**Training for Crisis Preparedness**

**&**

**Management**

**for**

**Mental Health**

**First Edition**

**Training for Crisis Preparedness & Management for Mental Health**

**Table of Contents**

CHAPTER I - Introduction to Crisis Preparedness & Management………………………..4

1. Overview of CrisisTrauma…..…………………………………………………...5-6
2. Development of a Crisis…………………………………………….………………6
3. Individuals in Crisis…..…………………..……………………….………….......6-7
4. Helping Individuals in Crisis……………………………………………………..7-8

CHAPTER II –Response to Trauma: Internal Factors…………………….………….…....9

1. Equilibrium and Stressors…………………...…………….…….………….............9
2. Development of Crisis Reaction...……………………………..……………......9-11

CHAPTER III –Response to Trauma: External Factors………………………..………...12

1. Sensory Inputs from Event……………………..……………………………...12-13
2. Chronology of the Event and the Individual’s Participation

in the Chronology...................................................................................12-13

1. Possible Disaster Impacts………………………………………………….......13-15

CHAPTER IV - Long-Term Stress Reactions………………………………………….....16

1. Introduction………………………………………………………………………..16
2. Types of Long-Term Stress Reactions…………………………………………….16

CHAPTER V –Grief and Loss….……………………………………………..…....…….17

1. Confronting Grief………………………..……………………………….……17-18
2. Hints for Helping……………………………………..………………………..18-19

CHAPTER VI - Crisis Across the Ages………………………………………..…………20

1. The Continuum…………..…………………………………………………….….20
2. Trauma in Children…………………..…………………………………….......21-23
3. Trauma in the Elderly…………………………………………………….…....23-24
4. Trauma in the Disabled…………………………………………………….…..24-25

CHAPTER VII - Cultural Perspective with the Impact on Trauma……………..…..……26

1. Understanding Cultural Diversity…………………………..…………………..…26
2. Trauma and Culture…………………………………………………….............…26
3. Planning for Working with Cross-Cultural Population….………………….….....26

CHAPTER VIII – Trauma and Spiritualism………….……………………………..…....27

1. TheImportance of Spiritualism……………………….………………………….27
2. Issues of Spirituality that are ImpactTrauma Survivors……….......................27-28
3. Dialoguing with Survivors Regarding Spiritual Issues……………………….......28

CHAPTER IX - Elements of Crisis Intervention…………………….………….…….29-31

1. Safety and Security………………………………………………………........31-34
2. Ventilation and Validation………………………..……………………...…....34-39
3. Prediction and Preparation………………………………………………….…39-41

CHAPTER X - Art of Active Listening…………..………………………………….……42

1. Active Listening Skills………………………………………………………...43-46
2. Communication…………………………………………………......................46-47

CHAPTER XI - Group Crisis Intervention Techniques………………….………….……48

1. Introduction………………………………………………………….………....….48
2. Goals………………………………………………………………….……..…….48
3. Scope and Nature of Group Crisis Intervention Services…….………….….....48-49
4. Description of NOVA Protocols………………………….………………........49-56
5. Group defusing protocol………………………………………………….........56-57
6. Post-Trauma Counseling……………..………………………………….………...58
7. Foundations of Post-Trauma Counseling……………………………..….…….58-59
8. Elements of Post-Trauma Counseling…………………………………..…..…59-65
9. Therapeutic Interventions……………………………………………………...65-66
10. Counseling Suggestions…………………………………..……………………66-67
11. Hints for Helping…………………………………………………………....…67-68
12. Helpful Hints for Caregivers………………………..……………………..…..68-71

CHAPTER XII - 1:1or Small Group Sessions……………..………….………….…….....72

1. Review of Basic Crisis Intervention……………………………………….…….....72
2. Intervention Models…………………………………………………………….72-74
3. Stages in the Counseling Relationship………………………………………….74-76

CHAPTER XIII - Coordinating a Crisis Response Team……………..…...……………...77

1. NOVACommunity Crisis Response Team..............................................................77
2. Goals of a NOVA……………...…………………………………………….…77-80
3. Code of Professional Ethics For Victim Assistance Providers…..……….........82-85

CHAPTER XIV - Managing the Media in Crisis Situations…..……………….……........86

1. The Media in Crisis…………………………………………………..….……..…86
2. How a Disaster Unfolds…………………………………………………….…86-88
3. Managing the Media…………………………………..………………………88-90

CHAPTER XV - Crisis Caregivers and Stress Reactions……..………………………….91

1. Handling Stress Reactions of Crisis Responders………….....................................91
2. Burn-out Factors and Vicarious Victimization……………………………......91-92
3. Compassion Fatigue……………………………………..………………...……...92
4. Crisis Responder Preparation………………………………………………….92-93

CHAPTER XVI – The Crisis Aftermath……………………………………….…………94

A. Recovery Takes Time………………………………………………………….94-95

B. When the Challenges Are Ongoing…………………………………………...…..95

BIBLIOGRAPHY………………………………………………………………….…….96

* **Chapter One:**

1. **Introduction:**

The worst time to prepare for a crisis is when one occurs and in today’s uncertain world, we need to be prepared for any eventuality. Research has emerged over the past ten years supporting a proactive approach to a crisis, as opposed toone that is reactive in nature. Such an approach is significantly better in dealing effectively with a large-scale crisis situation. A reactive approach is spontaneous, and not fully thought out, planned, or practiced, and can result in the response that is less effective in meeting the immediate, and possibly the long-term needs of those effected by a traumatic event. A proactive approach to a crisis is one that is organized, planned and practiced and more likely results in a response that can have a dramatic effect on reducing the short and long-term consequences of the crisis on the individuals who have experienced trauma.

The purpose of **community response teams** is to respond to collective trauma caused by natural; and/or manmade disasters by assisting community members through crisis intervention for groups and individuals, and providing training to community caregivers in ongoing crisis intervention for groups and individuals, and post-trauma counseling skills. By helping communities reduce acute stress factors caused by the disaster and enhancing adaptive capacities of community members, communities can become stronger and better prepared with future threats of harm and injury.

Founded in 2017, Training for Crisis Preparedness and Management for Mental Health (CPM-MH) is the first victim assistance program of its type in Bangladesh. The mission is to coordinate and facilitate education training, consultation, and support services in comprehensive crisis preparedness, intervention, and disaster management through dignity and compassion for those harmed by critical incidents.

Crisis Preparedness and Management for Mental Health (CPM-MH) training provides crisis preparedness, intervention, and recovery procedures for those affected by both natural and manmade disasters. The training affords the opportunity for crisis responders from all backgrounds to be adequately trained to address a range of crisis events. It is imperative to understand the systems and procedures that need to be in place to respond to a crisis, and to address the unique mental health needs generated by crisis exposure. In addition, understanding crisis reactions in order to prevent psychological trauma is key to mental health risk reduction. **It is important to note the scope of training does not lend itself to diagnosis of mental health conditions but rather to identify risk factors and provide referrals as needed.**

There are various approaches to supporting individuals in crisis. For this training, we go beyond psychological first aid, which only uses non-counseling methods. More technical models have been combined, such as NOVA, PrePare, Roberts 7 Stage Crisis Intervention, and Traumatology, which permit utilization of cross-cultural techniques. These approaches involve strategies for listening, assessing and acting in crisis intervention, or activities related to responding to trauma. The information in this manual describes interventions that require specific skills and development training. Information alone is not sufficient for crisis responders to be able to apply these techniques, and individuals should not conduct crisis intervention without proper training and supervision.

**A. Overview:**

A variety of crises may occur that can impact people in different ways. Although people view traumatic events through their own filter, there is a commonality of emotions on the continuum that can be addressed through crisis response. Those affected by natural or manmade traumatic events, such as cyclones, floods, fire, terrorism, etc. experience a range of emotions. Despite the traumatic event, crisis intervention provides immediate assistance that an individual in crisis requires in order to reestablish equilibrium. There is a need to stabilize trauma survivors as they may experience the following emotions: anxiety, pain, fear, shame, grief, horror, anger, shock, flashbacks, hopelessness, isolation, and disconnect. Through CPM-MH trained crisis responders can assist trauma survivors cope and return to a previous level of physical or emotional functioning. Through short-term professional support, the immediate crisis or problem is addressed. Prompt and focused interventions aid in preventing serious long-term trauma, such as Post Traumatic Stress Disorder.

As **crisis is a state of emotional turmoil or an acute emotional reaction to a powerful stimulus**, such as confronting death, serious injury, or some other physical threat, it is necessary to address those individuals who have been victimized. Further, it is those individuals who may also become victimized through initial or secondary trauma by witnessing traumatic events when they occur to others who may benefit from crisis intervention.

* Crisis is an internal experience with the manifestation of feelings such as confusion and anxiety. When previous coping strategies fail due to ineffective decisions and behaviors taking their place, an individual may feel helpless, hopeless, angry afraid, confused, and vulnerable. The traumatic event may further impact their lives through faulty perceptions and distorted memories. When humans are confronted with unexpected, sudden, or devastating violence resulting in the loss of family, friends, or life as they know it, they begin to question the importance of their existence.

Throughout our lifetime, we are presented with various stressful events. As unique individuals, we have unique ways of coping with these events in order to preserve a stable emotional balance. It is when our typical coping mechanisms breakdown, we search for replacement coping skills. We are confronted with a crisis state when these new coping efforts fail to restore our pre-crisis level of emotional balance.

A person cannot stay in crisis, as the body cannot withstand continual physical and emotional strain. The circumstances will need to change and the person will return to a pre-crisis state; the person will develop new coping skills; or the person will avoid crisis by engaging in destructive behavior. Some precipitating events can never be undone (such as death of a spouse) and so the option of returning to a pre-crisis emotional state is not an option.

* Crisis maybe viewed as opportune time to expand coping skills (both internal and external) and to acquire new skills, resulting inthe evolution of better developed competency and autonomy. A crisis is perilous when the person experiencesan overwhelming inability to cope with pain and anxiety manifested in a negative manner.
* Crisis intervention provides help for individuals or groups during a period of extreme distress. The intervention is temporary, active and supportive. With the implementation of crisis techniques, the person reclaims external control over his or her life and begins to live their new normal. The goal of intervention is to assist with successful crisis resolutions, which assists with good mental health.

**B. Development of a Crisis**

1. A precipitating event such as a perceived loss or traumatic experience produces intense anxiety and dependence on problem-solving skills.
2. Usual coping skills fail; the problem is still present and anxiety increases. The individual must look outside himself for help.
3. External resources may be tapped (religion, other people, alcohol, etc.) and fail to return the person to a comfortable emotional level. Anxiety continues to increase and the person may feel helpless. Perceptions are altered and the individual may think of nothing else but his situation.
4. All known internal and external resources fail; this tension and anxiety become unbearable. At this point something must change.

**Developmental Crisis** is a crisis resulting from a normal life change (i.e. puberty, leaving home, marriage, birth of children, retirement). These are changes that are normal parts of life and can only be successfully transitioned through as one learns to cope with her situation.

**Situational Crisis** is the result of the unexpected trauma such as losses, illness or displacement. Because of the unexpected shock, one typically experiences these events as more stressful.

At times these developmental or situational crises can occur simultaneously, and when that happens the crisis is usually more disruptive.

**C. The Individual in Crisis**

There is not a clear-cut description of a person in crisis. Below are some feelings commonly experienced by someone in crisis:

1. Anxiety – Any substantial threat produces anxiety that can be helpful in mobilizing us to defend ourselves against the threat through change, action, etc. However, too great an amount of anxiety can lead to confusion, poor judgment, immobilization, and self-defeating behavior.
2. Helplessness – Being faced with an external or internal situation that we are not prepared to face can leave one feeling vulnerable. Intense emotions may contribute to the experience of helplessness.
3. Anger – Anger may be directed at another person, an event, or at the self.
4. Shame/guilt – The person in crisis often feels incompetent and out of control. S/he may experience feelings that are not acceptable or usual to her/him. The pain may be further complicated by being ashamed of one’s plight.
5. Confusion – Crisis may interfere with one’s ability to think straight, problem-solve, or event accurately perceive one's experience. This distortion in itself may be frightening and the persons in crisis may fear s/he is “losing his mind”.
6. Fear – The fear may be of actual components and possible outcomes of the crisis situation, as well as of the powerful effects listed above.

**D. Helping the Individual in Crisis**

We may begin to sense that a person is in crisis by the intense feelings of fear, anger, sadness, pain, etc., which s/he expresses. In addition to the feelings of the person in response to the painful event, there may be another group of feelings as a result of his reaction to being in crisis. Through empathic, reflective listening we accept the person and his/her feelings and also identify and clarify the feelings. In a sense we say, “But you do feel that way and that’s ok”. Help the person sort out what is going on, what the crisis is about.

In a crisis situation a here-and-now focus is helpful. It is highly unlikely that we can resolve a large or complex problem in one session, but we can help the person to reduce their level of anxiety to a more manageable level and to develop short-term plans aimed at beginning to work him/herself out of the crisis. The plan should be simple, concrete and behavioral (something he can do and see the results of quickly).

If a person’s physiological needs are adequately met, they can direct more effort on their emotional and other needs. They can comprehend, understand, and marshal their emotional ability, which will increase their coping skills. See Maslow’s chart.

**Maslow’s “Basic Hierarch of Human Needs”**

Self

actualization

Intellectual and spiritual growth

Love and

belongingness

Cognitive functioning

(activities of daily living)

Safety and

security

Basic human/survival

needs

**Chapter Two:**

**Response to Trauma: Internal Factors**

***(adapted from NOVA)***

1. **Equilibrium and Stressors**
2. **Variable equilibrium**

Adults develop variable equilibrium specific to physical, emotional, mental and social realms in which to balance their lives. A well-adapted person is one where everyday stressors are balanced with success coping abilities. This balance is not a fixed state but is prone to ups and downs. It is the person’s resiliency that allows them to maintain themselves and to change and develop.

**The impact of a crisis event on equilibrium**

When a person is confronted with a traumatic event, they are ejected from their homeostatic or ordinary state of equilibrium in such a manner of force that they do not have the ability return to their previous stress level. The person is then required to redevelop a new equilibrium, merging the lessons learned from the traumatic event and their newly acquired adaptive skills.

1. **Development of Crisis Reaction**
2. **Physical response to crisis**
3. Disorientation, shock, numbness, and somatic issues.
4. Shock results in the physiological mobilize of the body as it engages in the fight or flee from the crisis.
   1. Adrenaline pumps through the body.
   2. The body may relieve itself of excess materials through regurgitation or defecation.
   3. Heart rate increases.
   4. Hyperventilate or sweat.
   5. Increased attention to sensory perceptions. In the initial reaction, attention will often be focused on one sense. Sometimes to the exclusion of others. Visual sensations are normally most acute in human beings, but important to recognize that all senses are involved. While sights or sounds may leave indelible memories, so many things touched, smelled or tasted.
5. Heightened physical arousal associated with fight or flight cannot be prolonged indefinitely. Eventually it will result in exhaustion. The impact of exhaustion affects an individual’s psychological response. Some of the distress at this process is caused by the sadness of what has happened and the fact that it can never be changed.
6. When disaster occurs for many, there is a desire to keep the present alive as long as possible in order to be able sustain the belief either that things can be returned to normal, or the emotional sense that so long as the present is still continuing, their life as it was will continue. Sleep brings the knowledge that time does go on and today’s disaster – symbolized by an asterisk in the illustration below – will become a part of history.
7. **Psychological response to crisis**
8. The mind’s response parallels the physical response. Typically an initial cognitive reaction of shock, disbelief, and denial. The mind simply cannot recognize the traumatic event as a reality in its initial encounter as it seeks to find a benign interpretation of the threat.
9. Regression

When cognitive functions seem to cease momentarily, it is not uncommon for individuals to experience a regression to a childlike state. In that state, emotions become dominant.

1. Deluge of emotions

After the physical danger has ebbed, the individual may fell overwhelmed with myriad, disorganized emotions but in fact there seems to be a logical order in which emotional reactions are manifested.

1. Fear and terror

Fear seems to be a primal reaction. Fear may be inspired by the loss of autonomy – the ability to control impulses and to address situations through planning, a uniquely human characteristic.

Fear becomes terror when victims internalize the knowledge that they, their loved ones, or their communities will not survive the threatening situation.

1. Angry, fury, and outrage

Anger’s force devices from the need to respond aggressively to a threat through the “fight” reaction. Everyday anger at frustratingevents does to begin to describe some victims’ reactions to a traumatic event. Often, traumatic anger is directed at an offender or a person held responsible for a tragic event, although it may be displaced onto God, family members, or social institutions, or turned inward towards oneself. Traumatic anger also may result in overgeneralization in the definition of its target.

Anger may be associated with the desire for vengeance. Anger may also be associated with hatred. The intensity of anger and its antisocial aspects is often new to victims and survivors of catastrophe

1. Confusion and frustration

Confusion stems from the victims initially narrow perspective on what happened and how. Victims often remember only scattered impressions of a traumatic event. Many of these impressions may be sensory perceptions or sporadic feelings about what happened, but they do not form a coherent whole. The confusion becomes frustration when victims think they should remember or could remember if they only tried. As they attempt to piece together a picture of the event, the confusion may be compounded as they try to understand why it happened – or why it happened to them.

1. Guilt or self-blame

Guilt or self-blame are cognitive emotions that arise from the effort to sort out confusion. They often are characterized by two aspects. The first can be called “cognitive” guilt, which may be legitimate or illegitimate. Legitimate cognitive guilt focuses on the ‘could have’, ‘would have’, or ‘should have’ of the victims’ or survivors’ actions before, during, or immediately after the event. They involve actions that might have been taken but were not because there is no way to predict the future. Self-blame based on an erroneous reconstruction of facts is “illegitimate,” as it is when there are no facts on which to attribute any guilt to the victim.

Another type of guilt is known as “survivor guilt” or “existential guilt.” Victims are often plagued with internal questions about why they survived while others died, or why their love ones didn’t survive when others did.

1. Shame or humiliation

Shame seems to be associated with guilt or self-blame but it reflects the internalization that victims are responsible for the event as well as that they are somehow intrinsically more vulnerable to such tragedies.

1. Grief or sorrow

Grief may be the most intense long-term emotional reaction to traumatic loss. It is not ordinary grief. The traumatic emotions that are also precipitated by the extraordinary event complicate the grieving process.

1. Reconstruction of equilibrium

With good support systems and effective interventions, the emotional fluctuation can eventually turn into a new equilibrium for functioning. It will be different from the original equilibrium.

**Chapter Three:**

**Response to Trauma: External Factors**

***(adapted from NOVA)***

1. **Sensory Inputs from Event**

The nature of sensory information and its strength when people encounter a traumatic event may relate both to the developmental stage of the individuals as well as previous life experience. For most adults, the visual or auditory senses are the strongest initial perceptions, but visual perceptions are often critical to the eventual formation of a narrative.

The immediate impact of sensory information is affected by the proximity of an individual to the trauma. It is also affect by prior experience. Since the senses are the primary source of information, they become the foundation for memory of what happened.

1. **Chronology of the Event and the Individual’s Participation in the Chronology**

Understanding the perception of time its relation to trauma reactions is crucial since the sense of time helps the brain organize and transcribe feeling and thoughts.

The use of chronology to form a cognitive narrative for a story of events is helpful to victims. It is also helpful if they can comprehend the circumstances of the event and their involvement in it as they seek order and meaning in the world. It is useful for crisis responders to try to sort out the stages of the event and roles that victims played in the event as they listen to victims’ stories. Some of the issues associated with the chronological recounting of the story will involve the following stages of disaster as interpreted by individuals and the community:

1. **Pre-disaster equilibrium**

The community equilibrium before a disaster is defined by cultural transitions or tensions, previous disaster history, or political, economic, or historical tensions. That equilibrium and the effect of stressors on it is similar to that of an individual.

