocation of resources
- Negative perception by community
- Weather conditions
- Over-identification with victims
- Human errors
- Time pressures
- Perceived mission failure

Personal Situation/Stressors

- Personal injury
- Injury or fatality of loved ones, friends, associates
- Property loss
- Pre-existing stress
- Low level of personal and professional preparedness
- Stress reactions of significant others
- Proximity to scene of impact
- Self-expectations
- Prior disaster experience
- Negative perception/interpretation of event
- Low level of social support
- Previous traumatization

STRESS REACTIONS OF DISASTER WORKERS

Stress reactions in disaster workers are normal and to be expected. Even experienced workers never fully become desensitized to exposure to mass violent death and they remain particularly vulnerable when victims include children. Stress reactions may result in psychic numbing, short-term impairment of memory, problem-solving abilities, and communication. Long-term stress reactions may include depression, chronic anxiety, or symptoms resulting from vicarious traumatization (re-experiencing, psychic numbing/behavioral avoidance, physiological arousal), and they may cause or exacerbate marital, vocational, or substance problems.

Common Stress Reactions of Disaster Workers

Emotional
- shock
- anger
- disbelief
- terror
- guilt
- grief
- irritability
- helplessness
- despair
- loss of pleasure from regular activities
- dissociation

Cognitive
- impaired concentration
- confusion
- distortion
- intrusive thoughts
- decreased self-esteem
- decreased self-efficacy
- self-blame

Biological
- fatigue
- insomnia
- sleep disturbance
- hyperarousal
- somatic complaints
- impaired immune response
- headaches
- gastrointestinal problems
- decreased appetite
- decreased libido
- startle response

Psychosocial
- alienation
- social withdrawal
- increased stress within relationships
- substance abuse
- vocational impairment

It is recommended that disaster mental health services for workers be pre-arranged with their purpose and protocols understood and accepted by command staff and team managers. Generally, on-scene mental health support is delivered through consultation, defusing, debriefing, or crisis intervention services. These services may be informal or systematic, and may be conducted individually or with a group in a quiet setting away from (but not too far) from the disaster scene. The goals of these interventions are to:

- Consult with team managers and line workers regarding information about stress reactions and stress management strategies

- Facilitate enhanced group cohesion and peer support

- Provide opportunities for emotional disclosure and cognitive reframing

- Identify and reinforce resiliency and positive coping styles

- Mitigate long-term stress reactions (PTSD)

- Improve readiness for future operations

TYPES OF EMERGENCY WORKERS

Emergency workers may be members of highly trained teams, victims trying to help those who have been more seriously affected, or bystanders. Many types of helpers respond to emergencies:

- Search and rescue workers

- Fire and safety workers

- Transport drivers

- Medical personnel and paramedics (EMTs)

- Medical examiner and staff

- Police, security, and investigators

- Clergy

- Mental health and social service personnel

- Elected officials

- Volunteers who staff shelters, provide mass care, assess and repair the infrastructure

- Media professionals

THE RESCUE WORK CULTURE

The culture among rescue workers combines shared values and individual differences. Myers (1987) noted that emergency service workers often seem to possess contrasting personality traits:

• Gentleness	• Great strength
• Trust	• Caution
• High self-confidence	• High self-criticism
• Dependence	• Independence
• Toughness	• Sensitivity

For example, whereas emergency workers often have a high capacity for trust among each other, they tend to be cautious about the competencies of individuals perceived as outsiders; rescue workers may demonstrate mental and emotional resilience during an operation, but have intense emotional reactions afterwards because of their sensitivity to the feelings of survivors and their families. If mental health workers tactfully acknowledge these polarities, it may serve to achieve the confidence of rescue workers while increasing their willingness to disclose feelings of vulnerability or self-criticism, and receive emotional support.

How rescue workers cope depends on several variables. The circumstances of the disaster, preparedness, pre-existing team/organizational stressors, and pre-existing personal stressors are all key factors. Generally speaking, many disaster workers appear to favor coping responses that take problem-solving action or use logical analysis to understand work-related stressors. Some workers value and benefit from solitude while others seek the company of others. Some are more comfortable talking with an unknown professional, others prefer to talk with a few trusted individuals. Given the short amount of time that mental health clinicians have contact with disaster workers, it is difficult to assess the effectiveness of these individual coping processes. However, the process of defusing can provide useful information to guide mental health workers in their efforts to help the helpers.

