

Caring for Helpers in Disaster Situations: Psychological Debriefing

By A. Dyregrov*

Following a disaster, diverse and comprehensive mental health services are required by all those affected. Needs range from the physical to the spiritual and emotional, depending on the type of disaster. Survivors, and also the bereaved and those involved in helping at the scene of the disaster, or with its victims, should receive support through both short and long-term measures, including information services (telephone hotlines, pamphlets, media releases, public meetings), emergency counselling and support, crisis intervention, psychological debriefings (PD) for workers, community network building, and post-traumatic therapy. This paper describes psychological debriefing exercises for people who have had a direct involvement in a disaster situation. The author details the structure of a PD, as led by personnel from the Centre for Crisis Psychology in Norway, describing the effect it may have on participants, and how it helps alleviate the long-term ill effects often suffered after involvement in a major incident.

Psychological debriefing or critical incident stress debriefing (CISD) is a form of crisis intervention originally developed for use with groups of emergency workers (Mitchell, 1983). Following a disastrous fire at the Caledonien hotel in Kristiansand, Norway in 1986, where 14 people were killed, both on-scene and off-scene disaster personnel were offered psychological debriefing meetings. A total of 25 meetings were held, and around 250 of the disaster workers participated. Since then, such meetings have been used in all Norwegian disasters.

A Psychological Debriefing: What is it?

A psychological debriefing is a group meeting to review the impressions and reactions that survivors, bereaved or helpers experience during or following critical incidents, accidents and disasters.

The meeting aims at reducing unnecessary psychological after-effects.

Elements of a PD

A psychological debriefing is a group meeting arranged for the purpose of integrating profound personal experiences both on the cognitive, emotional and group level, and thus preventing the development of adverse reactions. Ingredients known to be helpful in crisis intervention are utilised in psychological debriefings:

***Rapid outreach:** It is recommended that psychological debriefing for disaster workers is held within the first two days following the disaster. It should not be held on the same day as the event, as both personnel and victims experience various degrees of shock and unreality, and many are still in an altered state of consciousness in which intake and processing of information is different from normal. This is not to say that psychological intervention, including emotional first aid for victims, has to wait until the day after the disaster. On the day of the event there should be crisis intervention to give reassurance about the absence of reactions which is commonly experienced in the primary stages of shock, and also to present the opportunity for verbal expression of the experience. It is important to give workers and direct victims the chance to talk about their impressions and experiences. However, the more structured work-through of the event has to wait until they have assimilated that which they have been part of. This is true for victims and workers alike.

***Focusing on the present:** The focus of the PD is on the present event and its consequences. However, sometimes previous traumas are reactivated and need to be addressed. This is helpful in reviewing the coping efforts that were used then, and whether they could be effective or dysfunctional in the present situation.

***Mobilisation of resources:** The group format is helpful in activating social support resources. The group's internal resources are used for normalising reactions, as well as for support within the meeting and afterwards. In addition, time is allocated for discussing how both family and friends can be mobilised as helpful resources.

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Both in crisis intervention and in psychological debriefings there is a departure from more traditional psychiatric approaches. In fact, in all disaster intervention it seems to be important to organise and affiliate the services outside of psychiatric institutions, and to avoid using labels associated with psychiatry.^{1,2} The emphasis should be that these are normal people who have experienced an abnormal event. The psychological debriefing meeting is not a traditional psychiatric group-meeting in the way it is physically arranged, nor in the way the meeting is conducted.

The author has found the PD format useful for numerous different groups, including: survivors of disasters and near-disasters, bystanders at suicides and disasters, groups of colleagues following worksite accidents or suicides, and for helpers in disasters. The same format has also been used for emergency workers following extremely upsetting "minor" situations, such as shoot-outs, the loss of a fellow worker in the line of duty, tragic deaths of children, and so forth.

Although present knowledge of the emotional after-effects of emergency and service providers following disasters dates back to the 70s, there is considerable resistance within the service organisations regarding psychological after-care of personnel. In the fire disaster in Kristiansand, mental health workers had to "sell" the idea of psychological debriefings to the leaders of the responding organisations. The morning after the fire, mental health representatives met with leaders of most of the organisations that responded to the scene and presented the most recent knowledge about the effects of such disaster work on personnel, describing the content of PD meetings and what they aimed to achieve (i.e. reduced sick leave and turnover and a more rapid return to normal functioning within the organisation).