1. **Warning and threat**

These stages for all intents and purposes often are merged in our understanding. The warning period is characterized by anxiety, wariness, and wonder. There may be excitement tempered by high vigilance. Post-disaster reactions to what happened during this period may involve concerns of evacuation and shelter.

Many individuals who live in disaster subcultures cope in the aftermath of the impact of a “predictable” disaster by relying upon their cognitive understanding that they had a choice in whether to live in the area or not. Recognition of pre-disaster choices made on an assessment of the risks can ameliorate stress and help to define future action.

1. **Impact**
2. *Timing*

Many victims and survivors think in retrospect that they had no warning of the danger. While this may be true, often such people simply do not comprehend the danger because the shock is so over-whelming and the timing of the threat adds to its unreality.

*2.Time warp*

The effect of trauma on one’s sense of time is dramatic. Sense of time extends itself through a knowledge of past, present, and future in a linear extension that no only includes comprehension of history but a projection of a future. When a traumatic event occurs, the “clock time” seems to cease and traumatized individuals go through time warp. At impact, victims often feel time stops.

There are practical aspects to this and there are moral aspects:

* Practical aspects: not going to work on time, social routines being disrupted, losing sense of hours, days, and weeks.
* Moral aspects: the suspension of rules, laws, and order may contribute to the rise in violence during or after the disaster. Looters may see nothing wrong in trespassing and stealing if everything is destroyed already.

*3. Duration of the event*

Even as the perception of time is distorted, the actual time elapsed during the impact of the vent on the sensory perceptions, emotional and cognitive brain structures, and community will affect the severity of the trauma reaction. The longer any of the following periods last, the greater the intensity of the experience of crisis.

* Duration of immediate life-threatening event
* Duration of ongoing survival concerns.
* Duration of sensorial involvement.
* Duration of morbid preoccupation by a community.

1. **Possible Disaster Impacts**
2. **Issues related to different causes of disaster**
3. *Natural disaster*
4. Often cause heavy casualties and severe damage to property.
5. Catastrophes may raise issues of faith or sin.
6. Many natural disasters have a clearer period of warning prior to impact.
7. Since personal blame is not primary issues, there may be a greater outpouring of altruism and compassion in efforts to help survivors.
8. *Industrial or technological disasters*
9. Other issues may have affected the installation or operation of a plant or industrial site and may be seen as the cause of the tragedy.
10. There is a lack of personal accountability for the event and institutional depersonalization of the victims.
11. Many such catastrophes have long-term impact.
12. *Human disasters*
13. Issues of justice/fairness are critical when human beings cause disasters.
14. Most tragedies caused by humans are seen as preventable, yet in a social context, little has been done to concentrate on prevention strategies rather than intervention strategies after tragedy occurs.
15. If the disaster is caused by purposeful human cruelty, there may be issues related to evil or the impossibility of understanding the criminal mind.
16. If the disaster is related to social conflict such as riots or wars, there may be demonization of different cultural groups in a society.
17. When humans cause accidents, there are often issues related to the preventability of the disaster. Accidents often cause more intense anger in survivors than do crime-related crises.
18. Human caused disasters may significantly affect the abilities of individuals to trust each other and thus exacerbate the deterioration of social bonds.
19. **Issues illustrating different elements of disaster**
20. *Earth*
21. The earth is assumed to be firm and safe.
22. Earth disasters often involve events that trap their victims.
23. Most earth disasters are sudden and often happen without.
24. *Air*
25. The air is perceived as erratic and less under the control of human beings.
26. Due to the unpredictability of the wind, the air and space, the randomness of community or individual impact often heightens terror during impact.
27. *Fire*
28. Fire is both terrifying and exciting to most people.
29. On a practical level, fire often consumes its victims and surviving family and friends may have difficultly dealing with these consequences.
30. *Water*
31. Disasters caused by water are varied. The consequences are also varied. A flood may destroy miles of property, homes and lives. The catastrophe changes the landscape or seascape of life.
32. Natural floods may be equated with natural forces such as those that are found in wind disasters. Floods caused by manmade structures may be more difficult to deal with by survivors.
33. *People*
34. People victimized by other people are often the most angry.
35. The particular dynamic that disasters based on human elements may include is the tension caused by cruelty and brutality executed by an offender.

**Chapter Four:**

**Long-Term Stress Reactions**

1. **Introduction**

Those who survive traumatic events often are plagued with reactionary stress for several years. The degree a catastrophic event impacts the individual depends on their perception.

1. **Types of Long-Term Stress Reactions**
2. **Post-traumatic stress**

Primarily occurs when a victim or survivor has experienced a significant loss or injury.

1. *Negative*impact to behavior may be comprised of:
2. Rigidity.
3. Flawed stress management.
4. Incapable of maintain or begin relationships.
5. Isolation or avoidanceof social interaction.
6. *Positive*impact to behavior may include:
7. Clarity or changing of life goals
8. Malleable coping strategies.
9. Ability to accept differences in others
10. Increase in communication of emotional responses.
11. **Conclusion**

Those who experience traumatic events often are impacted by long-term stress reactions. The greater the coping skills and the ability to adapt are reflected in emotional outcomes. However, the traumatic eventmaybe so troublesome the individual's ability to surmount the adversity is compromised.

**Chapter Five:**

**Grief and Loss**

1. **Confronting Grief**

An intrinsic part of life is death. Those who survive a traumatic event or lose a loved one to death are confronted with grief and sorrow with many varying responses. Grief reactions are likely to be intense and prevalent based on the closeness or the degree of the loss. Although painful to experience at first, grief reactions are healthy responses that reflect the significance of the death. Over time, grief reactions tend to evolve to pleasant thoughts, with memories providing comfort.

1. **Comprehending sadness after loss**
2. After death and loss, sorrow is expected with the ability to overcome after a period of time.
3. Sorrow lends itself to disengaging oneself from the lost individual or tangible item, understand and adapt to the world without the lost person or object, and an attempt tocreate new relationships with others with a focus on not attempting to replace.
4. Comprehension that the loss leads to immediate emotional and physical responses such as yearning and searching for what has been lost.
5. "The Six R Processes of Mourning" (from Rando, T., *Treatment of complicated mourning*, Champaign, IL, Research Press, 1993)

• **Recognize**the loss.

• **React**to the missing.

• **Recollect**the missing, the relationship, and the meaning of the relationship.

• **Relinquish**attachments to the world before the loss including assumptions that no longer hold.

• **Readjust**to a new world without forgetting the old.

• **Reinvest**in the world around you.

1. **Anticipatory grief**
2. Natural grief

Natural grief is described as resulting over the expected death such as an elderly loved one. Such grief is often experienced with less shock. However, factors that can make the anticipated death traumatic are due to the intensity of the relationship, lack of social support system.

The following reactions patterns may occur:

1. Intermittent sorrow episodes as family and friends acknowledge that their loved one’s death is imminent
2. Preparing and planning for the loss changes the dynamics of the relationship
3. When death does occur, the emotional impact is of a lesser duration.
4. Atypical anticipatory grief

Occurs when the grieving process follows the death of those who die young following a terminal illness.

a. Denial: leads to the long-goodbye

b. Protest/anger: prior to death there is bartering with God.

c. Despair:feelings of helpless and hopelessness.

d. Disengagement: distance themselves for self protection.

e. Preparing and planning for final loss.

f. Reconstruction: Communication during the anticipatory period is important for reconstructing lives of survivors.

1. **Traumatic grief**

Survivors whoare impacted by a sudden, random death must confront their traumatic reaction to the manner of deathor loss before the process of grieving can be initiated.

Denial and shock are concurrent with other emotions.

1. Despair then anger with depression, hopelessness, and agony. Survivors are unable to think or act knowing that there can be no recovery.
2. The sense of despair that accompanies the suddenloss requires a level of detachment as participating in the rigors of day t day living is too painful. everyday living is too painful.
3. Once the integration of the traumatic event occurs, reconstruction of a new reality/life can go forward knowing that life as they new it will never be the same. Survivors can move forward despite the pain.
4. **Duration of grief**
5. The length of the grieving process is unable to be.
6. Loss is forever. After the grief process, there will still be ‘moments’ of grief –as loss is forever.
7. **Hints for Helping**
8. **Suggestions for Survivors**
9. Put off important decisions.
10. Prepare for the "firsts.”
11. Prepare for the ups and downs of grieving.
12. Set realistic expectations.
13. Express reactions through a comfortable outlet.
14. Avoid perseverating on personal guilt.
15. Educate yourself on issues related to this specific type of death.
16. Maintain or develop routines.
17. Continue engagement with the living: pets, plants, children, and friends.
18. Give yourself permission to be sad.
19. **Hints for Helping**
20. Ask the survivors how they are doing and listen to their answers.
21. Permitsurvivors to discusswhat they and when they want and do not coerce them to talk.
22. Inquire as to their memories of their lost loved one.
23. Accept the validity of all feelings and reactions.
24. Despite the content of information, hear scenarios in a non-judgmental manner.
25. Do not exhibit time constraints and let them know that you will be there for as long as is necessary.
26. Accept and do not be afraid of silences.
27. Adhere to confidentiality.
28. After asking survivors how you can help them offer them practical options.Let them provide the level of help they want.
29. Do not attempt to make the survivor feel good, take the role of being supportive.
30. Discuss how to make special tributes for both the survivors and their loved ones at challenging times such as holidays or memorial dates.
31. Do not be afraid to use the names of the deceased in conversations about them.
32. Suggest the celebration the life of loved one who has died and shift from the death.

**Chapter Six**

**Crisis and Continuum of Age**

1. **The Continuum**

The survivors' ability to cope with crisis is largely determined by age. The development age provides a framework for trauma reactions.

1. **Human needs determined by age**

The impact of trauma on the differing age groups is a consequence of biological, environmental, and psychological evolution that individualstransition through at varied developmental stages.

The needs of a healthy, functioning adult are put forth in Maslow's Hierarchy of Human Needs (see Chart).

**Maslow’s “Basic Hierarchy**

**of Human Needs”**

**Child Development Adult Adaptation**

60-70

Self

actualization

14- Adult (Structure/Stability)

Intellectual

and spiritual growth

70-75

10-14 (Self-Esteem)

Love and

belongingness

75-85

6-10 (Relationships)

Cognitive functioning

(activities of daily living)

2-6 (Care/Trust)

85-90

Safety and

security

(Contact/Care)

0-2

90-100+

Basic human/survival

needs

1. **Developmental issues impacting the continuum of age**
2. In children and adolescents, physical and mental changes can be described as significant in growth.
3. In adults, physical and mental changes connect to their capacity to build on the foundation of growth during childhood.
4. In the elderly, physical and mental changes often are described by a decline in abilities.
5. **Trauma in Children**
6. **Stages of development thatimpacttrauma and grief**
7. Young children:
   1. May have only physical memories of an event.
   2. May not have words to put to the memory.
   3. May not be able to integrate sensory perceptions into a story of understanding of what occurred.
   4. Memory of trauma fraught with reinterpretations that combine misrepresentations of the event, combine fantasies, and parents or peers impressions.
8. **Reactions mimic growth stages.**
9. It is necessary for children to process traumas through each developmental stage.
10. Children process traumatic reactions and grief slower than adults due to developmental processes.
11. Children do not fully comprehend the impact of trauma or the permanence of death.
12. Children are unable to maintain awareness of anxiety or sadness for an extended amount of time.
13. Children do not usually deny the reality of what happened, but since they do not have an alternative reality, it may be emotionally more harmful and the cognitive impact may take years to sort out.
14. **Child and adult grief reactions are escalated by violent traumatic loss**
15. Intensity of emotion rises
16. Duration of grief may be prolonged for an extended amount of time

**D. Patterns of trauma and grief are comparative between children and adults but are dissimilar in manifestation**

1. Grieving extends throughout the developmental stages

As children develop, they should revisit and reprocess the impact of the trauma and loss at their developmental level.

2. Traumatic events may be comorbidwith crises and challenges in a child's life

Children are continually confronted with change and new situations andare required todistance themselves from grieving to confront new challenges in life.

1. Children's communication techniquesvary compared to the communication techniques of adults

Children participate in activities to handletrauma and grief.

4. Some adults have spiritual beliefs that assist them to deal with trauma and grief

Children may not have fully developed spiritual beliefs. Death is concretely identified in a child's life with death and loss areinterpreted literally.

1. **Expectation of reactions in children**
2. Children need to know that:
   1. Crying is a normal way to express sadness.
   2. Feeling lethargic or uninterested in things around them is a sign of their grief.
   3. Children may misbehave or isolate from ordinary activities.
   4. Not wish to engage but let them know that it is okay to laugh and play asit does not minimize the love of their lost loved one.
   5. Guilt or self-blame as children often perceive that their thoughts or feelings can *cause*things to happen.
3. **Typical coping skills among children**
4. Children naturally permit themselves to handle crisis and trauma in incremental stages.
5. They alternate their focus on grief and distress with everyday activities. They do not perseverate on events or the aftermath.
6. They reach out and relying upon support from others.
7. Utilize fantasy to cope and escape from reality.
8. **Interventions for children who have traumatized**
9. Focus on age-appropriate communication.
10. Encouraged children to express themselves in play, artwork, etc.
11. Assist children develop a story of the traumatic death or event. Key components include placing the death in the context of time, understanding what they observed, clarifying misperceptions, and aiding children as they search to garner the meaning or purpose of the event.
12. Permit children to take the lead in defining discussion or expression.
13. Answers to children’s questions should be answered factually and simply.
14. Assist children develop protective plans in the event of another traumatic incident were to occur.
15. Provide children with physical symbols of comfort or remembrance, such as teddy bears or stuffed animals.
16. Establish and reestablish routines to provide children reassurance of order in their life.
17. Rituals such as prayers, a regular time to remember their loved one may also provide children with a source of security.
18. Confirm that children understand differences between life and death.
19. Reassure children that emotions such as sadness and grief are neededtodeal with the death of a loved one.
20. Assistchildren to describe and comprehend reactions to trauma and death.
21. Discuss with children about what they saw of their parent’s, peers, or other significant adults reactions.
22. Do not minimize a child’s lossafter a trauma (i.e., death of a pet, loss of a toy).
23. Assist children in predict what will happen and assist them in the preparation or the future.
24. **Trauma in the Elderly**

Older people who have hadexperienced previous victimization are considered at greater risk for current trauma due to the aging process, whichis a result of being less resilient physically, financially, emotionally, and psychologically. Death or trauma experienced by an elderly person may produce thoughts of that this is a consequence of periods of loss.

1. **Stages of Aging and the Affect Trauma and Grief**

For elderly people, the aging process and the decline in their capabilities may impact their trauma and grief resolution.

1. **Natural coping skills of the elderly**
2. The elderly often shift in and out of a crisis as it is occurring. They may be reluctant to discuss the crisis event, yetexperience feeling of being overwhelmed. This reactionary process is advantageous as it permits elderly people to slowly process the event.
3. For some elderly, a traumatic event or disaster is the precursor to a identifying that their end of life is fast approaching. Their thoughts of imminent death can be frightening.
4. The elderly may engage in mental excursions, which are a reminder of past coping skills andan opportunity to revisit personal histories. Mental excursions are considered a goodtool in surmounting the emotional discord of trauma for older individuals.
5. **Interventions to assist traumatized elders**
6. Be aware that for many elderly, it maybe hard to listen to loud voices or to hear soft voices.
7. Elderly people with vision problems may need modification of written materials such as large letters.
8. Elderly people should be encouraged to articulate their reactions indifferenttypes of expression to aid in their construction of a narrative about the traumatic event they experienced.
9. For the elderly, key components of a narrative may assist in placing the trauma in the context of their past.
10. Behaviors should not be judged specific to the traumatic event and the grief reaction.
11. Assist older people to anticipate ant develop protective plans another traumatic event.
12. Provide older people with physical symbols of nurturing, love or remembrance.
13. Rituals, prayers and ceremonies are important with older people.
14. Permit older people the opportunity to regale their stories, which may not be related to the current trauma. Reliving the past is a way of integrating the present with their life story.
15. Many older people have previously experienced grief and survived the death of loved ones and it is beneficial to encourage them to utilizetheir memories to search for coping strategies to use for the current traumatic event.
16. Let older people share with you what is important to them.
17. Do not minimize an elderly person’s loss after a trauma. The death or loss may represent to them the loss of their connection to life.
18. Assist the older person to establish or reestablish routines that they find comforting.
19. Provide the older person with new ideas or activities. Although they may resist, new opportunitiesstimulate and energize cognitive and emotional abilities.
20. Encourage the interaction with other people.
21. Review the lessons learned by the older person regarding death and loss.
22. Encourage the older person to acquire reasons for living.
23. **Trauma in the Disabled**

Individuals with special needs require the same support as other individuals who have or are typically developing and will benefit from all of the strategies in the CPM**-**MHmanual. They may also require more specialized approaches that relate to their disabilities and specific experiences.

1. Individuals with cognitive disabilities: what to expect and how to help

For individuals with cognitive disabilities, maintain their regular schedules may be particularly important as a coping method. They may also benefit from strategies that address their information-processing differences.

1. *Use language the individual understands*. Speak at the individual’s level, giving short explanations. Individuals with cognitive disabilities often ask questions that adults or crisis responders do not have answers to, such as “Why did this happen” and “Will we have a war?” The response to “Will there be war?” might be “Our prime minster and leaders are thinking and planning, and we might have to go to war.” Give the individual change to respond. It is okay to admit there are things you do not know.
2. Abstract terms may lead to misconceptions. Avoid statements like “This was tragic and many lost their lives. One of Shukla’s loved ones passed on in the collapse.” Instead, say, “There was a big explosion and many people die. Shukla’s uncle was killed.
3. *Check the individuals understanding*. Ask often about what individuals are thinking and feeling. Encourage them to draw pictures if they are able. Draw, paint, or color with them. Provide choices of emotions they may be experiencing. Use pictures that represent “sad” or “upset” if they are not good at expressing themselves with words. Ask open-ended questions like “What have you seen and heard about the collapse of the garment building?” Prompt them with questions such as “What happened next?” Avoid yes/no questions that do not encourage individuals to talk more.
4. *Expect misunderstanding*. Individuals with language and cognitive disabilities may be particularly vulnerable to misconceptions. Multiple televisions rebroadcast may be confusing and individuals may become afraid that the attack continues or has started anew.
5. *Correct misunderstandings*. A news report about requests for blood donations confused one individual who could not understand why someone would take people’s blood from them. Ask children about what they hear and tune in closely to their reactions, including facial expressions. In this case, you might show the individual a photo of someone donating blood and tell how this helps. If you donate blood, show the individual your Band-Aid and explain that no one hurt you.
6. *Repeat your responses patiently*. Individuals may have questions about these events and ask them repetitively. Use clear examples and repeat yourself as needed. If you are aware of misconceptions individual has, you are in good position to help. Gently and carefully repeat correct information and be sure the individual grasps what you mean. Later, check in again about the same information because misconceptions can be hard to shake.

**Chapter Seven:**

**Cultural Perspective with the Impactof Trauma**

1. **Understanding Cultural Diversity**
2. **Culture definition**
3. Cultures is defined as a means for sharing wisdom and skills that are necessary to the survival of the community, the individual and the community's view of humanity.
4. **Personal cultural diversity**
5. Cultural identity influences how we identify the threat of or the traumatic events, how we interpret them, and how we exhibit our distress toward them.
6. The importance for crisis responders to understand their own cultural identities and their own values and judgments cannot be underscored. Recognition of similarities and cultural influences may enhance the ability to communicate with and understand others in the aftermath of trauma.
7. What assists in the definition of culture identity are attitudes towards belief systems, dress, and other factors
8. **Trauma and Culture**
9. **Basic concepts**
10. The capability for incorporation is broadened, developed and sustained in the realm of social relations.
11. **Impact of culture on trauma**
12. Culture impacts how individuals understand the meaning of a traumatic event. If the potential of a traumatic event occurring is incorporating into cultural expectations, the occurrence of a traumatic event may not be as stressful for survivors as for those who have not planned for the event.
13. Culture influences the expression of traumatic events by individuals and communities.
14. Cultures may assist in defining healthy systems to a productive aftermath after a traumatic event.
15. Routines and traditions of the culture may assist survivors of crisis event to reorient themselves.
16. **Planning for Working with Cross-Cultural Population**
17. **Education**
18. All culture brings with it a traumatic history. Importantly, histories bring hope and coping skills.
19. All cultures have routines and rituals.