GUIDELINES TO CONSULTING WITH COMMAND STAFF AND RESCUE TEAM MANAGERS AT THE SCENE OF OPERATIONS

A cornerstone of the effectiveness of mental health support at the scene of operations is establishing rapport between the mental health team and the command staff, rescue team managers, and workers. Knowing intervention protocols is not enough to be effective. As Alexander (1993) points out, when offering help to members of well organized professional groups, the helpers themselves must be well organized and professional. The mental health team can expect to encounter ambivalent feelings about their role and view this as a natural reaction by people who are in the midst of an extraordinarily challenging situation. Understanding the stressors associated with rescue work and the rescue work culture can facilitate alliance building. An early presence can also foster becoming an integral member of the response operations team.

Consulting Phases

1. **Initial entry and contact:** Introductions, inquiries about the incident commander's or team manager's expectations of mental health services, and a description of mental health services.

2. **Information gathering:** Assessment of services needed. Speaking with "key informants," observing environment and worker behavior in break areas.

3. **Feedback and the decision to intervene:** In giving feedback to incident commanders or team managers, respond to resistance through collaborative planning of objectives.

4. **Implementation:** Administration of interventions.

5. **Termination:** Evaluation of interventions and recommendations, if any, for further services.

Pragmatic Suggestions for Managers

The following suggestions for team managers are adapted from the Community emergency response team: Participant handbook and prevention and control of stress among emergency workers: A pamphlet for team managers (FEMA, 1994).

• Rotate personnel to allow breaks away from the incident area

• Provide break area, back-up clothing, nutritious food and the time to eat properly

• Rotate teams and encourage teams to share with one another

• Phase out workers gradually from high-to medium-to-low stress areas

• Provide defusings for all workers as they go off duty or take breaks

Disaster mental health consultants can best assist emergency team managers in utilizing these stress management interventions in the context of an ongoing low-key observer and advisor role. Workers and team managers will be most likely to accept these suggestions if they come to perceive the consultant as an ex-officio helper for their team, not as a detached professional "outsider."

As an unobtrusive consultant, the disaster mental health provider is positioned to provide crisis intervention in rare cases of severe adverse reactions by workers. The decision whether a worker can return to the job, be transferred to less distressing tasks, or be released from work must be made judiciously, with sufficient information about the worker's capability to satisfactorily perform rescue duties, mental status (severity of stress reactions), and the availability of organizational and social support.

Young, Ford, Ruzek, Friedman & Gusman
National Center for PTSD

DEFUSING INTERVENTIONS

Defusing refers to a process intended to facilitate opportunities for rescue workers to express their thoughts and feelings about the rescue tasks at hand without feeling obligated to do so. It is vital that mental health workers distinguish the process of facilitating voluntary emotional ventilation from a process that may be misperceived (e.g., "voyeuristic" probing).

If rapport is established, other topics related to personal and occupational stressors may be interjected.

Defusing gives rescue workers the opportunity to better understand their own reactions and allows mental health workers to look for indications of workers who may be at risk for long-term stress reactions. Unlike the time needed to conduct debriefings (2-4 hours), defusings can be brief (10-30 minutes) and offered continuously throughout the operation. "Aggressive hanging out," that is, finding ways to be in the vicinity of workers on breaks, is often a means to conduct informal defusings. (See page 40 for guide to defusing.)

Helpful questions:

"What are you from?"

"What rescue tasks are you involved with?"

"What is it about this situation that concerns you the most?"

"How do you handle what's going on?"

"How is this the same or different from other operations you've been involved with?"