Experience has shown that in the acute phase following disasters and other traumatic situations, victims, bereaved and helpers are unaware of how long such an experience may continue to affect them, so that to some degree mental health professionals have to impose their help on the affected groups. If such an outreach model is not applied, many victims will be unattended and develop more serious disturbances in the long run.³

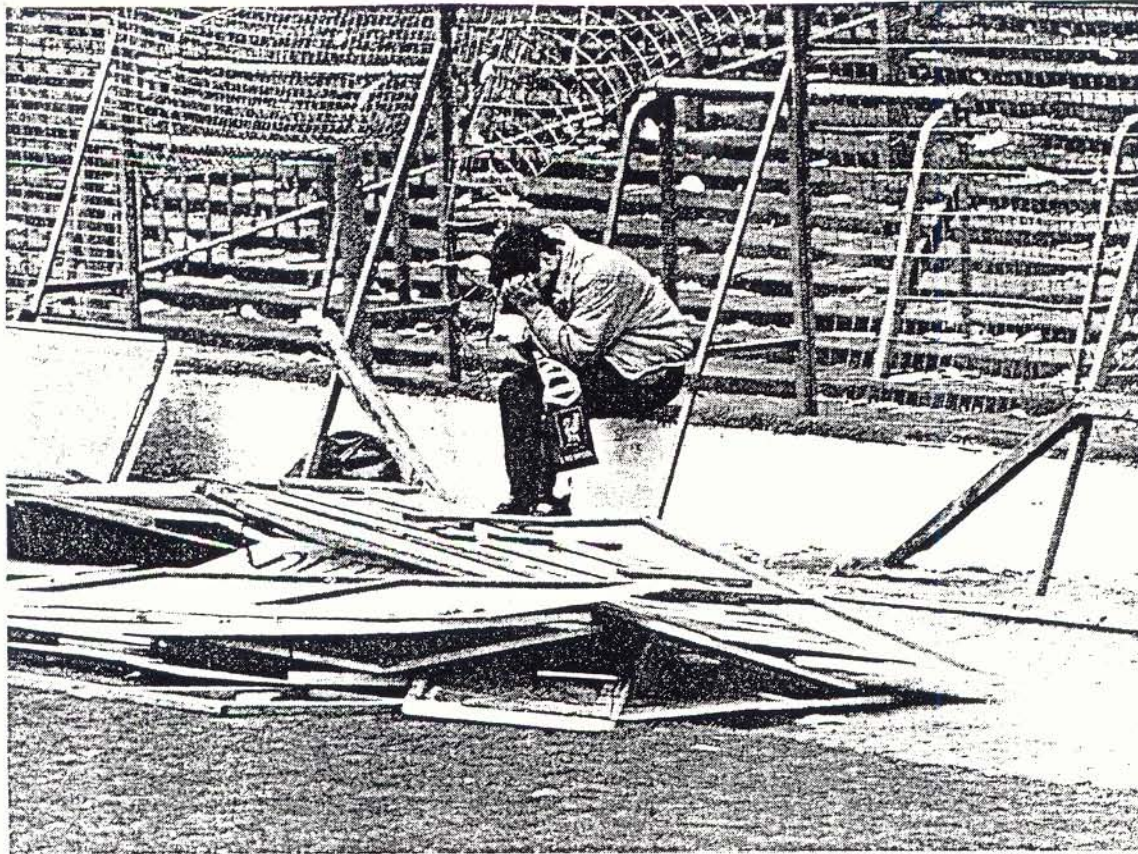
Although the leaders in Kristiansand understood the need to take care of their personnel, some doubted the workers' willingness to participate in such meetings. The police representative, for example, doubted that many policemen would attend. However, following the first debriefing with the police, where nearly half of the involved officers attended, word spread that this was a most helpful way to talk through what happened, and almost all of the remaining officers involved in the disaster work came to the second debriefing meeting.

The way in which the service is presented has a direct effect on the level of attendance. There is a need to stress that psychological debriefing is catering for normal people who in their line of duty have been exposed to strong impressions. Helping leaders to present such meetings in a way that will maximise participation is a task requiring organisational knowledge as well as a degree of salesmanship. Last year, when the Centre dealt with an air crash that killed 36 people and a bus disaster killing 15 people, 12 of them children, the psychological debriefings were presented as part of the normal follow-up of personnel after such an event. When the service is presented like this, as "normal routine", with leaders conveying a clear expectation that their personnel will take part in the meetings which are held in paid time, good attendance level is attained.