**Chapter Eight:**

**Trauma and Spiritualism**

1. **The Importance of Spiritualism**

At the core of spirituality is belief and hope.

1. **Spirituality definition**

There is a spiritual aspect interwoven in the fabric of life, whichdenotes the fundamental core of values that is dynamism within human beings. This spirituality is the origin that links people, nature, and the world. Religious ideology directs some individual’s in their comprehension of spirituality. For others, their spirituality meaning assist in explains their value systems. For the purpose in this crisis training manual, spirituality is used to includethe meaning of the universe and life.

Spiritual faithjoins philosophy or theology that looks to understand existence, nonexistence, relationships, life, death, and life after death. How one believes in spirituality is frequently influenced by culture.

1. **Traumatic events are an assaultto our meaning systems.**

Meaning systemsareconsist of one’s:

a. Belief system regarding the universe.

1. Perception of reality.
2. Dynamics of the relationship between the universe and reality.
3. Pursuit of the meaning within reality and universe.
4. Those confronted trauma typically review their belief system and meaning of life.
5. Traumatic events question the assumption about the world as they know it.

These questions are:

1. Connection between the universe, the world, people, and God.
2. Life, death, or afterlife.
3. Principles and values.
4. Interpretation of the world.
5. How life should be lived moving forward.
6. **Restoring life with prayer and ritual**
7. Ritual is a foundation of social support as it links and strengthens ties of individuals to the community and traditions that are followed.
8. Ritual assistsindividuals confronthappiness and sadness together.
9. **Issues of Spirituality that ImpactTrauma Survivors**
10. **"Why?” “Why me?" "Why is this happening?"**
11. One of the most common questions asked after tragedy.
12. Fairness and justice is also dominantafter a traumatic event.
13. **“Why continued to live with this world full of pain?”**
14. Suicide may be considered as an option. Suicidal ideation may have its origin in loneliness, emotional or physical pain.
15. Ask what will suicide accomplish?
16. Ask about the effects will suicide have on survivors?
17. Ask how they bring meaning back into life.
18. **Open Dialogue with Survivors regarding Spiritual Issues**
19. **Do Not:**
20. Explain or provide answers to spiritual questions.

a. Survivors know there are no absolute answers.

b. Survivors needto search for their own spiritual answers in order restructure and move forward in theirlife.

**B. Do:**

1. Assist the survivor focus on thoughts of an afterlife that is part of their belief system.

2. Investigate how their belief may assist with their cope in the after math of a traumatic event.

1. Confirmthe right to question the judgment of God.
2. Confirm their exploration for spiritual answers.
3. Permit them to talk about forgiveness.
4. Confirm the injustice of what occurred.
5. Stress that everyone has to search for their own path understanding to the reason for the traumatic event.

**Chapter Nine**

**Elements of Crisis Intervention**

Effective crisis intervention must follow ethical principles which ensure that survivors are not placed in further harm, their decisions and opinions are respected throughout the process and the intervention upholds a rights-based approach. This involves good communication skills and demonstrating empathy.

***A crisis is not an event; a crisis is a*reaction*to any event.*** Disasters like earthquakes, volcanoes, tsunami’s and other natural or man made calamities involve many losses, but these are not necessarily crises in themselves.

It is the individual or community ***reaction to what is lost through these situations*** that constitute a crisis. In other words, it is not the event itself that determines whether or not this is a crisis, it is the person’s ***perception*** that defines an event to be a critical incident. This explains why in the same situation some people appear to cope well and handle things, while others fall apart.

In short, any situation can cause a traumatic reaction which may or may not result in a crisis, depending on how well the individual’s coping mechanisms are able to handle the stress caused by that event. The crisis occurs when a person’s coping mechanisms are overwhelmed.

Practical steps are needed to help an individual or a group in crisis. Flexibility in adaptation is required when applying these steps to specific situations.

**Step 1:        Immediate Intervention:**

The first necessity in crisis management is immediate intervention. Crises are perceived as danger and a threat to someone in the experience. This is a time of turmoil and a high level of distress, and their primary focus is on RELIEF. Therefore this is not a time for delay or for scheduling sessions three days, weeks or months ahead. The person needs to be seen and the situation dealt with NOW. In a true crisis situation, help is needed immediately.

**a)   Create or Restore a State of Equilibrium.**

People simply cannot tolerate the stress of a crisis for very long and will try to get help wherever they can. In a crisis, the tension and sense of urgency can lead to misperceptions and lowered efficiency. They are desperate for “quick relief.”  Your speedy assistance can make the crisis less severe, by reassuring the person that they will be OK.

It is “face to face” that you can best assess reactions by not only hearing words but by observing body language and other indicators of the person’s state of mind and reactions.

**b)          Use Sustainment Techniques.**

Sustainment techniques are used to lower anxiety, tension and guilt and to provide emotional support. Techniques to calm things downinclude being reassuring, slowing down your responses and your speech, lowering your voice, both in volume and in pitch, and speaking in a very slow and methodical way. This approach alone can give the assurance of strength and control, which will help the person feel less anxious. Practice this and you will be surprised how calming an effect it can have.

**c)        Begin by talking about the LIFE rather than the DEATH.**

Often, when a person is in crisis after a death, it is better begin by asking them to talk about the person’s life, because the death is just too traumatic to even think about. When we can put the death in the context of the life, it is often easier for the person to “go there.”

**Step 2:        Take Action.**

People in crisis tend to flounder because they feel unstable. In order tomove them towards meaningful and goal directed behavior, something needs to HAPPEN right away. They need to know that something is being done BY them and FOR them. The person needs to understand the crisis and recognize the feelings that are being experienced.

**a)        Probe into the past.**

It is important to determine how the person was functioning before the crisis, and how that functioning has changed as a result of the crisis. We should not assume that any dysfunction is necessarily due to the crisis so we have to assess what was their emotional state, their behavioral patterns, thought processes, relationships with other people and any physical problems. Then you seek to determine what happened, who is involved, when it happened, and how life is different etc. The “who, what, when, where and how” questions will help you paint a picture.

**b)       Determine Immediate Needs.**

As you gather this information, you are seeking to discover which issues in the person’s life need to be attended to immediately, and which issues can be dealt with later.

**c)       Seek Clarification.**

If you are confused by what is said, ask for clarification. Even asking the person to explain what they mean by a vague statement can give you more information and clues.

**d)      Explore their Strengths and Weaknesses.**

What resources can we draw upon to help the person through this time? Does the person have abilities or strengths in their life style that you can draw on? For example someone who is involved in a physical exercise program may draw upon that for self-confidence or comfort. Is family going to be strength or a weakness?

We need to be aware that the goal of overcoming trauma is “empowerment of the survivor” which enables them to operate from a position of strength rather than weakness.

**e)       Consider New Alternatives.**

Encourage the person to consider new approaches and actions, or an alternate way of looking at the situation. When people feel like they or the situation is out of control, it can be terrifying. Here is often an opportunity to let the person know that their reactions are natural and understandable, which often comes as a relief. Statements like “have you considered this possibility … “ or “What would happen if you would … “ or “What if you were to …” can enable them to consider possibilities.

**Step 3:        Avert a Catastrophe**

The short-term goal of crisis counseling is simply to avert a catastrophe and to restore the person to a state of balance. Some of the more severe outcomes of crises are suicide, physical harm, psychosis, family breakup, or engaging in dangerous or life-threatening behaviors.

Our task is to help the person achieve some type of limited goal. Just the simple task of completing some action will encourage them to believe that they will make it through this crisis, and this alone will bring a sense of relief.

NOVA is one such crisis counseling model that assists victims of trauma re-establish equilibrium.

***NOVA model:***

1. **“Safety and Security”**
2. **Safety**

Safety is an issue for victims who survive. Until it is addressed, other issues or concerns will be tangential. Providing for the safety of victim-survivors involves the following services.

1. Assisting with the showing concern for the victim’s or survivor’s physical safety and medical needs. Issues to be addressed include:

* Is the victim in need of medical care?
* Is the victim in immediate danger?
* Are the victim’s family, friends or neighbors in immediate danger?
* Are the victim’s home or belongings in immediate danger?
* Is there a safe place to which victims and their loved ones can be taken while waiting for immediate danger to pass?
* Are there belongings significant to the victim that needs to be rescued, if possible?

1. Taking care of witnesses’ and family members’ safety and medical needs. The following question should be asked:

* Are any people in immediate danger?
* Do any people need immediate medical care?
* Is there a safe place where these people can be taken while waiting for further word of loved ones of for further question from investigators?

1. Ensuring that victims or survivors have warmth, food, clothing, and are able to sleep.

* Is there a source of power for heating?
* Are there sufficient blankets for maintaining warmth?
* Do they have a change of clothing?
* Is there a quiet place where they can rest and feel secure?

1. Giving victims and survivors a sense of connection with other people in a secure setting.

* Are telephones or others forms of communication available so that victims and survivors can get in touch with friends or relatives?
* Is there someone the caregiver can contact for the survivors so that they feel more secure?
* Can groups of survivors meet and talk in order to get a sense of the range and the extent of the disaster?
* Is there a respected authority who can talk to survivors?
* What information do survivors want and need to feel more secure?

1. **Security**

Survivors who know they are physically safe may still feel insecure. Individuals who have survived the death of loved one are not often concerned about their own safety. But they do need to be given a sense of *security.*

1. Help survivors find privacy for the expression of emotions.

* Most survivors are uncomfortable with intrusive or sensational media scrutiny.
* Many survivors do not want family, friends, or members of their own culture to witness their loss, pain or grief.
* Some survivors feel more secure if they talk to only one or two caregivers at a time.

1. Ensure confidentiality of communication.

* Confidentiality of communication can be assured when survivors talk with professionals who are legally bound by confidentiality laws, at least within the limits of those laws.
* Confidentiality of communication may be assured when survivors talk with crisis responders who are ethically bound to keep information private.
* Assurances of confidentiality should be expressly limited if a crisis responder cannot guarantee for legal or policy reasons that what is said will not be repeated.
* Assurances of confidentiality should be expressly limited if other people are present during the course of communication and the crisis responder cannot guarantee their trustworthiness.

1. Reassure survivors that their reactions are acceptable and not uncommon.

* The reason for knowing the range of crisis reactions and their various manifestations is so that caregiver can let survivors know that they are not “going crazy” and the patterns of response are not unusual.
* Telling survivors of common grief reactions, and assuring them of the validity of such reactions, is also important.
* Immediate family members should be reassured that family members, friends, and others may react differently to the notification of death, but that grief reactions and crisis reactions of many different types are not unusual

1. Help survivors begin to take control of the events going on around them.

* Ask survivors where they would like to sit and talk so they can make initial decisions over their environment.
* Ask them if they would like a glass of water or a beverage while they talk.
* Offer them refreshments, if available.
* Ask them what their names are and what they would like to be called while you talk to them.
* These are all simple questions that have no “correct” answer but help survivors make small decision in gaining control over certain parts of their lives.

1. Support survivors in their efforts to achieve a sense of emotional safety.

* Sometimes victims and survivors are not physically safe after a traumatic event. Crisis responders may not feel safe either – an earthquake may be followed by scary after-shocks; a hurricane may be followed by a flood; an assailant may not have been apprehended. Crisis responders may be called upon to help victims or survivors gain a sense of mental safety (thinking of a place or a time when they did feel safe); safety in the belief that others care (perhaps giving small gifts of pictures, ornaments, soap or shampoo, stuffed animals); or spiritual safety (participating in prayer or meditation).

1. Hints for Helping
2. Make sure the victims/survivors feel safe or secure when you are talking to them.
3. Respond to the need for nurturing – but be wary of becoming a “rescuer” on whom the victims become dependent.
4. Help survivors contact loved ones whom they trust and would be willing to assist them.
5. Help survivors solve immediate problems that have been caused by the tragedy.
6. Help survivors re-establish a sense of control over the small things, then the larger ones, in their lives.
7. **“Ventilation and Validation”**
8. **Ventilation**

Ventilation refers to the process of allowing the victims/survivors to “tell their story.” Survivors often need to tell the story of the disaster over and over again. Each time it is told it may take differences will be due to memory problems. Sometimes the differences will reflect what is important to survivors at that particular time. Ventilation involves identifying appropriate words to express experiences, reactions, and responses. Sometimes it helps survivors to read or hear synonyms for words they are using, words which may more accurately express their reactions through art, dance, music, prayer, or other forms of ventilation. Caregivers may encourage “story-telling” by asking appropriate questions and engaging in active listening. When encouraging survivors to talk about their experiences, caregivers should remember that body language, facial expressions, and tone of voice are as important as the words used in conversation.

1. Compassionate presence

* Caregivers and survivors should be seated during conversations. Chairs should be arranged at an angle so the discussions seem less confrontational. Seating is not always available, so when standing, caregivers should allowthe victim or survivor to set the standard for a comfortable distance between the conversant.
* Lean forward in your chair or incline your head to indicate attentiveness.
* Keep facial expressions generally neutral but reflect concern or sadness when appropriate to the content of the victim’s story.
* In most cases, it’s important to maintain eye contact with survivors. However, in some cultures, it may be more appropriate to only occasionally look a speaker in the eye, particularly when conversations are held between people of opposite sex.

1. Speaking style

* Speak distinctly and clearly, with modulated tones.
* Convey calm and avoid agitated voice levels.
* Pace your words so that your speak neither too rapidly nor too slowly for the listener.

1. Effective words

* Focus what you say on concrete issues.
* Ask, “How should I address you?”
* Ask, “Is there someone you would like me to contact so they can be with you?”
* Ask questions like: “How do you think that happened?” “Where were you when this happened?” “Who were you with?” What do you remember seeing, hearing, smelling, touching, or tasting at the time?” “What did you do?”
* Follow up questions, if necessary, with questions such as: “How did you react to that?” “Were you afraid?”

“Were you angry?” “What did you do that makes you think you were at fault?”

1. Effective listening

Ineffective listening styles occur when listeners are affected by the following behaviors and attitudes.

* *Assumptions* are often made by listeners, that they already know what will be heard so they listen carelessly.
* *Boredom* may occur when listeners do not think that what they will hear is important.
* *Concentration* is interrupted by distractions with other things.
* *Disagreement* is perceived with another’s thoughts or interpretations of events.
* *Ego-involvement* by listeners so that they focus on their own words and think it is more important to hear themselves talk or teach rather than listen.
* *Failure* by the listener to understand what has been said or to interpret what was meant.
* *Generalizations* made by the listener that the survivors of one crisis are equated with the survivors of another.
* *Hearing* only what the listener wants to hear.
* *Interruptions* by the listener to complete the speaker’s sentences or thoughts.
* *Judgments* of the speaker’s behaviors or actions.
* *Kindnesses* that can kill when listeners respond to stories with their own emotions.
* *Listening* to words only – not the intent, meaning or physical reactions of the speaker.

Effective listening is a skill developed with training and patience. It is based on the following principles.

* *Ask* questions only to facilitate the flow of story-telling
* *Believe* that speaker’s impressions and reactions are the most important concern.
* *Clarify* what is being said.
* *Discern* unspoken message from speakers in their body language, voice tone, and facial expressions.
* *Echo* words or phrases that survivors use to indicate that you are paying attention and following their stories.
* *Find* new or alternative words that repeat or enhance the meaning of speakers in order to respond affirmatively to their reactions.
* *Give* information that might help survivors understand and situation more clearly, if it might dispel specific concerns, without arguing with them or answering unasked questions.
* *Help* survivors remember what happened by asking them about the chronology of time during which the event took place and chronology of what has happened since the event, or asking them to describe the contextual nature of the event, such as colors, sounds, sensations, or impressions.
* *Instill* peace trough silence by waiting for survivors to decide when they may want to continue their stories.
* *Journey* with survivors though their narrative. If parts of the story are confusing, as survivors if they can repeat those parts or remember other things that might help you understand what they are saying.
* *Keep* your personal values, beliefs, biases, and judgments to yourself, and avoid imposing them on others.
* *Listen,* summarize, and remember you are helping survivors develop a narrative for the event to create words to describe their emotional reactions.

1. **Validation**

Crisis intervenors try to help survivors understand that most reactions to horrific events are not abnormal. Validation should be content-specific. A caregiver should refer to the actual tragedy that has taken place.

1. Validation is based on effective hearing by caregivers.

In order to validate and affirm survivors’ reactions, caregivers should not only learn how to listen but also be aware of the skill of hearing what is said. Hearing has for different registers: decoding ordinary meaning; resonating these meanings for another’s lives; awakening to the meaning for the survivor who lives and speaks; and communing with the survivor through dialogue. (Egendorf, A., “Hearing People Through Their Pain,” Journal of Traumatic Stress, January, 1995).

1. Decoding ordinary meaning involves an effort to understand a survivor’s story in terms of our own. It means listening carefully and identifying the story and the survivor’s reaction with his or her past experiences and identity. Hearing requires someone willing to listen, and who brings at least some experience to the listening process.

Hearing ordinary meaning in the case may entail listening to the anger and the reason for the anger. The mother was not angry at the son; she was angry at the fact that she could not respond as she would have liked.

1. Hearing resonance refers to a musical metaphor that incorporates harmonies, dissonance and counterpoints.
2. Awakening to what has been heard means trying to understand the context of the trauma and what it means now for the person who survived it. It is recognition of life and hope.
3. Communicating our abilities to hear and learn from survivors provides them with support in their process of learning to live from their pain. Caregivers can be very effective in this if they hear well since their hearing is dependent upon their ability to live from and through their own pain.
4. Words should be used carefully in validation.

* Let survivors find their own words and use their words in response.

Victim: *“I get so frustrated when I read about this airplane “crash.” This was no crash! The airplane exploded because of a terrorist bomb.”*

Intervenor: *“An airplane crash is certainly different from an airplane explosion.”*

* Allow survivors to name their own reactions, but when repeating their descriptions, provide team with synonyms for their responses.

Victim: *“I am so angry, I could kill him.”*

Intervenor: *“You say that you are angry, perhaps even outraged or furious. It is not uncommon for people who are hurt so badly to think about killing the person who hurt them.”*

* Apologize if you use words that upset survivors or words that they indicate are inaccurate for their situation.

Intervenor: *“You seem to be very angry about what happened.”*

Survivor: *“I am not angry. I am just very confused and frightened.”*

Intervenor: *“I am sorry I misinterpreted what happened. Could you tell me more about your confusion and fright?”*

* Avoid careless phrase.

Intervenor: *“I am sorry to hear that this tragedy happened to you.”* This sentence may convey the idea that you were sorry to listen to the victim, not that you were sorry that the tragedy took place.

*“Thank you for sharing that feeling.”* “Sharing” involves both persons experiencing that same feeling. Survivors often resent caregivers who assume that they can share feeling or stories. Some survivors also dislike discussing *feelings* while they may be willing to talk about *reactions* and *responses.*

1. At times, repeating key elements of the survivors’ stories back to them may be useful validation. It also confirms what the caregivers thought they heard said.