Photo by Donna Hastings

Topics for Defusing with Disaster Workers

- Exposure to unpredictable physical danger
- Encounter with human remains
- Stress reactions of significant others
- Encounter with suffering of others
- Perception of cause of the disaster
- Perception of assistance offered victims
- Long hours, erratic work schedules, extreme fatigue
- Cross-cultural differences between workers & community
- Inter/intra agency struggles over authority
- Time pressures
- Lack of adequate housing
- Equipment failure and perception of control
- Personal injury
- Injury or fatality of loved ones, friends, associates
- Self-expectations
- Level of personal and professional preparedness
- Property loss
- Pre-existing stress
- Encounter with mass death
- Encounter with death of children
- Role ambiguity
- Difficult choices
- Communication breakdowns
- Low funding/allocation of resources
- Perception by community
- Weather conditions
- Over-identification with victims
- Human errors
- Perceived mission failure
- Proximity to scene of impact
- Prior disaster experience
- Level of social support
- Previous traumatization

TEACHING RELAXATION TECHNIQUES TO DISASTER WORKERS

Disasters workers have a deep commitment to working long hours without breaks and may quickly dismiss suggestions about using time to relax. The following guidelines are suggested to help mental health professionals establish rapport with disaster workers and to encourage them to consider stress-management strategies.

Guidelines:

1. Inquire about how long they have been on the job and about previous disaster experience.

2. Inquire about how coping styles (how he/she see their fellow workers coping, what he/she typically does to relax).

3. Inquire about unexpected stressors.

4. Inquire about sleeping patterns and level of fatigue.

5. Provide rationale for relaxation, first validating fatigue and its effects. Discuss disaster workers' general vulnerabilities (e.g., inability to stop working or thinking about the disaster).

6. Begin instruction and demonstration of techniques (e.g., muscle relaxation, conscious breathing, autogenics, visualization, etc.). Remember, the circumstances and settings that you will be teaching in are, more often than not, far from ideal. You may have from five to fifteen minutes to demonstrate the value of relaxation. The challenge is to efficiently facilitate the experience of relaxation in the midst of chaotic environments.

7. When possible, have handouts available that describe the techniques.

Sample script to use with a disaster worker

"You're working 15 hours a day, and its your second week here. I know you gotta be getting a bit tired. You're experienced and I know you know about burn-out and being here for the long haul. It sounds like the only break you get is when you hit the sack. I'd like to show you some simple, quick, and proven relaxation techniques that you can use on your own a few minutes each day to help you get some mini-breaks."

DEBRIEFING RESCUE WORKERS

Originally developed by Jeffrey Mitchell (1983) to mitigate the stress among emergency first responders, critical incident stress debriefing (CISD) is now a widely used protocol with victims and providers of all kinds (e.g., teachers, clergy, administrative personnel) in a wide range of settings (e.g., schools, churches, community centers).

Debriefing has become a generic term applied to a structured process that helps workers understand and manage intense emotions, further understand effective coping strategies, and receive the support of peers. Two types of protocols are commonly used: an initial debriefing protocol and a follow-up debriefing protocol. The rationale for this process is that providing early intervention, involving opportunities for catharsis and to verbalize trauma, structure, group support, and peer support are therapeutic factors leading to stress mitigation (Everly & Mitchell, 1992).

Case reports and anecdotal evidence about debriefing emergency workers suggest that the process may lead to symptom mitigation, however, there has not been rigorous controlled investigation to date. CISD may provide some immediate opportunities for rescue workers to talk with one another, but it is unlikely to be effective as the sole intervention for complex problems that are the result of stress reactions to the operation, pre-existing stress, or various organizational stressors. In such cases, additional individual assessment is recommended.

Initial Debriefing Protocol (IDP)[6]

The protocol for an initial debriefing (IDP) generally consists of eight steps:

1. Preparation	5. Reaction phase
2. Introduction	6. Symptom phase
3. Fact phase	7. Teaching phase
4. Thought phase	8. Re-entry phase

Depending on the emergency service roles of workers, time allotted for the debriefing, and the number of workers in attendance, debriefers will necessarily have to evaluate how much time to spend on each phase and whether or not each worker will have equal time to speak.

1. **Preparation:**

   • Make necessary arrangements with incident commander or rescue team managers and obtain information about the conditions of the rescue operation and if there are particular concerns about individual workers.