Recent Applications

In Kristiansand and some of the other disasters, psychologists, psychiatrists, psychiatric nurses and social workers were given a one hour presentation on how a psychological debriefing should be conducted. The format presented was based on the model for critical incident stress debriefings as described by Mitchell.⁴ Then those of us with experience of conducting PDs acted as team leaders in the first debriefings, each assisted by two local co-leaders from the above mentioned group of less experienced mental health personnel. After being co-leader in a PD the local personnel had sufficient experience to act as leaders in the next debriefing. Although it would have been preferable to give the group more formal training in the debriefing procedure, the disaster situations set constraints on what could be achieved in a short period of time. More recently, the Centre has trained professionals throughout Norway and Sweden on how to work with disaster and emergency workers, to make them better prepared for forthcoming disasters.

In many professional and voluntary emergency organisations use of PD meetings is now integrated into the routine of the unit's personnel assistance following critical events. In the event of a disaster, it is much easier to respond to victims' and workers' needs if mental health aspects have been integrated into disaster plans and disaster drills, and the concept of psychological debriefing has become part of the normal functioning of responding services and agencies in the organisational routine to be followed after certain kinds of events. To give the mental health services organisational validity ahead of critical events is an important part of disaster mental health planning.



1 A survivor of the recent Hillsborough ground crowd crushing disaster, April 15, 1989 in Sheffield, England, sits in the wreckage of the football stadium. The psychological impact of the tragedy on all those involved is thought to be immense, provoking widespread response from mental health professionals. (PA)

Structure of a PD meeting

The structure of PD meetings can be outlined as follows:

- * Introduction
- * Facts
- * Thoughts and sensory impressions
- * Emotional reactions
- * Normalisation/anticipatory guidance
- * Future planning and coping
- * Disengagement

Introduction

At the Centre we regard the opening phase or introduction as possibly the most important part of the meeting. Here the teamleader and co-leaders introduce themselves and outline what will take place in the meeting. Without a good introduction giving reasons about why the meeting is held, motivation for taking part will be low, and participants will be unreceptive. It is essential to build up the participants' expectations, and to take a stance of authority as a group leader. This is done by the group leader giving an outline of his experience in this line of work, as well as relating when such meetings have been used before. It should be stressed how such a meeting helps participants to integrate experiences and reduces their chances of more long-term difficulties. A firm, "mild" leadership, open to the needs of the group, builds trust in the leader and in the process.

Rules

Rules for the meetings are set. Such rules have the function of emphasising the role of the leader, and they encourage further trust in the process as an ordered and structured one. In organisations with a hierarchial structure, rules reduce the anxiety that less structure (such as more traditional psychiatric groups) may evoke. Among the rules are:

- * Participants are not forced to say anything, other than stating how they learned about the event, how they came in contact with the situation, and what their role was.
- * Confidentiality is emphasised. No person outside the session will read or hear about what is said in the session. No note-taking, tape-recordings etc are allowed. Participants are, of course, free to report on their own reactions to others, but not to describe to outsiders what they were told by other participants at the meeting.
- * The meeting is not a critique or a tactical evaluation of what was done. Its main focus lies firmly on the reactions and impressions of those involved.

Usually the participants are warned that in the course of the meetings they may feel worse than before, but that sharing impressions and reactions will reduce problems in the long run. After explaining the rules, each participant presents himself, addressing the questions: How did you learn about the event? How did you come in contact with the situation? What was your role during the event?