Survivor: *“I was in bed asleep when I was awakened by a noise. I was disoriented and confused but went back to sleep for a moment because I heard nothing more. The next thing I knew was that a large man was on top of me and I could not breathe. He told me not to scream or he would kill me. I did what he said without thinking. I was just thinking about staying alive. He tied me to the bed post before he left. I was able to free myself fairly quickly but I waited for the sun to come up before I called the police. Then, I didn’t know what to say because I couldn’t explain why I didn’t call sooner.*

Intervenor: *“Let me see if I heard you correctly. You were awakened suddenly. You went back to sleep. And then you awakened again while this man was attacking you. You were so terrorized that he would kill you so you followed his instructions and when you were able to call the police, you did.”*

1. The emphasis in the validation should be on the fact that most types of reactions such as fear, anger, frustration, guilt, shame and grief are not unusual and that each survivor’s situation is unique.

Survivor: *“I have always tried to do what was expected of me and what I expected of myself. No one ever taught me about what to do if someone broke into my house and stole everything. When I got home that night, I could not believe my eyes. Everything was gone. I was so angry. It was so unfair. Why did someone feel they had a right to my stuff? But then I became scared because whoever took my things might come back and kill me. I didn’t cry because I was so frustrated and worried. I called my sister and stayed the night with her. It was when I returned home the next day and I realized that not only were most of my things gone but that the burglar had stolen my mother’s wedding picture that I cried.”*

Intervenor: *“Most people don’t expect someone to break into their homes and steal their possessions. It is unfair and you have the right to be angry. And, it is very frightening to think that someone can come into your home, at will, to steal or perhaps to hurt you. You survived, and I cannot imagine how painful it must have been to lose everything, most particularly to lose you mothers’ picture. Anger, fear, frustration and grief are a part of a pattern of many reactions that victims often have to such a violation of their lives.”*

1. Although most people manage their reactions well, some may become violent or dangerous to themselves or others. Intervenors should be alert to any signs of potentially harmful responses. Of particular concern are statements of intent to harm when linked to a well-thought-out plan of action in which the victim also identifies the means to carry out the plan.

Victim: *“I have decided that I will have to kill my neighbor. He raped me. I identified him. The police have done nothing. He sees me every day and acts like everything is all right. I know how I will kill him. I have my father’s gun. I have ammunition. I think I will invite him over to my house for dinner. If the gun accidentally discharges when I show it to him, it won’t be my fault.*

1. Do not validate the survivors’ experiences by telling them of your own experiences. Previous experience with similar tragedies may be mentioned to help build credibility and create a sense of commonality, but everyone’s experience is different. Caregivers should stay focused on the survivors and not use intervention to validate their personal reactions.

Survivor: *“I don’t know why I’m talking to you. You can’t possibly understand what it is like to have a child murdered. I has been hell every day. I think I see Joe coming home from school even though I know that he will never come home from school. I hear him getting ready for bed even thought I know that he won’t be in the bedroom when I look. I feel like I’m going crazy. I try to continue working and looking after my daughter but is seem impossible now that Joe is gone. Sometime I put Jane to sleep reading a story then wake her up with my own tears.”*

Intervenor:  *“I can’t imagine what anguish you face each day. I do know how I felt when my daughter died, but the circumstances of Joe’s death seem overwhelming. I don’t think you are going crazy, but I would like to hear more about the problems you are facing. Can you tell me about some of your time with your daughter this last week?”*

1. **Hints for Helping**
2. Open discussions with words, such as “I am sorry that this tragedy happened to you.”
3. Ask survivors to describe the event.
4. Ask them to describe where they were at the time they heard of the event or saw it happen.
5. Ask survivors to describe their reactions and responses.
6. Ask survivors to describe their reactions and responses in the aftermath of the disaster – the time period between the disaster and the point in time at which you are talking with them.
7. Let survivors talk for as long as they want, but when there is a pause, validate what was talked about. (If you have a reason to limit the time of discussion, indicate what those limits are at the beginning of the talk.)
8. Don’t assume anything. Survivors will tell you what happened and how they reacted.
9. **“Prediction and Preparation”**
10. **Prediction**

Assist survivors in *predicting* the practical issues that will face them in the aftermath of the tragedy. One of the most important concerns of survivors is “what is going to happen next?” Ask them about the problems they think they will have over the next few days or months. If there are some that you can predict, and that they don’t realize will occur, give them as much concrete information about such issues as you can.

1. Practical predictions
   * + Some survivors will have to relocate after a catastrophe. The relocation may be temporary or permanent. They may have concerns about what to take in the relocation how to contact relatives or friends, or what type of transportation will be provided.
     + It is not unusual for financial issues to be of paramount concern. If an employment site has been disrupted, employees may be out of a job. Serious physical injury may result in hospital or medical bills that are not reimbursed by insurance.
     + If a crime has been the cause of the disaster, victims may become involved in the criminal justice system as witnesses. Many catastrophes also result in civil litigation. In either case, the survivors may be involved in the legal system for years.
     + Any medical prognosis should be made as clear as possible to survivors.
     + Often survivors are not aware that they must identify loved ones who have dies or they are not prepared to deal with funeral arrangements or notifications of relatives. These issues should be explained as quickly as possible.
     + Survivors should be warned about the possibility that the media will want to do interviews or may broadcast stories about the disaster. Sometimes the treatment of the disaster story by the media can cause a great deal of anger and distress for victims and survivors.
2. Possible emotional reactions should also be *predicted*.
   * + It is important to describe the immediate physical and mental responses that characterize the crisis reaction and grief reactions.
     + Long-term stress reactions should be explained.
     + Stress reactions that might occur in family members or friend should be described. It is particularly useful to describe possible reactions of children. It is not uncommon for parents to underestimate the effect of a disaster on children.
     + Certain things can trigger physical and emotional reactions after a disaster. For instance, holidays or birthday may trigger grief over the loss of a loved one. Sights or sounds that are similar to those experienced during the disaster may trigger responses of fear or horror that were prevalent at the time of the catastrophe.
     + Reassure survivors that long-term and many may not face them at all.

**2. Preparation**

In addition to predicting what might happen in the aftermath of a disaster, it is helpful of caregivers to assist survivors to *prepare* and plan for such events.

1. Provide survivors with as much information as they want and need concerning financial aid, insurance, and compensation to meet financial concerns. Help them fill out eligibility forms if needed.
2. Help survivors with developing plans for future protection of themselves and their families. Assist them in rehearsing the implementation of such plans.
3. Provide survivors with referrals to additional resources of counseling, advocacy, or assistance.
4. Provide survivors with information on prevention of possible similar events in the future or the mitigation of the consequences of such events.
5. Give survivors accurate and truthful information about the length of time you will be able to assist them and what they might do when you are no longer available.
6. Help survivors decide what things they can do to deal with specific problems and if there are any that they do not have the capacity to deal with, provide them with assistance once they have decided upon a particular plan of action.
7. Tell victims and survivors what their rights are in the criminal justice system. Let them know how they might enforce these rights. Let them know what is happening in your state and in the United States concerning victim rights.
8. Do not make promises that you cannot keep.

**3. Hints for helping**

1. Remind survivors to focus on living one day at a time.
2. Help tem explore options and use problem solving techniques with everyday concerns.
3. Encourage survivors to talk and write about the event.
4. Suggest that survivors establish a daily routine that they can easily follow.
5. Help survivors plan time for memories and memorials.
6. For some survivors, finding a “buddy” who can support them during times when they confront practical problems is helpful.
7. **Useful phrases for crisis intervenors**
8. “You are safe now” (if the survivor is safe).
9. “I’m glad you’re here with me now.”
10. “I’m glad you’re talking with me now.”
11. “I am sorry this (tragedy) happened to you.”
12. “This wasn’t your fault” (if the survivor has done nothing to contribute to the tragedy and its consequences).
13. “Your reaction is not an uncommon response to such a disaster.”
14. “It’s understandable that you feel that way.”
15. “It must have been upsetting to see (hear, feel, smell) that.”
16. “I can’t imagine how terrible this must be for you.”
17. “You are not going crazy.”
18. “Things may never be the same, but they can get better, and you can get better.”
19. “If you can’t tell me what happened to you, try to tell me what has been happening to your family.”

**Chapter Ten:**

The Art of Active Listening isall about building rapport, understanding, and trust.



1. **Active Listening Skills**

Active listening is a way of paying attention to other people that can make them feel that you are hearing them. It does not mean doing what other people want, but it does mean making it clear that you understand what they are saying.

This type of listening is called active because it requires certain behaviors of the listener. These behaviors include listening carefully, not interrupting, using words and body language (like eye contact and sitting forward) to show that you are trying to understand what the other person is saying.

**The most important active listening behaviors**

* Be silent. Being quiet without interrupting encourages the other person to speak.
* Accept. Nod your head or say "Yes," "I see what you mean," or "Go on, please." This indicates that you have heard the other person and that you will not be disagreeing. These words and gestures encourage most people to speak more.
* From time to time, restate what you believe the other person has said: "So you are saying that . . . ."
* Clarify with questions about what you think he means: "Let me see if I understand. Do you mean . . . ?"
* Summarize when the person is finished speaking: "In the last few minutes you have been saying that you believe . . . and think . . . ." This summary restates briefly the speaker's point of view.

**The key body poses for active listening**

Nonverbal cues can be an indicator of how a person is feeling, underlining or adding emphasis to what he or she says. To demonstrate active listening body language:

* Keep up good eye contact. Look at the person you are listening to. Do not turn away. You may want to lean forward.
* Nod your head, say "mm-hmm," as a sign you are paying attention.
* Relax your body. Being tense or fidgety makes the other person wonder if you are listening.
* Make encouraging gestures with your hands.
* Take notes of what the person is saying, when appropriate.
* Set aside whatever you are doing in order to concentrate.
* Do not do something else or leave the room.

**Difficulties of active listening**

A number of feelings and circumstances can get in the way of active listening and make it difficult:

* When people are preoccupied with current life stresses or difficult situations, it is hard for them to listen.
* Anxiety can make it hard to listen. For example, children who are anxious at school often have difficulty learning.
* Being angry at the person who is talking also makes it hard to listen, especially if the person is blaming you or talking about something he or she feels is your fault.
* Having an idea in mind of what a person "should" do makes it hard to listen to that person's point of view. This is particularly true if the feelings he or she is expressing do not seem logical to you.

**Behaviors that should be avoided in active listening**

* Avoid "why" questions. These tend to make people feel defensive.
* Do not tell the other person what to do.
* Avoid quick reassurance, saying things like, "Don't worry about that."
* Avoid rejecting, making fun of the other person, or refusing to listen to the person about something.
* Avoid digging for information and forcing the other person to talk about something he or she would rather not talk about.

**The importance of active listening**

Active listening is important because it can help you understand other people. This can make you more successful in the workplace and help you have better relationships with friends and family. When other people feel you really listen to them, they can be much easier to deal with because they feel you understand their position.

Key techniques

**A. Restating**

To show you are listening, repeat every so often what you think the person said — not by parroting, but by paraphrasing what you heard in your own words. For example, “Let’s see if I’m clear about this. . .”

**B. Summarizing**

Bring together the facts and pieces of the problem to check understanding — for example, “So it sounds to me as if . . .” Or, “Is that it?”

**C. Minimal encouragers**

Use brief, positive prompts to keep the conversation going and show you are listening — for example, “umm-hmmm,” “Oh?” “I understand,” “Then?”“And?”

**D. Reflecting**

Instead of just repeating, reflect the speaker’s words in terms of feelings — for example, “This seems really important to you. . .”

**E. Giving feedback**

Let the person know what your initial thoughts are on the situation. Share pertinent information, observations, insights, and experiences. Then listen carefully to confirm.

**F. Emotion labeling**

Putting feelings into words will often help a person to see things more objectively. To helpthe person begin, use “door openers” — for example, “I’m sensing that you’re feeling frustrated. . . worried. . . anxious. . .”

**G. Probing**

Ask questions to draw the person out and get deeper and more meaningful information — for example, “What do you think would happen if you. . .?”

**H. Validation**

Acknowledge the individual’s problems, issues, and feelings. Listen openly and with empathy, and respond in an interested way — for example, “I appreciate your willingness to talk about such a difficult issue. . .”

**I. Effective pause**

Deliberately pause at key points for emphasis. This will tell the person you are saying something that is very important to them.

**J. Silence**

Allow for comfortable silences to slow down the exchange. Give a person time to think as well as talk. Silence can also be very helpful in diffusing an unproductive interaction.

**K. “I” messages**

By using “I” in your statements, you focus on the problem not the person. An I-message lets the person know what you feel and why — for example, “I know you have a lot to say, but I need to. . .”

**L. Redirecting**

If someone is showing signs of being overly aggressive, agitated, or angry, this is the time to shift the discussion to another topic.

**M. Consequences**

Part of the feedback may involve talking about the possible consequences of inaction. Take your cues from what the person is saying — for example, “What happened the last time you stopped taking the medicine your doctor prescribed?”

**II. Communication**

**A**. Blocker: These roadblocks to communication can stop communication dead in its tracks:

* 􏰀“Why” questions. They tend to make people defensive.
* 􏰀Quick reassurance, saying things like, “Don’t worry about that.”
* 􏰀Advising — “I think the best thing for you is to move to assisted living.”
* 􏰀Digging for information and forcing someone to talk about something they would rather not talk about.
* 􏰀Patronizing — “You poor thing, I know just how you feel.”
* 􏰀Preaching — “You should. . .” Or, “You shouldn’t. . .”
* 􏰀Interrupting — Shows you aren’t interested in what someone is saying. \_\_\_\_\_\_

*SOURCE: Excerpted and adapted from Lee Scheingold, “Active Listening,” McKesson Health Solutions LLC, 2003.*

**B. 6 Simple Conversation Courtesies**

1. “Excuse me...”  
2. “Pardon me....”  
3.“One moment please...” “Let’s talk about solutions.” “May I suggest something?”

**C. The Art of Questioning**

The four main types of questions are:

1. LEADING

For example, “Would you like to talk about it?” “What happened then?” Could you tell me more?”

2. OPEN-ENDED

Use open-ended questions to expand the discussion — for example, lead with: “How? What? Where? Who? Which?”

3. CLOSED-ENDED

Use closed ended questions to prompt for specifics — for example, lead with: “Is? Are? Do? Did? Can? Could? Would?”

4. REFLECTIVE

Can help people understand more about what they said — for example, someone tells you, “I’m worried I won’t remember. . . ” Reflective Q: “It sounds like you would like some help remembering?”

**Chapter Eleven:**

**Group Crisis Intervention Techniques**

***(NOVA model)***

**I. Introduction**

Group crisis intervention builds upon the lessons of individual crisis intervention while opening avenues for building stronger communities and increasing the depth of understanding in human tragedies. While the focus of such group work is often portrayed as simply the overwhelming emotions of trauma and helping survivors gain cognitive control and understanding of what happened, group sessions should always include not only listening to reactions and allowing participants to tell their stories but assisting them in facing their futures. Reestablishing human connections and affirming hope is critical.

**II. Goals**

1. **Guiding the release of emotional steam after the pressure-cooker of trauma.**
2. **Addressing great numbers of individuals after a community tragedy.**
3. **Peer group validations of individual reactions enhance the effectiveness of the validations provided by crisis intervenors.**
4. **Group work helps establish social support; rebuild a sense of community bonds; and repair the social fabric rent by the disaster.**
5. **Education of community members about trauma and its aftermath.**
6. **Affirmation or reaffirmation of hope in the future.**

**III.Scope and Nature of Group Crisis Intervention Services**

1. **Definition**

NOVA has adopted the term “group crisis intervention” rather than using the term “group debriefing” because there is a group reluctance to refer to “debriefings” in a community crisis response effort for several reasons. First, the term is often confused with what is known in military and law enforcement populations as “logistical debriefings” which are used to obtain from participants details of an operation. Second, for many community members, “debriefing” sometimes carries with it mental health connotations that may inhibit participation. Third, even among crisis responders, there is often debate over what the “debriefing” process implies. And finally, it is often used carelessly to describe social exchanges that have little value in addressing trauma or crisis.

1. **NOVAprotocol**forGroup crisis intervention is useful both as an immediate response to acute crisis and as a way to continue to integrate the trauma into community life. NOVA’s protocol for group crisis intervention relies upon a chronological approach for addressing the crisis event. Group participants are asked to remember what happened at the time of the trauma, what has happened in the aftermath, and what they expect to happen in the future. If the trauma isparticularly intense, it may be useful to pace the group session to avoid initial feelings of being overwhelmed again. To avoid premature exploration of trauma material, group facilitators may want to start group sessions with questions, “What was life like before the event happened?” While facilitating this review, the group leader constantly seeks to ensure the group’s sense of safety and security, to provide opportunity for ventilation and validation, and to help participants predict and prepare for problems in the future.

**IV. Description of NOVA Protocols**

If a catastrophe such as a serial murder or massive bombing takes place, it is likely that many victims and survivors may not have a great deal of time to focus on group work. Intermittent sessions may be better than on lengthy group session. However, in some cases, a horrific crime can occur in a matter of minutes and community members may find time to participate in comprehensive group sessions. If a catastrophe is a no-low-point tragedy or lasts over an extended period of time, there may be a need for repetitive interventions. When there is no opportunity for repletion, the sessions may be focused on somewhat different issues than those used in immediate post-trauma situations. Because of these variables, several types of group crisis intervention protocols have been developed. Thischapter will first review the basic NOVA protocol used in the immediate aftermath of sudden, immediate, low-point tragedies and then when and how NOVA employsmodifications of this protocol.

1. **Group crisis intervention – basic protocol**
2. Overview

Group crisis interventions often take place at or near the site of the community trauma coincident with in the first days or week of trauma event. The technique allows the facilitators to address thoroughly all of the elements of crisis intervention; to educate participants on the common pattern of crisis reactions and what long-term stress reactions are to be expected; and to help participants consider coping responses. The group sessions usually last between 1½ hours and 3 hours. All victims and survivor populations can benefit from participation. NOVA conducts sessions for both homogenous groups, such as school personnel, firefighters, or survivors, caregivers, or community members who want to attend. Although groups of 20-25 participants are ideal, group sessions have been conducted with as few as five people and as many as 600 people. In extremely large groups, not all members can participate verbally, but most benefit from listening to those who choose to participate, hearing the commonalities in stories and reactions, and observing the process itself.

1. Timing of Sessions
2. Try to arrange sessions so that they do not conflict with events such as funerals, memorials and the like.
3. Night sessions are generally better form community-wide group meeting. Day sessions are generally better for school personnel, children, and employees.
4. NOVA group sessions are usually no more than two hours in length. The following estimates of how that time might be spent will vary based on group participation but are included as a guide for crisis responders.
5. 1½ hours of group work.

* 10 minutes: introductions by facilitator focused on providing guidelines for discussion and establishing parameters of *safety and security* for participants.
* 35 minutes: questions designed to help review immediate physical sensory perceptions and emotional reactions of shock and disbelief and to give an opportunity for *ventilation and validation* of these reactions.
* 25 minutes: questions designed to help review reactions reflecting emotional turmoil, including fear, anger, frustration, shame, guilt or grief, and to provide an opportunity for *ventilation and validation*.
* 10 minutes: questions designed to elicit participant expectations for future coping strategies and to help *predict and prepare* group members for what may happen over the next few weeks, months or year.
* 10 minutes: summary by facilitator of what has been said in order to review validation and emphasize preparation for the future, and conclude and sessions.

1. Post-group session.

Allow 10 to 30 minutes for distributing handouts, answering individual questions, talking to individuals and saying good-bye to individual participants.

1. Logistics

The following logistical guidelines are listed in order to describe ideal situations, but crisis responders should be aware that in many disasters, group sessions will be conducted under onerous conditions.