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[6] IDP Model developed by Bruce H. Young

- Try to limit each debriefing group to 8-10 workers, but anticipate as many as 20-30 workers. The greater the number of workers attending, the less time each person has to actively participate. Advise that attendance be mandatory, but active participation during the debriefing be voluntary. The rationale given for mandatory attendance is that it reduces the stigma of attending and increases the potential for support among team members. Those who choose to solely listen can benefit from hearing peer experiences and receiving information about stress reactions and stress management strategies.

- The number of debriefings that workers should attend is best guided by the length and conditions of the rescue operations and the degree of worker exposure to traumatic stimuli. If conditions allow only one debriefing to take place, it may be preferable to schedule it as an "exit" debriefing; however, there is no empirical evidence to support this suggestion.

- Arrange to work with a co-debriefer and discuss respective roles.

- Arrange for a private quiet room for 2 to 4 hours.

- Those in attendance should not be on call. Have educational/referral handouts ready.

- Schedule time for post debriefing discussion with co-debriefer.

2. **Introduction:**

Debriefers begin with self-introductions, including brief description of disaster mental health experience, the purpose of debriefing (clarifying that debriefing is not a critique of how they have responded, nor a critique of agency operations and that it is not a "fitness for duty evaluation"). Explain that debriefing is an opportunity to talk about personal impressions of the recent experience, learn about stress reactions, and stress management strategies and that it is not psychotherapy. (See sample script, page 48.)

- **Review confidentiality:** Personal disclosures are to be held in strict confidence by the group. Educational information may be shared outside the group. Inform attendees about mental health professionals' limits to confidentiality and the duty to report .

- **Explain group rules:** Inform attendees that no one is required to talk, but participation is encouraged. Agree on length of time. Inform attendees that everyone must stay

until the end and that there will be no breaks. Advise that notes are not to be taken. Ask if anyone cannot meet these requirements and reconcile accordingly.

- **Facilitate participant introductions:** Depending upon the number of workers in attendance, worker introductions may include name, role, hometown or vicinity, and whether or not there has been previous experience with debriefing.

3. **Fact phase:**

Depending on the number of workers in attendance, the next phase of the debriefing is asking participant/volunteers to describe from their own perspective what happened, where they were, what they did, and what they experienced sensorily (perception of sights, smells, sounds). If there more than 12 workers in attendance, it may be necessary to limit 6-10 volunteers to share their descriptions.

4. **Thought phase:**

In this phase, workers are asked to describe their cognitive reactions or thoughts about their experience. In many instances, there are several events within the entirety of the rescue experience that make a memorable impact. Target most prominent thoughts. If there are more than 12 workers in attendance the debriefer may ask each worker to recall their thoughts about the one event that "is the one thing you constantly think about."

During the course of descriptions, debriefers may interject to ask if other workers had similar thoughts. The intent, of course, is to universalize and normalize common cognitive reactions.

Helpful questions:

"What role did you have in the rescue operation?"

"What happened from your point of view?"

"What do you remember seeing, smelling, hearing?"

"Was there anything anyone said to you that stands out in your memory?"

Helpful questions:

"What were your first thoughts when you heard about the disaster?"

"What were your first thoughts when you learned you would be involved in the rescue operations?"

"What were your first thoughts when you first arrived at the scene?"

"What are your thoughts now that the operation is over?"

"What thoughts will you carry with you?"

Helpful questions:

"What was the most difficult or hardest thing about this (event) for you?"

"How did you feel when that happened?"

"What other strong feelings did you experience?"

"How have you been feeling since your part of the operation finished?"

"How are you feeling now?"

Common stress reactions in disaster workers:

- Emotional:
  Shock, anger, disbelief, terror, guilt, grief, irritability, helplessness, anhedonia, regression to earlier developmental phase.

- Cognitive:
  Impaired concentration, confusion, distortion, self-blame, intrusive thoughts, decreased self-esteem/efficacy.

- Biological:
  Fatigue, insomnia, nightmares, hyperarousal, somatic complaints, startle response.

- Psychosocial:
  Alienation, social withdrawal, increased stress within relationships, substance abuse, vocational impairment.