Psychological Debriefing Process

- Introduction
 - * introduction of team
 - * rules
- Facts
 - * what happened
- Thoughts and impressions
 - * first thought
 - * decisions
 - * impressions
- Emotional reactions
 - * questions about thoughts lead to answers about feelings
 - * what was the worst about what happened?
 - * accepting reactions
 - * reactions at the scene, and later
 - * emotional, physical and cognitive reactions
- Normalisation
 - * commenting on reactions
 - * anticipatory guidance
 - * advice on helpful coping
- Future planning and coping
 - * mobilising support
 - * family and children
- Disengagement
 - * summing up
 - * follow-up resources

Expectation and Fact

These questions usually bring forward facts about the situation – what the situation looked like, and how time sequences were seen from their perspective. It is important for participants to express what their thoughts and expectations were while responding to the scene, as it provides information on how activated or mentally prepared disaster workers were when they entered the disaster site. In the airline disaster previously mentioned many of the fire personnel thought it was a disaster drill until they saw the bodies and body-parts. The reason for this was that they had taken part in a very realistic, unnotified disaster drill some weeks before. A further example emphasises the contrast between reality and expectations: Personnel responding to a bus-disaster where 12 children were killed in Måbødalen (August 1988) believed they were responding to an incident involving adults or elderly people, as it is mostly older tourists who traffic the steep mountain area by bus. This was reinforced by the fact that some years earlier a bus transporting elderly people had run off the road in the same area. The shock was great when the emergency responders came upon a scene where a school-bus of Swedish children had run into the wall of a tunnel. Dealing with children is known to be among the worst possible stressors for all kinds of disaster workers.

Thoughts and Decisions

When the facts are described, the debriefing-leader can focus on the participants' decisions and thought processes, asking: What was your first thought upon entering the scene or becoming involved in the incident? What did you do? Why did you decide to do that? The last question often brings forward facts about the event which alleviate blame.

In the debriefing following the bus disaster mentioned, where many children were killed, one of the leaders at the scene described the pressure he was under from his superiors in the nearest city. They demanded several times to know how many dead children and adults there were at the scene. He had to order one of his personnel to look at all the bodies several times to get the exact numbers. This caused great stress on the officer involved, who had to examine the corpses. It was only during the debriefing that the rationale behind the officer's gruesome task became comprehensible to him, when he heard his commanding officer give the rationale behind the order. A great deal of relief and understanding developed as a consequence of this.

Although the PD is not a technical debrief, many facts known only to individual members of the group are brought to the attention of others. This makes it easier for the participants to put their own actions into perspective, get a cognitive grip on the situation, and integrate their personal experiences. It also helps to clarify their own and other workers' roles.

Sensory Impressions

At the end of this phase the attention is turned towards the participants' impressions from the scene or event. It is very important to detail all the sensory impressions, as they form the basis of intrusive images and thoughts in the period following the event. What they saw, heard, smelled and touched is specified. If the event involved taste impression, for instance in near drowning experiences (saltwater), this sensory mode is also explored. Examples of the type of impressions that are dealt with at this stage are:

"The stretchers were so light" (indicating that they were bearing children).

"Material things like life-vests, potatoes, teddybears and tape recorders made it so alive, and reminded us that it was people like you and me, and furthermore that it could have been my children."

"I felt the curls of a young child in my hands."

"The smell was horrible, I will never forget it."

"A hand fell down on my back from a tree."

This detailed work-through of sensory impressions is extremely important in individual crisis intervention as well. It seems to be the best way of preventing such memories from gaining intrusive control of consciousness. It also represents a good method of cognitively organising the experience and triggering emotional abreaction and work-through, as it makes the participant confront the experience.

Emotional Reactions

Questions concerning thoughts and impressions often lead to feeling-answers. Personnel describing the decisional conflicts they had to face openly describe the fear and helplessness they experienced:

"I did not know if I was saving lives or taking lives"

"I had to shout that they should remain where they were, that we should save them, but I knew inside we were lying."

By adding questions such as: "What was the worst part of what happened for you?", the team leader gets to the core of the participants' reactions. However, often there is little need for the team leader to interfere with the process during this phase. The participants talk about helplessness, fear, frustration, self-reproach and other reactions. When disaster or emergency workers feel helpless because of lack of equipment or knowledge, or there is nothing they can do or say, they feel particularly vulnerable. It challenges the very core of their job values, where being of help is their principal function and motive. Usually it is the period of relating impressions and reactions which takes up the longest part of the debriefing. It is during this phase that people discover that their reactions are similar to those of others. It also provides them with a model of how to talk about similar and less serious events in the future.

Rather than the team leader making normalising comments when the participants describe different reactions during this phase, normalisation is achieved by asking the participants questions such as: Did others experience this?/did others note the particular smell?