1. The room should be accessible and comfortable for group member.
2. Mental health and other caregivers intersperse themselves among the participants. NOVA conducts most sessions with two intervenors but encourages local caregivers to participate in order to assist individuals who may need to take a “time out” during the session and to identify the caregivers to participants if they need additional assistance or referrals in the future.
3. Sessions should be conducted with the participants in a horseshoe or circle configuration where possible.
4. Flipcharts are used to record reactions of participants if possible and with permission of participants. Flipcharts will be destroyed after the session unless the participants want to keep them.
5. Sessions are conducted by a pair of intervenors.
6. Handouts are provided buy should not be distributed until the end of the session.
7. Make sure tissue is easily accessible.
8. Make sure water is available.
9. Let people know where the nearest toilet facilities are located.
10. Let people know where they can smoke.
11. Group Intervention Team Roles
12. Group facilitator (one person should be “in charge”).

The group facilitator is the only team member who talks during the group session. Facilitators are responsible for introducing the session, stating, the guidelines, asking the questions, providing validation, assisting group members in validating each other, summarizing the session and concluding it. If possible, the facilitator should be seated with the group either at the open-end of the horseshoe or in the circle.

The facilitator:

* Begins with “I am sorry it happened” to you
* Introduces self and other team member.
* Introduces NOVA, gives NOVA references, if needed, describes NOVA’s role in the community and the team’s voluntary involvement.
* Introduces local caregivers who are present.
* Gives permission to the group to say what they want and to come and go as they please. Reminds them that if they leave, someone will follow them out to see if they are alright. Emphasizes that while they are not confined to the room, it would be helpful if they would return after taking a break.
* Defines ground rules for sessions.
* Facilitates the session.
* Summarizes and concludes the session.

1. Supporting team member- “The Scribe”

This person is not a facilitator, but he or she is an active member of the group crisis intervention team. NOVA has designated this member as the “the scribe” because of his or her role in taking notes during the session. However the scribe does far more than simply taking notes. The scribe should stand while taking notes and be as unobtrusive as possible.

The scribe:

* Provides emotional and practical support to the facilitator, if needed. For example, a facilitator may begin to cough and need water – the scribe would make sure the water was available.
* Assists with individuals who go into crisis within the group by distributing tissue, providing physical comfort, or helping them leave the room. (If local caregivers are assisting, they take on this role as described below.)
* Records notes on a flipchart of participant crisis reactions.
* Takes over the group if the leader cannot continue. For example, if the facilitator becomes ill, the scribe would provide immediateassistance and perhaps relieve the facilitator for the rest of the session.
* Contributes only when called upon by the facilitator. For example, the facilitator may know that the scribe has particular expertise in helping elderly people cope with disaster and may ask the scribe to address a question on this subject during the prediction and preparation stage of the session.

1. Other crisis intervention team member (optional).

* Local caregivers, when available, should be prepared to assist with the individuals in crisis.
* Other NOVA team members, if available, should be prepared to assist with the individuals in crisis.
* Other NOVA team members, if available, should be prepared to replace the scribe if the scribe must replace the facilitator.

1. Ground rules for group session are established.
2. Confidentiality of communication.

NOVA team members are expected to assure the group that all discussions in the group will be confidential. This does not mean that issues raised in the group cannot be talked about outside the group but rather that no story or concern will be attributed to any specific group member or described in a manner that can be used to identify that group member. NOVA team member cannot guarantee that all group members will abide by such promises of confidentiality but they can encourage the group to make a sign of assent to confidentiality to help underscore the importance of it. The facilitator should indicate that participants will not be allowed to take notes or to record the session.

1. Agenda for session.

* The session is designed to help the group define the crisis reaction, provide some crisis intervention, and to predict and prepare the group for possible future events.
* In describing the agenda, the facilitator indicates that the group will talk about:
* How the participants reacted or are reacting.
* How their family or loved ones reacted or are reacting.
* Expectations for the future.

1. Permission should be given to participants to express any thoughts or reactions they might have, but the facilitator should make it clear that no physical violence or verbal abuse will be allowed.
2. Ask that individuals identify themselves when they talk, if they are willing to do so. However, assure them that they may participate anonymously if they prefer.
3. Session Procedure
4. After the introductions and orientation, the facilitator should:

* Ask participants to tell about their experience during the event.
* Where were they when it happened?
* Who where they with?
* What did they see, hear, smell, taste, or touch at the time?
* What did they do? How did they react at the time?
* Wait patiently through silences.

These questions are asked as a group to prompt participants to remember and to think about their initial reactions. They are not individual questions for which the facilitator awaits a response. After the questions are reviewed, the facilitator may ask if anyparticipant would like to volunteer to tell what he or she remembered. At times, there may be an initial silent period. The facilitator should simply allow the silence to take place until a volunteer begins to talk. After one person participates, in most cases, others will follow rapidly. If that does not happen, the facilitator may repeat the series of questions again.

* Respond to each participant by thanking him or her for telling about his or her experience.
* Listen and validate any statements that fit within the crisis reaction framework.
* Underscore similarities between participant responses.

1. After the first series of questions, the facilitator should:

* Ask participants to describe what has happened to them in the aftermath of the event.
* Since the time of the disaster, what re some of the memories that stand out in your mind?
* What has happened in the last 48 hours? What do you remember seeing or hearing during that time?
* How have you reacted?
* Listen, respond, validate.

1. After the second series of questions, the facilitator should:

* Ask participants to think about what has happened; to think about what will happen in the next few days or weeks; and consider what possible reactions they might have to those issues.
* After all that you have been through, what do you think will happen at your job in the next few days or weeks?
* Do you think that your family has been or will continue to be affected?
* Do you have any practical concerns about what will happen next?
* Ask participants about how they think they will deal with problems or issues that they have raised?
* In many cases, they will have developed coping strategies in the past that they will refer to.
* In some cases, they will seek information about how to deal with specific problems.
* As they identify coping techniques, reinforce positive methods and suggest an alternatives to negative methods.
* Answer questions about problems, if possible, and tell them about written information that is available.
* Suggest referrals if they are available.
* Avoid making promises that cannot be kept.

1. After each set of questions has been addressed, and reactions or issues explored, the facilitator should move to summarizing what has been said during the session.

* The scribe stops making notes on the flipchart.
* The facilitator stands to review the notes and uses them to identify:
* descriptions of acute sensory perceptions.
* descriptions of shock and disbelief.
* descriptions of emotional turmoil.
* concerns about the future.
* coping strategies that might be used to address such concerns.
* The facilitator indicates that the descriptions of reactions are all reflective of crisis or trauma reactions.
* The facilitator talks about expectations for the future that were mentioned but adds others not addressed that may arise.
* The facilitator reassures participants of useful coping strategies.

1. The facilitator closes the session by sitting down again with the group, and then:

* Thanks the group for participating in the session.
* Repeats “I am sorry that this tragedy happened to you.
* Gives participants a safety net for the future.
* a plan for future group meetings.
* a contact with community caregivers.
* CPM-MH’s telephone number and other resources.
* if needed, ideas for a rumor control mechanism through which the community can get accurate and prompt information in the future.
* Indicates that the session is over but that the facilitator and scribe will remain in the room for a few minutes if anyone has additional questions or concerns.

1. Session Process
2. Be prepared for emotional reactions and behavioral symptoms of trauma as manifested by the following:

* Fear, anger, confusion, shame, guilt, or grief. All six responses may emerge during group sessions, but occasionally only one is predominant.
* Inability to articulate reactions. Participants are trying to sort through their reactions and organize them into a story, but often that process is sporadic and words cannot be found to describe what they have experienced.
* Physical agitation. Participants may find it difficult to sit or stand still for discussion. They may need opportunities to get up, move around, smoke cigarettes, or drink water. They may also fidget, bit fingernails, laugh or cry at seemingly odd moments.
* Speech agitation. Sometimes participants find themselves stuttering, talking very rapidly, or being choked up when trying to say something. Facilitators should use patience and silence to allow participants to gather their thoughts or words.

1. Provide emotional support and understanding.

* Project competence, calmness, authority, and encouragement.
* Maintain a non-judgmental attitude about situations and responses.
* Promote physical comfort.
* Establish rapport through active listening, eye contact, and empathic responses.
* If children were involved in the trauma or the event, allow them to attend sessions with their parents.
* Listen and validate.

1. Special Issues
2. Dealing with anger: anger at you or anger at each other.

It is not unusual for participants to direct anger at the facilitator or at other people in the group. This is particularly true if the session takes place a number of days after the tragedy. Participants consolidate their anger and outrage at the event and channel it towards others. Remind participants that violence is unacceptable but the anger is not uncommon. Facilitators are often perceived as “safe” person to express frustrations towards, and should be prepared to listen to all concerns. It can be useful to apologize for any things that participants think have been done wrong and to try to explain how such things might have happened.

1. Dealing with grief: extent or hierarchy of grief.

Sometimes participants start to compare notes on their feelings or grief in a manner that suggests that certain group members have a right to feel greater sorrow than others. The facilitator should try to encourage the group to recognize that many are grieving and that everyone should have a chance to define their own grief. If sadness becomes overwhelming in the group, it is sometimes helpful to encourage the group to remember positive experiences with the person for whom they are grieving. This, at times, can lead to laugher instead of tears.

1. Dealing with practical issues: financial, criminal justice, and the facts surrounding the event.

The facilitator would address any practical issues that are raised in the group succinctly with whatever information he or she has available. If nothing is known about the issues, the facilitator should simply say something like, “I don’t know, but I will try to find out. Please feel free to get in touch with me at CPM-MH (or a local number) tomorrow.”

1. Dealing with multiple traumas.

If participants raise other tragedies that they have been reminded of due to the current disaster, allow them briefly to tell about those tragedies. If they need to discuss those previous events in more detail, refer those participants to crisis intervenors in the room or make time to talk with them after the group session. Refocus the group on the event at hand.

1. Dealing with issues of God or the world beyond.

Be accepting of all beliefs. Sometimes facilitators can be accepting, but other group members ridicule beliefs. Encourage the group to recognize that faith isn’t scientific. Everyone has their own concept of values and the comic universe. Two issues are common.

Many people believe in an afterlife. There may be differing concepts regarding heaven or the spirit world, but the concept of life beyond death is not unusual. In some case, survivors believe thattheir loved ones contacted them as they die through supernatural means. In some cases, victims believe that they had a message from God that saved them from death. The facilitator may want to allow the group to explore such experiences while confirming that each person searches form meaning in their own way.

At times, the experience of the group process may be powerful enough that someone may be moved to offer a group prayer. Prayer can be inhibitor to the group process. It also is difficult to ascertain whether everyone in a group will feel comfortable in prayer. It is advisable to suggest that a prayer might be appropriate for those who wish to participate after the group session is concluded.

1. Behavioral problems: silence, monopolization, and hysterical behavior.

Silence is golden. Accept silences as moments when groups are thinking and processing their reactions.

If a participant tries to monopolize group conversations, use judgment to discern whether the rest of the group is interested in what the participant is saying. If they are not, suggest that the participant talk to someone after the meeting or take a break to talk to another crisis responder. In most cases, facilitators can find something in what the participant is describing to link his or her reactions to others in the group. Facilitators may say something like, “Is it okay if I stop you there, because you have just talked about being frightened and I heard someone else say he was frightened. I wonder if anyone else here might have been frightened?”

If participants become out of control or hysterical during a group session, the Scribe or another crisis responder should offer to talk to them outside. If they resist leaving the group, allow the group to help reassure them that their story is heard and their reactions are reasonable.

1. Use of humor in group crisis intervention.

Facilitators should let the group lead the way in using humor. Facilitators should not try to be humorous. The only time when facilitators would intervene in the use of humor is when it sued maliciously against another group member or an absent person who the group knows. Facilitators should try to defuse reactions that have precipitated cynical or sarcastic remarks and focus on the group process as a way of exploring reactions.

**V. Group defusing protocol**

1. **Overview**

Group defusing usually are conducted at or near the site of community trauma coincident with the first days or week of the crime. They are purposely short in length, lasting between 30 and 45 minutes. Often the primary target populations for such defusing are emergency workers who face competing demands on their time, but short defusing sessions can be helpful to others as well. Because of the time limit involved in defusing, they do not address all elements of crisis intervention. Their focus is on immediate issues of safety and security, flash-points of trauma reactions, and thoughts on how to continue to livethough immediate re-exposure to the crime scene or its aftermath. It is usually recommended that participants in defusing sessions also participate in follow-up group crisis intervention sessions.

1. Timing of group defusing.
2. Defusing are usually done immediately after shift rotations.
3. They last for no longer than 30 to 45 minutes.
4. The following is an example of the timing of various segments of a 45 minute defusing.

* 3 minutes: introduction and orientation emphasizing *safety* and *security* issues for the group.
* 10 minutes: *ventilation* and *validation* of immediate reactions to announcement of disaster.
* 20 minutes. *Ventilation* and *validation* of flashpoints and reaction to them.
* 7 minutes: *prediction* and *preparation* for continuing work at the trauma event.
* 5 minutes: summary and conclusion.

1. Questions used during defusing.
2. Ventilation of immediate reactions.

* Where were you when you first learned of the disaster?
* What do you remember seeing, hearing, smelling, touching, tasting?
* What did you do?

1. Ventilation of flashpoints.

* Many people who do emergency work find that there is a specific incident during their immediate response that sticks in their minds or troubles them. Can you think of any such incidence that has occurred during your work over the last shift (or use relevant time frame such as 8, 12, or 24 hours)?
* Do you have any thoughts or reactions about the incident now?

1. Prediction and preparation.

* As you go back to work, do you think that incident will continue to trouble you?
* Are there things you can do or think that can help you to cope with such thoughts or reactions?

1. Key issues for facilitators.
2. Validation for reactions.
3. Reassurance of workers’ competence.
4. Education on coping strategies.
5. Reassurance of continuing support for workers.

**VI. Post-Trauma Counseling**

1. Why Do Crisis Responders Need to Know About Post-Trauma Counseling?
2. In many communities, immediate crisis responders are also caregivers.
3. They will continue to provide supportive counseling after a major community catastrophe.
4. Post-trauma counseling is related to crisis intervention in the integration of an individual's health with new hope and meaning.
5. Crisis responders from other communities need to understand the dimensions of the long-term stress effects.
6. Crisis responders are often called on to provide community members with an understanding of coping strategies.
7. Crisis responders should not provide trauma counseling unless they have had specific training and education on each technique or therapy that they try to provide.
8. **Foundations of Post-Trauma Counseling**
9. **Trauma specific counseling**

The focus of counseling interventions should be directed at the trauma itself. Other pre-existing problems such as marital issues, alcoholism, drug abuse, employment problems, and the like should not be addressed except as they relate to this trauma. If there is a need for counseling or help in those areas, the survivors should be referred to an additional counselor for assistance.

An exception to the trauma-specific nature of counseling intervention is when there are other traumas in the individual's lifethat may affect that victim's coping abilities in dealing with the current trauma.

1. **Normalization**

Post-trauma counseling should focus on reassuring the survivors that they are not "crazy" and that their traumatic reactions are not uncommon. In this way, post-trauma counseling is an extension of crisis intervention. The goal of post-trauma counseling is to assist individuals mobilize their own capacities to deal with the experience. Labels that are used to describe those who have experienced trauma as "victims" or "survivors" may be counter-productive. Counselors should follow the lead of individuals as they describe themselves.

1. **Collaboration with the victims or survivors**

The post-trauma counselor serves as a partner to the survivors in their effort to reconstruct a new life. The counselor should be involved as a listener and as a resource in developing and suggesting options - not a decision-maker - in response to the survivors' questions. Trauma focused counseling is an extension of the natural processes of mutual support which occurs in post-disaster contexts.

1. **Unique pathway to reconstruction or healing**

Each survivor will find a unique way to develop a new life. Counselors should be non-judgmental, supportive and open in their response to decisions. Some survivors choose negative coping methods \_ becoming involved in substance abuse, considering suicide, or destroying existing relationships. Counselors should be prepared to deal with ethical issues and to refer survivors for appropriate in-depth mental health counseling if necessary.

1. **Elements of Post-Trauma Counseling**
2. **Education, experience and energy are keys to learning to live with trauma and its aftermath.**
3. *Education*
4. Content of education

* Safety education

Traumatized people are unable to regain a sense of equilibrium or master to the trauma experiences if they continue to feel unsafe. Counselors should help survivors assess their safety and to develop safety plans if they remain in dangerous situations. Safety plans are also useful for confronting trigger events such as "anniversary" dates or holidays. Education about the importance of routines, boundaries, social activities, and self-destructive behaviors is also crucial to re-establishing feelings of safety.

* Trauma education

Survivors of traumatic experiences also need to know that exposure to trauma affects their physical, emotional and mental abilities. Information useful for survivors includes understanding of the crisis reaction and long-term stress reactions. Symptoms of PTSD, grief, or depression do not mean that they are going crazy. They may be suffering from pain and anxiety but these are the result of trauma. It is also important to underscore that the impact of trauma varies. While there is much to be learned from the experience of others, each person will have their own reactions based on the dimensions of the trauma, their adaptive capacities, pre-existing sources of stress, and post-trauma experiences.

* Second assault education

Survivors also need to know what happens after a disaster and how they might deal with it. Knowledge of civil and criminal law or legal proceedings, social institutions, media behavior, financial options, and useful resources or referrals can be helpful as they plan their lives.

* Symptom management

Strategies for handling trauma related symptoms should be discussed. These may include prescribed medications when symptoms are severe enough to diminish the functional capacity of individuals. However, education in behavioral and cognitive techniques such as arousal management, stress inoculation, modification of sleep patterns, relaxation exercises or biofeedback can help survivors regain a sense of control and diminish symptom anxiety.

1. Methods of education

* It is helpful for survivors to educate themselves by reading articles or books on the effects of trauma and its aftermath. Not only can such readings stimulate the processing of individual trauma experiences, they can form the basis of discussion sessions in which experiences can be compared and contrasted. Going to classes or seminars often provides additional educational stimulus.
* Some people find that watching tapes or films on disasters or educational tapes on trauma experiences is also useful. However, for some this can be re-traumatizing if survivors do not have caring, understanding support from counselors, family members or friends.
* Similarly, writing or dictating journals or stories of their experiences, tape recording their thoughts or reactions can be helpful. Writing about traumaexperiences is educational and serves as testimony for many victims. It helps them to preserve their memories as well as to bear witness to what happened.

1. *Experience*
2. It is useful to help survivors think of past experiences that have been traumatic or extremely stressful and to consider the coping strategies they have used with such experiences - whether they were helpful or harmful - to assess whether such strategies may be relied upon in the present.
3. Many survivors learn a great deal by talking with others who have experienced similar things in the past. Such survivor support is useful in identifying how to cope with holidays, anniversaries of the tragedy, everyday routine and practical issues.
4. Survivors may also benefit from new experiences that help them learn new skills and practice new routines. Indeed action-based approaches in the treatment of PTSD have been very powerful for some survivors.
5. **Rehearsal, reassurance, and referral**are functions of post-trauma counseling that relate directly to ventilation, validation, and preparation elements of crisis intervention. Counselors should continue the process as well as seek additional assistance, when necessary or appropriate.
6. *Rehearsal*

Rehearsal is accomplished by revisiting the trauma event in the mind, physical and mental review of the trauma, and going to the scene of the trauma to reframe the event. Rehearsal allows victims to begin to understand the event and to integrate positive thoughts or feelings with the event and its aftermath. Many of the therapeutic interventions that may be provided by trauma therapists and are described below focus on either mental or physical rehearsal of the event.