5. **Reaction phase:**

In this phase, workers are encouraged to discuss the emotions they experienced during the course of the operations.

During the course of descriptions, debriefers may interject to ask if other workers had similar feelings. As in the thought phase, the intent is to universalize and normalize common reactions.

6. **Symptom (stress reaction) phase:**

In this phase, workers stress reactions are reviewed in the context of what they experienced at the scene, what stress reactions have lingered, and what they are experiencing in the present. Help participants recognize the various forms of stress reactions avoiding pathological terminology.

7. **Teaching phase:**

Teaching, in actuality, occurs throughout the process of debriefing. As debriefing becomes a more common intervention, workers are increasingly understanding the effects of stress. Debriefers must assess what workers know and don't know and ensure that they have accurate information about stress reactions and stress management strategies. Topics may include:

A. **Defining traumatic stress**

Quantitative and qualitative dimensions (DSM-IV criterion A; sensory exposure; phenomenology of loss – loved ones, property, perceived control, and meaning)

B. **Common stress reactions**

1. Emotional (shock, anger, disbelief, terror, guilt, grief, irritability, helplessness, regression to earlier developmental phase).
2. Cognitive (impaired concentration, confusion, distortion, self-blame, intrusive thoughts, decreased self-esteem/efficacy).
3. Biological (fatigue, insomnia, nightmares, hyperarousal, somatic complaints, startle response).
4. Psychosocial (alienation, social withdrawal, increased stress within relationships, substance abuse, vocational impairment).

C. **Factors associated with adaptation to trauma**
1. Degree of sensory exposure (severity, frequency, and duration).
2. Perceived and actual safety of family members/significant others.
3. Characteristics of recovery environment (existence, access, and utilization of social support).
4. Perceived level of preparedness.
5. Pre-disaster level of psychosocial functioning (coping efforts).
6. Pre-disaster level of psychosocial stress (vulnerability/resilience).
7. Interrelationship among factors of personal history, developmental history, belief system, and current and past stress reactions including previous exposure to trauma (war, assault, accidents).

D. **Self-care and stress management**
1. Relationship between behavior and stress (exercise, eating habits, exercise, receiving and giving social support, relaxation techniques – excessive and deficient behaviors).
2. Self-awareness of emotional experience and selected self-disclosure.
3. Stress-related disorders (PTSD; disorders which may be exacerbated by stress).
4. Parenting guidelines (how to enhance children's coping).
5. Disaster preparedness.
6. Characteristics of the disaster environment (phases of disaster).
7. When and where to seek professional help.

8. **Re-entry phase:**

The final phase of the debriefing is allotted to discussing unfinished issues, reactions to the debriefing, a summation of the debriefing, and the referral process. When possible, a follow-up debriefing should be schedule to take place within two weeks. The protocol for follow-up debriefings is described on the following page.

Debriefers should remain available after the debriefing to allow anyone in attendance to meet with the debriefers privately.

Large Groups Debriefing Protocol

Occasionally, circumstances require that you provide a "debriefing" to a large number of workers and adjustments to the formal debriefing protocol are necessary. The protocol for large group debriefing involves a modification of the process and content of the eight steps used in formal debriefings. The objective of these debriefings is to provide information about common reactions disaster work, useful stress management strategies, signs that suggest individual help may be beneficial, and where to get additional information or help. Even though not everyone will be able to participate, encourage participation and interaction and relate the material to their experiences.

Follow-up Debriefing Protocol

A follow-up debriefing should be held when circumstances allow, 10-14 days after the initial debriefing. A third debriefing is recommended 3 months later. Mitchell and Dyregrov (1993) recommend the following four questions for discussion:

- "How are things since the debriefing?"
- "Is anyone stuck on any particular part of the incident?"
- "How have things been on your own (or-off duty time)? "
- "What else do you feel you might need to get you past this particularly bad event?"

Additional questions for discussion:

- "What, if any, changes have you noticed in your work habits since the disaster?"
- "How has the disaster affected your personal relationships?"
- "What stress management strategies have you used?"
- "Which stress management techniques work for you?"
- "Which ones don't?"
- "Has this experience resulted in any positive changes in your professional or personal life?"