1. The elements of crisis intervention focus on "rehearsal" and "recall" when crisis intervenors assist victims or survivors to remember the event with clarity and in chronological fashion.
2. Counselors should be aware that safety of the survivors is critical any time that they may physically walk through a reenactment of what happened or mentally replay the scenes of what happened. Skilled support and assistance during those re-enactments should be available in case survivors re-experience the trauma with physical and emotional reactions. There are cautions about rehearsal that intervenors should consider when working with victims.
3. Rehearsal is a voluntary and controlled event when used as a post-trauma counseling tool. Survivors should be allowed to stop at anytime when their feelings or reaction become too painful or intense. They should be allowed to be in control of the rehearsal, which also means that if they want to continue, even if in some distress, counselors should support them. Controlled rehearsals also mean that relaxation exercises or other forms of soothing comfort should accompany the rehearsals to assist survivors in coping with the memories. Counselors should be aware of the possibility of intense reactions or flashbacks. They also should be aware that traumatic events do not have to be fully remembered for individuals to regain a sense of control.
4. Involuntary or intrusive re-experiencing the event followed by diverting thoughts elsewhere or distressing emotional responses may indicate that not all aspects of the trauma are remembered.
5. Initial avoidance of thoughts or experiences relating to the trauma may assist coping by allowing the mind and the body to gradually absorb the intense impact of the event.
6. Continuation of thought avoidance over time is usually counterproductive.
7. Continuation of involuntary re-experiencing of the event is also counterproductive.
8. Even controlled rehearsal may cause victims to feel re-victimized so that any mental or physical rehearsal event should include a phase that focuses on defusing emotional reactions, restoring control in the present, and returning victims to a state of calm.
9. The value of such rehearsal is found when victims can begin to perceptually remember events so that they can complete their narratives. Then they are better able control their reactions as well as realize that they had, and have, the capacity to survive the tragedy.
10. *Reassurance*is derived from social support systems.
11. Reassurance is predicated on individuals reconnecting with social relationships. This means that some survivors must learn to establish or reestablish emotional intimacy. Intimacy is based on trust and a capacity to reciprocally self-disclose, thoughts, feelings, and reactions with another. Non-traumatized people may fear intimacy for a number of reasons. Five types of fears have been identified all of which can be intensified due to a traumatic event.

* Fear of merger - losing one's identity or control over one's life.
* Fear of abandonment - losing someone who is loved.
* Fear of exposure - being rendered vulnerable, inadequate or inferior.
* Fear of attack - being emotionally or physically harmed.
* Fear of one's own destructive impulses - becoming angry and aware of the ability to hurt others who are close.

(Feldman, L.B., "Marital conflict and marital intimacy: An integrated psychodynamic-behavioral-systemic model," Family Process, vol. 18, 1979)

1. Peer support groups with family, friends, and community members who have suffered the same catastrophe, or with people in similar situations, can provide new opportunities for human connections. The post-trauma counselor may want to assist victims in establish support groups.
2. Such groups provide people in similar circumstances with an opportunity to describe their experiences with the emotional aftermath of crime and to discuss effective coping strategies.
3. The focus is on confrontation and acknowledgment of grief, crisis, and trauma, and on support for efforts to reconstruct new lives.
4. Dr. Alan Wolfelt outlines the developmental stages of support groups as the following:

* ***Stage One: Warm-up and establishing of group purpose and limits.***Leadership roles: clarifying the purpose of the group; gently encouraging each member to tell his or her story; assisting in the creation of ground rules for the group; modeling listening and helping everyone feel as if they belong; facilitating details such as time of meetings, formats, etc.
* ***Stage Two: Tentative self-disclosure and exploration of group boundaries.***Leadership roles: continuing to model listening, openness and caring; continuing to clarify member expectations; reminding members of the ground rules; providing a group format and facilitating any activities or homework to be discussed; being responsive to conflicts and problems that might evolve.
* ***Stage Three: In-depth self-exploration and encountering the pain of grief.***Leadership roles: continuing to model listening, openness and caring; being supportive of continued participation of group members; assisting the group in dealing with any conflicts and problems that might evolve; making appropriate adjustments to content and format; allowing and encouraging the group to be more self-responsible.
* ***Stage Four: Commitment to continued healing and growth.***Primary leadership roles: continuing to model listening, openness and caring; being supportive of continued participation of group members; modeling of shared leadership principles; assisting the group in dealing with any conflicts and problems; and making appropriate adjustments to content and format as the group evolves.
* ***Stage Five: Preparation for, and leaving the group.*** Leadership roles: creating safe opportunities for members to say good-bye to each other and to the group; recognizing the dynamics that occur when a group begins to end; encouraging reflection on individual group growth; providing referral for additional resources to those in need; conducting a summary evaluation of the group.

1. *Referral*to mental health professionals may be needed for victims who are
2. suffering intense trauma or who have other complicating conditions.
3. It is advisable for post-trauma counselors who are not mental health therapists to develop a network with mental health professionals in their area. Such a network should include professionals who are educated in trauma work and have experience in working with survivors of trauma events. They should be willing to work with counselors, peer support groups or victim advocates if the survivors so desire. Some referral networks involve reciprocal trainings for mental health professionals and trauma counselors or advocates so that partnerships can be formed in the best interest of the survivors.
4. *Activism*
5. Many victims and survivors become activists when they choose to tell their stories at forums or conferences to help others learn about trauma. Some people employ activism as a basis for choosing new vocations or avocations in life.
6. There are ten reasons why victim activism can be therapeutic for survivors.

* ***Focus -*** When one's world has been thrown into chaos by trauma, there is a need to restructure order through focus on specific functional activities.
* ***Catharsis***- Activism can provide a way to express intensely frightening emotions in a safe and socially-acceptable way. For instance, anger may be expressed in outrage at laws and a determination to change them \_ instead of venting at family members.
* ***Relationships -*** Many victims and survivors lose touch with once-close friends and family. Those friends or relations may be afraid of the emotional upheaval in the victim's life, may not know what to do or say, or may blame the victim. Victim activism often gives survivors a chance to form new "families" and relationships bound together by trauma and commitment.
* ***Repetition -*** A vital part of healing is "telling your story." Victim impact panels, legislative testimony, speak-outs, support groups and so forth, all provide opportunity for telling and retelling the story.
* ***Self-Esteem -*** Victimization is often a humiliating, degrading experience. Activism can give victims tangible evidence of their accomplishments and self-worth.
* ***Testimony***- Victims not only need to tell their story but to have it validated through the knowledge that someone listened to and believed the story, and it made a difference.
* ***Insight -*** Activism provides a way to hear from others who have suffered similar traumas as well as from people who work in the field. Hearing other people's experiences can help clarify one's own experiences.
* ***Integration -*** An important therapeutic goal for many is to be able to incorporate the story of their own tragedy into their lives. Activism allows victims to restructure their lives and recognize how their victimization and survival has altered them forever.
* ***Purpose -*** For many, the impact of crime shatters their sense of meaning and purpose in life. Their plans are thrown asunder. A person whose life has been centered around her child dies a special kind of death when the child is murdered. Activism can be the key to developing a sense of triumph over tragedy and providing meaning for both that woman's life and her deceased child.
* ***Hope -*** Activism may provide survivors with hope. The nine elements of activism described above and its positive benefits lead to a re-establishment of hope and a new life for victims and survivors.

1. *Actualization*

It is difficult to describe the concept of self-actualization, but essentially it seems to represent the goal that survivors have of integrating their lives such that they include the past, the present and future visions. Recognition of the ability, capacity and tenacity to survive and the perpetuation of faith in the existence of one's self, one's children, and others is central to most human lives. But actualization goes beyond simple survival, it involves finding meaning in the trauma event and drawing upon the positive aspects of it that can lead to personal growth and transformation.

1. **Therapeutic Interventions**

Some crisis responders may also be mental health therapists experienced in trauma. Others may be experienced in law enforcement, nursing care, teaching, victim assistance, or other professions. However, no matter what their background, all should be acquainted with some of the therapeutic mental health interventions that might be available to survivors with long-term stress reactions in order to more effectively respond to questions about appropriate treatment. This manual does not attempt to describe all such interventions but outlines some of the newer techniques used over the last decade. These techniques are presented with no attempt to evaluate their effectiveness but rather to describe some of the protocols involved, and to alert crisis responders to the fact that therapists certified or trained in these techniques are available for referrals. Counselors should not attempt to employ such techniques without comprehensive training. In most cases, such training is provided only to mental health professionals so that the techniques can be used in conjunction with other therapy, as needed.

1. **Counseling Suggestions**
2. **Counselors should be aware of, and accept, traumatic reactions.**

Fighting emotional flooding or numbing is doomed to failure by the survivor. Emotions are integral and physiological. The counselor should be aware that survivors may not like their own reactions, but they will have reactions, and such reactions need to be acknowledged. They may not be able to define their reactions. The counselor can suggest words or alternative ways to describe sensations.

1. **Reviewing the traumatic event may involve thinking about the event, telling about the event, or revisiting the site of the event.**

Re-exposure to the trauma is most likely to be helpful when the re-exposure is voluntary and the survivors are in control of the process. Even then re-exposure to the trauma may cause distress or discomfort.

1. **Stress inoculation programs are helpful to some survivors.**

Such counseling programs involve identifying the primary causes of stress reactions and helping survivors to modify their responses to these causes through relaxation techniques and deep breathing exercises.

1. **Sometimes mental health professionals consider medication to suppress certain disturbing symptoms associated with the trauma.**

Suppressing symptoms may be useful if the symptoms are causing survivors to become dysfunctional in daily life. However, medication should only be used under a doctor's supervision and trauma counselors should be alert for signs of over-medication.

1. **Counselors may encourage survivors to confront trauma-related cues or issues in order to make them less intrusive and bothersome to the survivors.**

Often people behave in a manner contradictory to their intentions. For instance, if survivors are told to avoid thinking about something, they may find it impossible to do so. On the other hand, if they are told to think only about something that bothers them, they may find it impossible to keep their minds from wandering on to other things.

1. **The sense of meaninglessness or emptiness may create barriers to a reconstruction of life.**

If survivors can identify unique meanings in their lives, they are better able to begin a new life. For some, the recognition that they still have choices in life and still have control over some aspect of their life is important. Choice and control may be limited to one's own attitude. Survivors may not have control over environmental circumstances or biological or physiological characteristics but they can have a choice over how they decide a traumatic event will affect their attitudes and responses to their situation. Attitude is a product of awareness, imagination, will, and conscience.

1. **Hints for Helping**
2. **Be aware of the range of traumatic reactions**and assist victims in putting words or names to their emotions.
3. **Try to ensure that rehearsal or re-exposure to the event is voluntary**and that the survivors are in control of the process.
4. **Try to ensure that there is support for survivors**whenever they are re-exposed to the event.
5. **Provide survivors with information and relaxation techniques**, deep breathing exercises, and other forms of physical stress reduction.
6. **Help survivors re-establish routines and maintain daily schedules.**
7. **Make sure that the physical needs of survivors are being met**when they face potential second injuries in the aftermath of the event.
8. **Remind survivors to predict and prepare for issues that might arise.**
9. **Plan 24-hour safety-nets**on which survivors can rely, including protection action plans.
10. **Encourage and facilitate peer support groups.**
11. **Encourage survivors to confront trauma-related cues or issues.**
12. **Provide survivors with educational materials**to help them understand long-term stress reactions and to develop personal coping strategies.
13. **Encourage survivors to explore issues associated with the meaning of life**or the sense of meaninglessness.
14. **Refer survivors to mental health therapists**or consult with mental health professionals when needed.
15. **Specialty group techniques**
16. General thoughts

All of the above group crisis intervention techniques can be modified to address unique population groups. Groups for children utilize art and play methods of ventilation and validation. Elderly group sessions may incorporate special visual or auditory aids, and may integrate long-term memories into the interpretation of current trauma. Non-English speaking groups may require facilitation through translators or creative nonverbal expression. Coping strategies and interpretation of crisis reactions should take into account differences in cultural backgrounds.

1. Homogeneity or heterogeneity in group work

For many years victim assistance professionals have conducted peer groups for survivors or victims together who have suffered similar crimes or disasters. Examples of peer group counseling have been found in support groups organized by Parents of Murdered Children, Mothers Against Drunk Driving, rape crisis centers, and domestic violence programs. While it may be that crisis response group work is most effective when done initially in homogeneous groups of victims, survivors or emergency responders, there is growing evidence that over time integrating groups with different types of victims, survivors of different types of disasters, and different age groups of victims or survivors may have particular advantages.

**XII. Helpful Hints for Caregivers**

1. **Hints for the Scribe**
2. Record precise language used by participants. Do not paraphrase.
3. Denote in record when there is a change in speaker: the use of bullets, different colored markers, arrows or such can help make the denotation.
4. Underline words or phrases that stand out as illustrations of crisis reactions, long-term stress symptoms, effective coping strategies, spiritual issues.
5. Record at least on comment from every group member who participates.
6. Record at least one phrase that can help identify the participant who is speaking: “my father died in the crash,” “walking nearby when the building blew up,” “eating lasagna when the shots rang.”
7. Write legibly and spell accurately.
8. Record words and phrases – not complete sentences.
9. Record selectively; do not try to record whole stories.
10. Stand to the side of the flipchart so participants can see their words recorded.
11. Do not react to the stories or the description on reactions.
12. Watch the facilitator for signs of distress or physical need.
13. If you must leave the room to care for a distressed participant, draw a double line underneath the last comment that was written so that, if you return and continue writing, this break is clearly illustrated from the facilitator.
14. **Hints for the Facilitator**
15. Make sure you have the factual details of the disaster as accurately as possible. Know the names of relevant locations, the names of victims who have dies, and any notable leaders in the community. Know when the disaster happened and how many people are dead and injured.
16. Prepare for any unique issues with which a particular group may be concerned due to the nature of the disaster or its aftermath. For example, after a fire-related disaster, many participants may be distressed about viewing or knowing about burned victims or survivors. After a disaster involving drowning victims, participants may be overwhelmed by seeing bloated and distorted bodies.
17. Do not emote in response to what is said. Show sympathy and concern through body language or validation of reactions.
18. Remain and act calm and assured.
19. Establish eye contact with the speaker and hold that eye contact throughout his or her story.
20. When asking questions of the group, look at as many group members as possible. If one or two members are conspicuously silent, be sure to include them in your eye contact.
21. Do not be afraid of silence.
22. Respond to individuals in the group when they tell their story by saying “I’m sorry.”
23. Do not argue with participants whose version of the story differs from the facts as you know them.
24. Be prepared to answer factual questions concisely.
25. Do not elaborate on extraneous details.
26. Do not probe for further explanations or descriptions of participants’ stories, but if they describe a part of the event without indicating reactions, ask them if they had any reactions at the time that they are willing to tell the group.
27. Validate key reactions verbally if the participant gives you the opportunity. Seek validation from other group members by asking questions as: “Did anyone else have a similar experience?” “Joe talked about being angry and Mary just said she found herself screaming at a police officer who wasn’t doing anything. Mary, were you angry when you were screaming?” If the participant does not give anyone an opportunity to validate verbally, nod affirmatively in response to key reactions.
28. Practice validating responses with a variety of words. Sample responses are:

* *“I can’t imagine how upset you must have been.”*
* *“Anger is not uncommon. Some people even talk of being outraged or furious when they are so distressed.”*
* *“Fear is not unusual. Many people are terrorized when they think their lives or someone they love is threatened.”*
* *“Everyday life is shattered by senseless murder.”*
* “*I’m not sure anyone can fully understand how much agony this disaster has caused you and your family.”*
* *“Pain is a common bond in disaster, but its experience can’t really be shared.”*
* *“It can be terribly frustrating not to know what happened.”*
* *“It must be very difficult to believe yourself to be to blame for this tragedy. It’s not unusual for us to think back on ways that we could have avoided a disaster, but you are not responsible for the behavior of a murderer.”*
* *“Some people are ashamed and humiliated when they are helpless to prevent or respond to tragedy. But tragedy often makes people helpless and you didn’t have any control over what happened.”*
* *“Disasters like this don’t make sense.”*
* *“It is difficult to comprehend anything as terrible as what happened to you.”*
* *“Sometimes it’s hard to put words to an awful event. Tears can serve as a useful alternative.”*
* *“Take your time, it’s all right to cry after someone you love has been killed.”*
* *“It’s not unusual to feel like a little child or baby when something this awful overwhelms you.”*
* *“It’s very difficult to think you will ever feel good again when such a bad thing has happened to you”*

1. Do not tell the group of your own experiences or those of others in this or other disasters to validate their own stories. Their experience is unique.
2. Sometimes a quotation or line of poetry can serve to offer validation or helpful response. Examples:

*You have to live through a time when everything hurts*. – Stephen Spender

*In our sleep, pain which cannot forget falls drip by drop upon the heart until, in our own despair, against our will, comes wisdom through the awful grace of God*. – Aeschylus

1. Keep track of time so that you can end on time.
2. Try to remember at least four or five names of the participants if the group members choose to identify themselves, and use those names in response or in the summary of the session.
3. Tie all comments back to the crisis reaction or long-term stress reactions.
4. Summarize the session with reference to the scribe’s notes, but retain the crisis reaction as a framework for the summary. In the summary, you should not necessarily follow the order of the speakers; rather draw the crisis reaction out of the notes in the order of your training and your handouts.
5. Remember to predict important events that will be facing the community in summary of future concerns. Inform them of any problem issues that may arise and make concrete suggestions for sources of further information if such referrals are available.
6. Underscore positive suggestions or thoughts that some participants might have raised during the segments focused on the future.
7. Thank the group members for participating in the session – include all group members in the thanks, those who told about their experiences and those who listened to others.
8. Distribute handouts to the group members as they leave the session.
9. Give them CPM telephone number along with a local referral if available for further information.
10. **Conclusion**

Crisis responders do not have to know how to provide post-trauma counseling, but they should know about methods and know how to make good referrals for survivors after a crisis or trauma event. Counseling or therapy may be the only option for some survivors who find it difficult to overcome trauma reactions or to integrate traumatic memories. When someone seeks such help it should be encouraged. Some people may not seek such help because of the fear of being stigmatized. A good referral entails identifying an appropriate person to which to refer. It also involves explaining the referral option in a positive way that focuses on the concrete building blocks of surviving and integrating a traumatic event. It has often been said that the willingness to seek or accept help when life seems most desolate is the first step in survival. It reflects a hope that things might get better. The goal of trauma therapy or counseling is to nurture that hope to help rebuild lives after disaster.

**Chapter Twelve**

**1:1 or small Group Sessions**

**I. Review of Basics of Crisis Intervention**

**A**. Three goals guide techniques used in crisis intervention:

1. Mitigate impact of event.
2. Facilitate normal recovery processes.
3. Restore adaptive function.

**B.** Crisis intervention techniques should also abide by the following seven principles:

1. **Simplicity**: In a crisis, people respond best to simple procedures. Simple things have the best chance of having a positive effect.
2. **Brevity**: Psychological first aid needs to remain short, from minutes up to one hour in most cases.
3. **Innovation**: Use creativity; specific instructions do not exist for every case or circumstance.
4. **Pragmatism**: Keep it practical; impractical suggestions can cause the person to feel more frustrated and out of control.
5. **Proximity**: Provide support services close to the person’s normal area of function. “The most important thing about proximity is that support must be given in a safe zone,” according to the book *Prehospital Behavioral Emergencies and Crisis Response*.
6. **Immediacy**: Provide services right away. Crises demand rapid interaction, and delays can undermine the effectiveness of support services.
7. **Expectancy**: Work to set up expectations of a reasonable positive outcome. The person or group in crisis should be encouraged to recognize that help is present, there is hope and the situation is manageable. It may be appropriate to tell the person or group that although the situation is overwhelming right now, most people can and do recover from crisis experiences.

**II. Intervention Models**

**A.** **Roberts’ Seven-Stage Crisis Intervention Model**

Roberts identifies seven critical stages that clients typically pass on the road to crisis stabilization, resolution and mastery:

1.Plan and conduct a thorough lethality/imminent danger assessment.

The biopsychological assessment should at least include the client’s environmental supports and stressors, medical needs and medications, current use of drugs and alcohol, and internal and external coping methods and resources. Assessing lethality must first determine whether a suicide attempt has been initiated and then can continue with the client’s potential for self-harm. Imminent danger must establish, for instance, whether the person is now a target of domestic violence, a violent stalker or sexual abuse.

2. Make psychological contact and rapidly establish the collaborative relationship.

Rapport is facilitated by the crisis worker offering conditions such as genuineness, respect and acceptance of the client. Traits, behaviors or character strengths of the crisis worker come to the fore to instill trust and confidence in the client. Strengths include flexibility, positive mental attitude, resiliency, reinforcing small gains, good eye contact, creativity and nonjudgmental attitude.

3. Identify the major problems, including what precipitated the crisis.

The crisis worker should determine what in the client’s life led to that person needing help. The worker should also try to determine which problems to work on first; these determinations can help understand the client’s coping style.

4. Encourage an exploration of feelings and emotions.

This stage involves the crisis worker allowing the client to express feelings, to vent and heal, and to explain the person’s side of the story about the current situation. Skills include active listening, communicating with warmth and reassurance, nonjudgmental statements and validation, and accurate empathetic statements. The crisis worker can, very cautiously, eventually work challenging responses into the dialogue, including giving information, reframing, interpretations and playing “devil’s advocate.” Challenging responses can help loosen clients’ maladaptive beliefs and consider other behavioral options.

5. Generate and explore alternatives and new coping strategies.

This stage can be the most difficult to accomplish. Achieving the goals in stage four means that the client likely has worked through enough feelings to have some emotional balance. Now, the crisis worker and client can put certain options on the table to ensure the client’s safety, such as a no-suicide contract or brief hospitalization, alternatives for finding temporary housing or considering the pros and cons of various programs for treating chemical dependency.

6. Restore functioning through implementation of an action plan.

An action plan helps provide concrete plans for ultimately restoring the client’s cognitive functioning. Many clients have trouble mobilizing and following through on an action plan; obviously, the action plan is critical for restoring the client’s equilibrium and psychological balance.

7. Plan follow-up and booster sessions.

The crisis worker should plan for a follow-up contact after the initial intervention to ensure the crisis will be resolved and to evaluate the client following the crisis. Follow-up contact should include physical condition, cognitive mastery of the precipitating event, assessment of overall functioning, satisfaction and progress with ongoing treatment, any current stressors and how those are being handled, and need for possible referrals.

**B.** **Critical Incident Stress Management (CISM)**

The CISM is a comprehensive crisis intervention system that may be applied to individuals, small functional groups, large groups, families, organizations and even entire communities. It spans the entire temporal spectrum of a crisis. Mounting empirical evidence demonstrates that the CISM approach provides the tools for prevention and corrective treatment, the *International Journal of Emergency Mental Health* says. CISM has seven core components:

1. Pre-crisis preparation. This includes stress management education, stress resistance and crisis mitigation training.
2. Disaster or large-scale incident, as well as school and community support programs including demobilizations, informational briefings, “town meetings” and advising staff.
3. Brief small group discussions called defusings, which are provided within hours of a crisis for assessment, triaging and mitigating acute symptoms.
4. Longer small group discussions known as Critical Incident Stress Debriefing (CISD). These structured group discussions are usually provided one to 10 days after a crisis to mitigate acute symptoms, assess the need for follow-up and, if possible, provide a sense of post-crisis psychological closure.
5. One-on-one crisis intervention/counseling or psychological support throughout the full range of the crisis spectrum.
6. Family crisis intervention and organizational consultation.
7. Follow-up and referral mechanisms for assessment and treatment, if necessary.

**III. Stages in the Counseling Relationship**

**A. Five Stages:**

## STAGE I Establish rapport / Build a relationship

* Unconditional Positive Regard, Genuineness, Empathy
* Establish trust. Engage in Active Listening
* Reflect, reflect, reflect. . .feelings or thoughts
* Open-ended questions
* Attending behaviors: “Ear contact,” “mmm’mm,” “I hear you.”
* Tracking - responding to what he or she has just said.
* “Take your time”. Give permission to ventilate
* Silence can be a powerful form of active listening.

**STAGE II Clarification / Define the Problem**

* What is at the heart of the session?
* Break it into smaller pieces. Gather information.
* What does this problem mean to him or her?
* Reflect, reflect, reflect . . .
* Open-ended questions or closed-ended questions.
* Assess the situation for risk, emergency, or danger.

# Bring up a difficult subject.

**STAGE III Explore Resources**

* Prior strains? Available resources? Perception of the problem?
* What has he/she tried before?
* What options does he/she see?
* Who can they turn to for support or help?
* What special considerations factor in to the resources?
* Facilitate his/her development of the solution or options.
* Refrain from giving advice! Let the caller do the work.

**STAGE IV Plan of Action**

* Pace him/her *and* yourself . . . “Rome wasn’t built in a day.”
* Break plan into manageable steps - Summarize. Anticipate problems
* The session may be resolved before it gets to action planning.

**STAGE V** **Wrap up the session**

* How does he/she feel now?
* Offer other resources.
* If there is a special reason follow-up, plan and make clear.
* Give feedback.

# B. COUNSELING “LEADS”

## Stage I Opening a session

* How may I help you?
* That’s what we’re here for. What would you like to share with me?

**Reflection***(Reflection will used A LOT!)*

* You feel \_\_\_\_\_\_\_\_\_\_\_\_\_ because \_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* I hear you saying \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?
* What you seem to be saying is \_\_\_\_\_\_\_\_\_\_\_\_\_?
* I feel \_\_\_\_\_\_\_ as I hear you.
* You must have felt \_\_\_ when \_\_\_\_\_\_happened

## Stage II Clarification

* Help me to understand.
* Tell me more about that.
* How are you feeling?
* How do you feel about \_\_\_\_\_\_\_\_\_\_?
* I’m wondering if \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?
* I’m not sure I understand. Can you repeat that?
* How long have you had this problem?

**Stage III Exploration of Resources**

* What do you feel are your resources?
* Who do you have in your support system?
* What has worked well for you in the past?
* What do you feel able to do about this just for today?
* Who can you count on to assist you?
* What do you believe prevents you from resolving this?
* What would have to happen first?
* How do you see your problem resolving?
* How would you like things to be if you could have them your way?
* What things have you tried before?
* What do you see as the next step for you?

### Stage IV Wrapping up a session

* How are you feeling now?
* What do you see happening after our call?
* It seems as if you’ve identified and explored your problem and now you have some things to reflect upon [*or a plan to act on.*]
* I want to applaud your courage for calling and for taking a chance on sharing your problem with me.
* I hear you having \_\_\_\_\_\_\_\_\_\_\_\_ [*specific positive assets*] and I really believe in your ability.
* I want to wish you well.
* We need to break now, but thank you for attending the session.

**C. Crisis Assessment and Intervention**

An individual in crisis may be experiencing some impairment of this usual level of functioning. It is important to assess the degree of that impairment of functioning and if the individual is in immediate danger (emergency risk). In effect, we as counselors are trying to assess how much control we need to take with this individual in order to help him/her. We make this assessment by gathering relevant information. The following questions are useful in making this determination.

* Is the person able to carry on normal responsibilities: are they paying bills, attending work, school, caring for children?
* Are they eating/sleeping normally?
* Is the caller catastrophizing? “No one cares”; “It’s hopeless”.
* Are there other behavioral indicators of distress: i.e. inappropriate laughter, hearing voices, can’t stop crying, inability to concentrate, make decisions, distorted perceptions of people, places, or things?

Generally, the more “yes” answers the assessment reveals, the more dysfunctional the individual, and the more directive the intervention should be.

Consider the following continuum when making your decision about intervention strategy.

**Chapter Thirteen:**

**Coordinating a Crisis Response Team**

***(NOVA model)***

1. **CRT Community Response Team**

A trauma-inducing event: a community-wide traumatic event is one that causes life-threatening injury or death. Criteria to consider when determining whether the event may cause widespread trauma include the following non-exclusive attributes:

a. Incidents that occur within communities where people are strongly-affiliated with each other;

b. Incidents in which there are multiple eye (or other sensorial) witnesses;

c. Incidents in which the direct victims have a special significance to the community affected, as may happen with the assassination of a public figure or the killing of a child;

d. Incidents in which the community is subjected to exposure to carnage or misery;

e. Incidents which attract a great deal of media attention.

1. **Goals of a CRT:**
2. To assist the local caregivers plan their immediate and longer-term activities in the aftermath of the catastrophe.
3. To give support to local caregivers in their efforts to respond to the catastrophe.
4. To train local caregivers in immediate crisis response and long-term stress reactions to trauma.
5. To help local caregivers by modeling and providing debriefing sessions to critical population groups.
6. **Guidelines for selecting appropriate team members for deployment.**
7. Assess the type of catastrophe involved and the individual’s experience with that kind of tragedy. Sometimes survivors of a similar disaster should not be used on a team because the crisis response effort may trigger unresolved reactions. On the other hand, some survivors of similar disasters can bring particular insight to the intervention as a result of their own experiences.
   1. The following professional affiliations are represented on most CRT’s (although one person can often credibly fill more than one role):
      * a psychologist or psychiatrist
      * a member of a medical profession
      * a child counselor or teacher
      * a person experienced with media relations.
   2. All team members will be trained community crisis intervenors, and will agree to follow NOVA crisis response guidelines, debriefing guidelines, and training outlines.
8. Roles of team members.
   1. Team leader: serves as the official liaison between the team and community; makes arrangements for team members at the site; serves as spokesperson for the team with the media when a separate media person is not assigned on the team; debriefs and cares for team members when necessary; writes and submits final report to NOVA on crisis response intervention. In most cases the team leader will be a mental health professional.
   2. Team manager: An experienced NOVA trained individual with crisis experience. The manager handles all logistics; is liaison between the team and headquarters – calling headquarters at least twice each day while in the field; provides briefing papers and other support to the team leader; is responsible for supplies and NOVA materials; makes reports to the headquarters at the conclusion of the response.
   3. Media liaison: this person handles all media inquiries; sets up media conferences when necessary; and serves as spokesperson for the team unless the team leader is designated to do so. The media liaison may be the same person as the team manager.
   4. Other team members: all team members must perform all assignments as given. They are expected to be able to provide a three-hour training seminar on the key issues of crisis response; do group or individual crisis intervention sessions (previously referred to as “debriefings”), either as group leader or group scribe, as necessary; and to understand the NOVA model or response for planning purposes. They are also expected to participate in practical assistance activities to the community, as assigned.
9. The length of stay in a community in response to a disaster of limited time duration will generally be approximately forty-eight hours. For disasters that span days, weeks or months, the length of stay may be longer. However, any team will probably stay no more than five days at a time. If a longer stay is necessary, a second team may relieve the first team.
10. Behavior guidelines for team members at the site:
    1. All team members will go to the site of the disaster, if possible.
    2. No team member will talk to the media without permission of the team leader.
    3. Team members should not make individual appointments without clearing them with the team leader.
    4. Team members should remember that breakfast dinner and are normally spent together as a team, unless other commitments have been approved by the team leader.
    5. Team members should avoid making derogatory remarks about any behavior or actions by local contacts, although problems should be noted and shared with other team members.
    6. Team members are to act as representative of NOVA and should participate as directed and take no actions except those authorized by the team leader or team manager.
    7. Team members must agree to abide by NOVA victim assistance Code of Ethics appended to this chapter.
    8. Team members must follow all rules set by the team leader or team manager. The rules are designed to ensure the delivery of high-quality services to the community and, to the extent possible, the safety of the team members. Team members who violate established rules may be required to return home immediately.
    9. Team members will be expected to be dressed professionally whenever possible.
    10. All team members are expected to contribute a written report to the team manager for inclusion in the final report.

**D. “How-to’s” of CRT response**

Outreach response:

1. NOVA Crisis Response Team Coordinator works with information from government and chosenteam members.
2. Contact chosen team members and give them their travel information. Place order for prepaid plane (or train) tickets for team members, if necessary.
3. The local contact person should be asked to collect the following supplies and services:
   1. Flipcharts, markers, and masking tape for all training and group crisis intervention sessions.
   2. Coffee and soft drinks for group crisis intervention sessions. Ashtrays and boxes of tissue will also be needed.
   3. Depending on the nature of the crisis, the team may need walkie talkies or cellular telephones.
   4. Local vehicles for use by the team. Often, these are provided by local governmental agencies, which also provide a driver.
   5. Identification of lodging for the team.
4. The crisis should be monitored on the news from the time NOVA makes outreach until after NOVA returns. All national newspaper articles should be clipped and saved.
5. The local contact person should be asked to save all local newspaper articles as well.
6. The team members should be advised (or reminded) of the following issues:
   1. Who is the team leader and who is the team manager
   2. Behavior and dress guidelines
   3. Any organizational concerns that they might find in the community.
   4. NOVA in-house staff/volunteer is responsible for providing a written summary of the key issues, brief biographies of team members, and people that the team will meet at the site.
7. The strategy for responding to a crisis generally involves the following activities:
   1. Team meeting at the first gathering point (team members should meet with each other prior to any other meetings). Meet local contact person and any other host representatives.
   2. Team visit to the site
   3. Planning meetings with local contact person/people
   4. Training sessions for all local caregivers
   5. Group crisis intervention sessions for identified high risks groups – possible groups will include:

* Victims/survivors
* Emergency services personnel
* Rescue workers
* Law enforcement officers
* Local victim assistance helpers
* Children
* Elderly
  1. One or more group crisis intervention sessions for the community as a whole
  2. Nightly group crisis intervention sessions for team members
  3. Final group crisis intervention sessions for the local contact person and any local team members prior to leaving
  4. Ad hoc meeting with local caregivers
  5. Press conference(s) and press interviews

1. NOVA in-house staff undertakes the following follow-up procedures:
   1. Outreach (where possible) to victims/survivors who could not be served at the site.
   2. Touching base with local contact person at minimum:

* Within week after site visit
* At months one, three, and six after site visit
* One year after site visit

**III.Conclusion**

NOVA’s rules and guideline for organizing and coordinating a Crisis Response Team are designed to reflect a step-by-step process for providing community crisis intervention. NOVA has found that if they are methodically followed they produce efficient and expeditious results. In some cases, the circumstances of a disaster will make it imprudent to follow the process exactly; however, it is NOVA expectation that team leaders, managers and members will abide by the rules and guidelines wherever possible. The implicit hierarchy andexplicit planning of the organizational protocols helps to provide structure and calm in the midst of the chaos of catastrophe.

Training for Crisis Preparedness and Management

**Code of Professional Ethics**

**For Victim Assistance Providers**

Adopted by the NOVA Board of Directors, April 23, 1994

Victims of crime and the criminal justice system expect every Victim Assistance Provider, paid or volunteer, to act with integrity, to treat all victims and survivors of crime – their clients – with dignity and compassion, and to uphold principles of justice for accused and accuser alike. To these ends, the Code will govern the conduct of Victim Assistance Providers:

1. **In relationship with every client,***The Victim Assistance Provider shall:*
2. Recognize the interests of the client as a primary responsibility.
3. Respect and protect the client’s civil and legal rights.
4. Respect the client’s rights to privacy and confidentiality, subject only to laws or regulations requiring disclosure of information to appropriate other sources.
5. Respond compassionately to each client – withholding opinion or judgement, and accepting the client’s statement of events as it is told, whether or not an offender has been identified, arrested, convicted, or acquitted.
6. Provide services to every client without attributing blame, no matter what the client’s conduct was at the time of the victimization or at another stage of the client’s life.
7. Foster maximum self-determination on the part of the client.
8. Serve as a victim advocate when requested and, in the capacity, act on behalf of the client’s state needs without regard to personal convictions and within the social and legal parameters of the advocate’s agency.
9. Provide each client with personalized services, working for the client’s welfare without concern about personal gain.
10. Should one client’s needs conflict with another’s, act with regard to one client only after promptly referring the other to another qualified Victim Assistance Provider.
11. Observe the ethical imperative to have no sexual relations with clients, current or past, in recognition that to do so risks exploitation of the knowledge and trust derived from the professional relationship.
12. Make client referrals to other resources or services only in the client’s best interest, avoiding any conflict of interest in the process.
13. Provide opportunities for colleague Victim Assistance Providers to seek appropriate services when traumatized by a criminal event or a client.
14. **In relationships with colleagues, other professionals, and the public,***the Victim Assistance Provider shall:*
15. Conduct relationships with colleagues in such a way as to promote respect and improvement of service.
16. Make statements that are critical of colleagues only if they are verifiable and constructive in purpose.
17. Conduct relationships with allied professionals such that they are given equal respect and dignity as professionals in the victim assistance field.
18. Take steps to quell negative, insubstantial rumors about colleagues and allied professionals.
19. Share knowledge and encourage proficiency and excellence in victim assistance among colleagues and allied professionals, paid and volunteer.
20. Provide professional support, guidance, and assistance to Victim Assistance Providers who are new to the field in order to promote consistent quality and professionalism in victim assistance.
21. Seek to ensure the volunteers in victim assistance have access to the training, supervision, resources, and support required in their efforts to assist clients.
22. Act to promote crime and violence prevention as a public service and an adjunct to victim assistance.
23. Respect laws of one’s state and country while working to change those that may be unjust or discriminatory.
24. **In her or his professional conduct,***the Victim Assistance Provider shall:*
25. Maintain high personal and professional standards in the capacity of a service provider and advocate for clients.
26. Seek and maintain proficiency in the delivery of services to clients.
27. Not discriminate against any victim, employee, colleague, allied professional, or member of public on the basis of age, gender, disability, ethnicity, race, national origin, religious belief, or sexual orientation.
28. Not reveal the name or other identifying information about client to the public without clear permission or legal requirements to do so.
29. Clearly distinguish in public statements one’s personal views from positions adopted by organizations for which he or she works or is a member.
30. Not use her or his official position to secure gifts, monetary rewards, or special privileges or advantages.
31. Report to competent authorities the conduct of any colleague or allied professional that constitutes mistreatment of client or that brings the profession into disrepute.
32. Report to competent authorities any conflict of interest that prevents oneself or acolleague from being able to provide competent services to a client, or to work cooperatively with colleagues or allied professionals, or to be impartial in the treatment of any client.
33. **In his or her responsibility to any other profession,** *the Victim Assistance Provider will be bound by the ethical standards of the allied profession of which she or he is a member.*

**Duties of a Crisis Response Team Leader**

1. Assemble and meet with the team members as soon as possible upon arrival.
2. Brief team members on details of the disaster and distribute briefing packets, if available. Make a list of any team concerns or ideas that might be useful in the planning of the response.
3. Meet with the local host to get update on disaster details, logistical arrangements for team transportation and housing arrangements, and details on site visit or any scheduled meetings.
4. Lead the team on a visit to the site of the disaster, when possible.
5. Attend planning meeting with local host or planning committee to outline plans for team activities for the duration of the stay. The leader should be the primary spokesperson for CPM-MH at this meeting. To the extent possible, other team members should raise questions or contribute comments through the team leader. The team leader should be thoroughly familiar with the goals of a CPM-MH and the standard protocols of implementation.
6. Based on the plan, the team leader should make assignments to team members concerning their duties. Such assignments should include designating:

* A media manager to handle media requests and to arrange for press conferences should the community request such assistance.
* Specific team members for each segment of each training session for caregivers. It is desirable to include multiple team members in training sessions to better acquaint the community with team member skills. The standard three-hour training has four separable components. Ideally, a different team member would be assigned for each segment.
* Group crisis intervention teams of two for each group sessions, identifying in each team who is to be the facilitator and who is to be the scribe.
* Specific team members, according to their expertise, to office assistance to and meet with representatives of various population groups that may benefit from services even if they were no represented at the planning meeting.
* Specific team members to assist with practical needs of the local host or community, as needed.

1. Serve as the spokesperson with any media should the community request CPM-MH involvement with media.
2. Meet with any local officials, upon request, to provide them with information on team plans and feedback on execution of those plans.
3. Supervise and monitor team members behavior and give feedback on compliance with CPM-MH guidelines and ethics.
4. Meet with team members each evening to discuss the day’s events and activities and to provide a team GCI, the leader should serve as the facilitator but should also begin the session by discussing his or her own reactions first to ensure that other team members feel comfortable in the session.
5. Encourage team cooperation and mutual support. The leader should look for opportunities for the team to enjoy laughter or fun together to keep spirits high.
6. Serve as consultant to team members when problems arise in trainings or group crisis intervention sessions.
7. Conduct final group crisis intervention with local host.
8. Serve as CPM-MH spokesperson and submit any team recommendations at final planning meeting prior to leaving the community.
9. Write and submit final report to CPM-MH following the crisis response intervention.

**Duties of a Crisis Response Team Manager**

1. Maintain “black box” during site stay.
2. Provide team leader with briefing paper prepared by CPM-MH, if available.
3. Maintain log of all flight arrangements for team members and ensuring that they are picked up from the airport or have alternate transportation to site, if needed.
4. Arrange for transportation and lodging arrangements, if local host needs assistance or alternatives to CPM-MH arrangements are needed.
5. Identify a headquarters for the team and ensure that the team has access to a copier, fax and several telephones.
6. Keep log and schedule of team assignments made by team leader, including when team members are due at assignments and when they will return; log all completed assignments by noting what kind of group was trained or counseled, how many were present, and an estimate of any one-on-one counseling during the day.
7. Work with local host to arrange for any logistics necessary for training sessions or group crisis intervention sessions. This includes assisting with implementing plans for disseminating information to the community for community crisis intervention sessions.
8. Provide training materials, hand-outs or supplies to team members, as needed.
9. Work with media manager to set up any press conferences.
10. Provide advice to team leader, upon request of the leader or the CPM-MH headquarters. Such advice should be given discretely and should not undermine the leader’s authority with the community or other team members.
11. Arrange for team meals at designated time determined by team leader.
12. Report to CPM-MH headquarters at least twice each day or any time when additional direction or information is needed.
13. Keep file of all local press coverage of the disaster and disaster related materials to be included in final CPM-MH report.
14. Keep file of all local contacts who should receive letters or certificates of appreciation upon the team’s return.
15. Ensure that all team members have transportation arrangements to return home.
16. Write and submit final report to CPM-MH headquarters upon team return.
17. Be prepared to do any service required of other team members, upon assignment, but management duties should take priority over other activities.

**Chapter Fourteen:**

**Managing the Media in Crisis Situations**

(The following section has been excerpted from NOVA’s basic textbook, *Victim Assistance: Frontiers and Fundamentals.*NOVA has also published a manual on victim assistance and the media that can be requested from the Office for Victims of Crime.)

1. **The Media in Crisis**
2. **The media’s coverage of a crisis situation can cause harm to all concerned.** The victims of the crisis may feel violated and betrayed. Their privacy is invaded, their character or lifestyle questioned, and the facts of the situation distorted.
3. The daughter of a woman who had been murdered told of her shoulder being dislocated when a reporter forced his way into her home to try to get a story.
4. **Victims and their advocates often are frustrated** because the media broadcasts gruesome photographs, inadvertent death notifications and misinformation.
5. A photograph of the body of a victim, still strapped into his seat by a seatbelt, hanging from a tree near Lockerbie after the Pan American Flight 103 explosion in 1988 was widely disseminated by the press.
6. **The community suffers**because useful information about available resources or predictable actions and reactions tends to take second place in the media to more sensational descriptions of the event. While some media representative are conscientious about serving as an educational conduit to inform the public, such information may become a back page story while speculations and rumors occupy primary coverage, causing hours of days of anxiety to families, friends, survivors.
7. In the 1993 disastrous siege of the Branch Davidians’ compound in Waco, Texas, many were distressed by rumors surrounding who might have set fire to the Davidian complex.
8. **Finally, public perception of the media and its role may become increasingly negative.**

Media coverage of a crisis does not have to leave permanent injury or ill feelings on the part of the victim and the community. If properly managed, the media’s coverage of a crisis can have a positive effect on the disaster.

1. **How a Disaster Unfolds: An Overview**

Although each crisis is unique, there often is a common pattern to the media’s response in the aftermath of any tragedy that affects whole communities. The type of information sought by the media as the trauma unfolds often follows the following pattern.

1. **0 - 12 hours**: In the immediate aftermath of a community crisis the media is scrambling to get information to answer the question – *What happened?* The media attempts to piece together a story, based on eye-witness accounts, monitoring police radios, and in many cases, grabbling anyone to talk about what happened. This results in incomplete, conflicting and inaccurate accounts of what actually happened. In the worst case scenario, the media has monitored the police radio frequency and arrives at the scene of the crisis before the police or rescue workers, thus obtaining unrestricted access to the crime or disaster scene.
2. **12 – 24 hours:** As the crisis unfolds, the next question the media seeks an answer to is *Who?* – who are the victims? There is often a struggle over the timing of the release of the names of injured and killed victims as the authorities try to notify the surviving family members. No one is immune from the media’s search for identifying information about the victim. The media will seek this information from a variety of sources, including hospitals, the police, rescue workers, families, neighbor, schools, passenger lists, coworkers **–** or though encampments at the crisis scene – all in an effort to identify who has information about the crisis and its victims.
3. **12-36 hours:** The next question the media tries to answer is the question of *Why?* – why did this tragedy happen? It is normal reaction on the part of many people, including victims, survivors, and community members, to try to understand what happened by finding someone or something to blame. Everyone has their own version of who is to blame and the media feeds into this hysteria by speculating on who or what may have caused the crisis well before the actual facts of the situation emerge. In cases of criminal acts of violence, where the obvious person to blame is identified suspect, the media will run stories laying blame on a variety of sources such as lax security, questioning whether the victim in some way contributed, or about those who could have foreseen or prevented this tragic crime. In crises involving natural disasters, where there is no offender to blame, issues of faculty construction, inadequate disaster preparedness capability, or why the victims did not carry adequate insurance coverage often arise.
4. **36-72 hours:**At this point during a community crisis the media continues to speculate on what happened and why, and in addition, often begins to evaluate the rescue efforts as to whether they were effective and timely. Often, this occurs even as the rescue or cleanup operations continue. Ensuring privacy for victims as they are released from the hospital, return to work, or begin to make arrangements for funerals or memorial services is critical at this time.
5. **72 hours – Forward:** The details of what happened at the crisis site is now old news, and the news story that is current concerns the funeral services of the deceased. In addition, the crisis story is now old news. In order to continue coverage, the media often tries to put a “spin” on a story to keep it in the news. The media looks for twists, or a new angle by which to present the same information. Issues concerning the lifestyle, social and religious pursuits of the victim, stories about victims who have suffered through similar misfortunes as well as any previous doubts about the employer, business, government agency or whoever is currently being blames for contributing to the crisis, now all surface.

The above time periods are encountered during what might be termed “immediate” crises. When crises occur over extended periods of time, such as in hostage-takings, war, hurricanes and the like, the media has even more opportunity to serve as an educator and also to become more involved in “victim” stories. This was starkly illustrated by the media coverage of the war in the former Yugoslavia. While the victims of war and genocide and dependent upon the media to get the word out about the atrocities that take place and, thus most cooperate willingly with the press, they also are fatigued and beleaguered by the media intrusions.

1. **Managing the Media**

The following overview of media management guidelines represents many

of the lessons CPM has learned in responding to communities in crisis.

1. **During a community crisis it is important to designate one person to serve as a spokesperson** and media liaison for the team. This person should be trained in handling the media and able to state psychological issues facing the community in understandable terms. It is critical to have one voice speak for the team so that consistency is established and the public does not receive confusing information.
2. **Advance preparation is the key to being prepared** for managing the media during a crisis. Before crisis strikes, assemble lists of local and state media contacts. Prepare information that can easily be assembled into press kits in an emergency situation, including the following: the impact of a community crisis, the psychological impact on the victims, rescue workers and the community, and publications that the media can use for background on community crisis, as well as the names of victims and experts who can speak about issues relating to a crisis situation.
3. **Hold a press conference as soon as possible** after the announcement of a tragedy. The goal is to take the offensive and get control quickly by inviting the media to attend and giving them a roadmap of what public policy officials, leaders in the community and you will do in response to the crisis. The media liaison for each agency involved should be identified, and the rules for media coverage should be established, including issues dealing with the privacy rights of victims. A victim service professional should be designated as a resource for expert option to reduce speculation andmisinformation about the psychological issues involved in the crisis. Press conferences should be held daily during the crisis with the intention of focusing the media’s attention on factual information about the tragedy. In the chaos of a community crisis, certain basic technical and logistical concerns about the location and timing of a press conference may be overlooked.
4. **In managing the media during a crisis it is critical to understand the media’s need for information** and to give the media positive, factual information. Offer suggestions on interesting perspectives that the media may want to cover as they search for stories. For example, provide an articulate expert who can describe a victim’s emotional reaction or identify a survivor of a similar crisis who will not be thrown into crisis by speaking to the media.
5. **The more specific and less technical and information, the more likely the media will accurately communicate your message.** Offer prepared statements, if possible, following any press conferences. Develop press release and one-pagers each day as the trauma unfolds that highlight issues you feel should be brought to the community’s attention. Continue to give the media information about resources that are available for help, our role, as well as disaster and trauma specific information.
6. **Although it is impossible to completely protect all victims from the media in the aftermath of a crisis, there are many ways to reduce the trauma,**or what we call the second injury, but the media. Maintaining privacy for the victim is critical. During a crisis, pay close attention to creating a “zone of privacy” whenever and wherever it is possible. Create private waiting areas for family members who may be waiting at hospitals or at the scene of the crisis for information about their loved ones – or worse, waiting for death notification. Create a “zone of safety” around any debriefing sessions so those attending can leave the session without walking straight out into the waiting glare of cameras. This includes making sure there is protection for victims on the way to bathrooms or their parked cars.

Even in a crisis situation, let victims know about their specific rights with respect to the media. Provide victims with the suggested media code of ethics which is published at the end of this chapter. Let victims know the following:

1. They do not have to talk to, pose for pictures or provide photographs to the media;
2. They can choose the time and the place for an interview – it does not have to be immediate or at the media’s convenience;
3. They can refused to answer a question even if they already agreed to discuss the topic;
4. Let victims know that they have the right to ask to review a story before it goes to press or on the news although most media during a crisis situation operate on too tight a deadline for this
5. In addition, quickly teach victims the difference between:
6. “on the record” – when everything they say is subject to publication;
7. “off the record” – when nothing they say should be subject to publication, although unscrupulous reporters may publish it with impunity; or
8. “for background only” – where the information may be used without attribution to the victim.
9. Emphasize that victims should make sure which rules they are being interviewed under prior to answering any questions.
10. Techniques to shield their faces with coast, arms or whatever it takes to prevent the media from filming them;
11. An understanding that no report is your friend when she or he is after a story.
12. **The media liaison/spokesperson need to be well versed in handling the media**and,before responding, should always ask the questions outlined earlier in this section – what happened, to who and why.
13. **Conclusion**

Many representatives of the media do a fine job of recognizing the trauma of survivors of victimization. Others focus on sensationalizing the tragedy that victims survived.

**Chapter Fifteen:**

**Crisis, Caregivers and Stress Reactions**

Caregivers are considered the unsung heroes. Those who serve our community, such as crisis counselors, mental health professionals, nurses, doctors, fire fighters, etc. Many who serve the community are confronted with crisis on a daily basis.

1. **Handling Stress Reactions of Crisis Responders**

Many of those who respond to crisis on a continual basis are repeatedly exposed to traumatic events with a propensity for vulnerability to long-term stress reactions.The most common issue is "Burn-out." The result of burn-out is physical, emotional and mental exhaustion. Crisis responders may begin to wonder as to the purpose of their role with cynicism also impacting their belief as they are exposed to aberrant or evil behavior they never perceived as possible.

1. **Burnout Factors**
2. **Professional who are isolated.**
   * + 1. Crisis responders need to process with other professionals.
       2. Perceived as self-sufficient without the same emotional needs as others.
       3. May be hesitant to share weakness.
       4. Providing continual empathy is emotional and physically draining.
       5. Crisis responders continually give of themselves.
       6. They are available to assist and provide services at all hours.
       7. Crisis responders are bound by an ethical necessity to give of themselves for the need of others.
       8. Crisis responders may feelconflicting emotions in the aftermath of a crisis response feeling gratification mixed with sadness/depression.
       9. Crisis responders may experience the breakdown of idealism as they are in constant view of the negativities that impact life.
3. **Vicarious victimization or countertransference**
4. Countertransference occurs when a crisis responder’s own sustained emotional injuries are revisited as a result of re-experiencing their own trauma due to the sights, sounds, stories, or brought forth by the survivors. The caregiver emotionally takes on the reactions of the victims or survivors.
5. Factors contributing to countertransference include:
6. A recent or similar trauma in the crisis responder’s life.
7. Working with a survivor who has suffered a similar trauma as they have.
8. Comparatives between victim and crisis responder.
9. Physical and emotional exhaustion.
10. **Change of life viewpoint as a result of burnout and vicarious victimization.**
11. Permanentchange in their belief systems that significantly impact feelings, relationships and life.
12. Crisis responders may be aware and think on a daily basis that there is achance of death.
13. Crisis responders may become hyperawareof safety issues.
14. Crisis responders may begin to impose order and control in their life as they continue to view the true level of powerlessness in the world.
15. Crisis responders mayhave their feelings of safety, trust, and purposefulness eroded over time due to:.

* Constant re-exposure to trauma.
* Lack of exposure to positive experiences.
* Lack of nurturing resources.

1. **Compassion Fatigue**
2. Charles Figleydescribes this as secondary traumatic stress reactions in caregivers. The three key features are as follows:
   * + 1. Trauma-specific as other stress reactions are usually the result of an ongoing process.
       2. Symptoms of compassion fatigue are comparative to the symptoms of posttraumatic stress syndrome (PTSD). Dr. Figley suggests that PTSD might be primary traumatic stress syndrome, with compassion fatigue being secondary traumatic stress syndrome.
       3. Symptoms of compassion fatigue may be alleviated with intervention provided immediately
3. Compassion fatigue results when caregivers experience a trauma event through listening to the story of the event, experience the reactions to the trauma through empathetic contact with victim or survivor, and are unable to distance themselves from the event. Without the ability to cognitively provide that distance, they begin to live with the trauma, re-experiencing the event as though it happened to them (NOVA).
4. **Crisis Responder Preparation**

It is imperative to build one's adaptive abilitiesor resiliency in order to minimize risk factors for experiencing daily stressors.

1. **Focus of physical health** 
   * + 1. Healthy diet and a knowledge of nutrition aids in the maintenance of

physical health.

* + - 1. Vitamins and minerals are key for maintaining health.
      2. Fluids assist in the reduction of stress and drinking water.
      3. Regular rest and sleep are for mental functioning and staying.
      4. Regular exercise to keep the body fit.

1. **Emotional Ability**
   1. Develop emotional resiliency through insight and reactions to emotions.
   2. Practicing good communication skills to develop the ability to assess the temperament of others.
2. **Cognitive Abilities**
   * + 1. Learning new skills across all areas contributes to the expansion of being

able to associate with different experiences.

* + - 1. Problem-solving techniques assist in the development of concrete goals and

for future planning.

* + - 1. Clarification of values, biases and prejudices help develop and awareness of

understandingthe possibility of difficult situations and issues.

* + - 1. Memory can be improved through practice and memory aids.
      2. Self-appraisal of their own responses to traumatic events and issues in their

own life.

* + - 1. Managing time and information effectively assists crisis responders cope

better with the chaos inflicted by crisis.

* + - 1. Information management controls the amount of negative information being

viewed or heard and minimizes feelings of being overwhelmed with continual reports of crime and crisis.

1. **Education/Experience**

The most critical factors in resiliency

The act of learning increase self-esteem.

1. **Community and Family Support Access**
   * + 1. Coping well requires strong supportive relationships.
       2. Clarify job assignments to ensure that everyone is aware of what their role is

whena trauma event occurs.

**Chapter Sixteen**

**The Crisis Aftermath**

One of the most challenging things about experiencing a traumatic event is how you feel afterward. You have formed coping strategies to deal with life, and even if you utilized them effectually before an event nothing is ever the same, you are never the same. When a community has been through a number of upheavals, a tragedy will bring people closer together. It is necessary to help those affected go though the emotional process of healing after experiencing the traumatic event. Once the initial mental health assistance is removed, it is imperative to be aware that emotions may surface many months after the traumatic event.

## According to the American Red Cross, in the aftermath of a traumatic event, we can have a variety of reactions, all of which can be common responses to difficult situations.

## I. Recovery Takes Time

## Getting ourselves and our lives back in a routine that is comfortable for us takes time.

## Take care of your safety. Find a safe place to stay and make sure your physical health needs and those of your family are addressed. Seek medical attention if necessary.

## Limit your exposure to the sights and sounds of disaster, especially on television, the radio and in the newspapers.

## Eat healthy. During times of stress, it is important that you maintain a balanced diet and drink plenty of water.

## Get some rest. With so much to do, it may be difficult to have enough time to rest or get adequate sleep. Giving your body and mind a break can boost your ability to cope with the stress you may be experiencing.

## Stay connected with family and friends. Giving and getting support is one of the most important things you can do. Try to do something as a family that you have all enjoyed in the past.

## Be patient with yourself and with those around you. Recognize that everyone is stressed and may need some time to put their feelings and thoughts in order. That includes you!

## Set priorities. Tackle tasks in small steps.

## Gather information about assistance and resources that will help you and your family members meet your disaster-related needs.

## Stay positive. Remind yourself of how you’ve successfully gotten through difficult times in the past. Reach out when you need support, and help others when they need it.

## II. When the Challenges Are Ongoing

Many people have experience coping with stressful life events and typically feel better after a few days. Others find that their stress does not go away as quickly as they would like and it influences their relationships with their family, friends and others.

If you find yourself or a loved one experiencing some of the feelings and reactions listed below for two weeks or longer, this may be a sign that you need to reach out for additional assistance.

 Crying spells or bursts of anger

 Difficulty eating

 Difficulty sleeping

 Losing interest in things

 Increased physical symptoms such as headaches or stomachaches

 Fatigue

 Feeling guilty, helpless or hopeless

 Avoiding family and friends

**Bibliography**

Information for the “Training for Crisis Preparedness & Management for Mental Health” was taken from the following websites and books:

American Counseling Association

<http://counseling.org>

American Red Cross

<http://www.redcross.org>

# Crisis Intervention Handbook (2005): Assessment, Treatment, and Research, Third Edition, edited by Albert R. Roberts, Ph.D.

Egendorf, A., “Hearing People Through Their Pain,” Journal of Traumatic Stress, January, 1995.

National Association of School Psychologists:

<http://www.nasponline.org>

National Association of School Psychologists, PrePare: School Crisis Prevention and Intervention Training Curriculum, Second Edition

National Center for PTSD (Post Traumatic Stress Disorder)

<http://www.ncptsd.org>

National Organization for Victim Assistance (NOVA), (1998). The Community Crisis Response Team Training Manual, Second Edition.

National Aging I&R Support Center, Washington, DC (2005)

Regehr, C. (2001). Crisis debriefing groups for emergency responders: reviewing the evidence. Brief Treatment and Crisis Intervention, 1, 87-100.

Scheingold, Lee (2003), “Active Listening”

Traumatology Pre-Intervention Training Manual: International Traumatology Institute

Un Women, United Nations Entity for Gender Equality and the Empowerment of Women, 2009 <http://www.endvawnow.org/en/articles/1418-intervention-techniques.html>

Waters, J.A. (2002). Moving forward from September 11: a stress/crisis/trauma response model. Brief Treatment and Crisis Intervention, 2, 55-74.