If a member of the group breaks down and cries or is obviously finding the meeting difficult, the group leader stimulates other group members to give support. It is important to mobilise the group's own resources rather than the debriefing team itself providing the support. This can be done by gesturing to the neighbours of the crying person to put an arm around him/her, or by asking the group if anybody would like to say something comforting.

During the reaction phase, the debriefers should take note of any participants who seem to be suffering particularly, or who are very silent, or show any extraordinary symptoms. Such participants can be gently approached after the meeting.

The reactions or symptoms the participants describe are made specific, as the participants are asked to relate emotional, cognitive and physical reactions they experienced at the scene, then when the incident was over and they returned to their station or home, during the night, and now. Often disaster workers experience a great deal of distress in their return to and interaction with their family at home. Just meeting questions such as: "What are we going to have for dinner tomorrow?" "Shall we go to the beach this weekend?" "Why on earth did you have to choose an occupation like that?" makes the workers tense, irritable and sometimes explosive, as the contrast between the life and death issues they have faced at work, and aspects of daily routine is so great. The Centre for Crisis Psychology has increasingly begun to include family in the follow-up of helpers, by arranging meetings where they can attend, by using time in the debriefing to focus on family integration of the event, as well as giving written material to take home to the family members to make them more aware of the needs of the emergency provider. Such work helps mend the conflict between family and work life, and it develops understanding and support within the family.

2 Police try to identify victims of the Pan Am jumbo jet crash in Lockerbie, Scotland - one of the most stressful activities for disaster response personnel. In this instance, debris from the crash was strewn over an area of up to ten miles, so that a large number of people were involved in the search for and identification of victims. (PA)



Normalisation

In the normalisation or anticipatory guidance part of the meeting, the debriefing-leader ties together the impressions and reactions the participants have spoken about. This is done by pointing to the commonality in their reactions, using examples the participants have given, as well as relating the experiences of others in similar situations based on the debriefing-leader's own experience and knowledge from studies on the reactions of disaster workers. This reinforces the participant's feelings of being normal, and makes it easier for them to accept their own reactions. Time is also taken to normalise the coping methods used, such as humour, distancing, dehumanising, focusing on few tasks, activity to prevent reflection and so forth.

Reactions that they may expect to experience in the following weeks, or over time, are then described. Reactions such as intrusive images and thoughts, increased anxiety and vulnerability (especially the fear that something will happen to their loved ones), sleep disturbances, concentration difficulties, irritability, shame or changes in values, etc. are explained as normal reactions that will decrease over time. When describing such reactions, the team leader tells group members that they don't have to react to be normal, but that it's normal to react. By providing those who have been involved in critical incidents with knowledge about what to expect, they are better able to cope with reactions should they emerge. This kind of anticipatory guidance is an important part of all crisis intervention.

Future Planning and Coping

Participants are more active again towards the end of the debriefing when future planning and coping are discussed. Here aspects relating to the mobilisation of support from family, friends and colleagues are discussed. The importance of family (including children) sharing and communication is emphasised, and suggestions are made of ways to handle the comments and reactions of colleagues. Experience at the Centre has shown that much of the additional stress on service providers comes from a recovery environment which does not understand the impact of the work on personnel. This is parallel to the non-supportive responses from the social environment of survivors and bereaved. Although we try to mobilise the social support systems of all afflicted groups, we have to acknowledge that at present such systems are often inadequate as resources following large-scale events, as people seem to draw back, careful not to "be kissed" by the vulnerability of those directly affected.

Disengagement

At the end of a psychological debriefing (disengagement), any unattended areas are discussed, questions can be raised, and information on when to seek additional help is given. Broadly this should be if:

- * symptoms do not decrease after 4 to 6 weeks (if a loved one died, this time sequence is far too narrow)
- * symptoms increase over time
- * one is unable to function adequately in work or family-life
- * one experiences marked personality changes, or this is commented on by others.

Before ending such meetings, it is important that the group members know where to get additional help. They should be given a phone number or address to contact. Often a follow-up meeting is arranged. For emergency workers in the hotel fire in Kristiansand only one debriefing session was conducted. Following the aircraft crash in the north of Norway in May 1988, it became clear that impressions and reactions provoked by disasters are strong enough to warrant follow-up meetings. Following the bus disaster, meetings were scheduled after an interval of three weeks. These meetings were very much appreciated by the participants, although not all personnel felt the need to attend. Although PDs are very helpful in themselves, they should be part of a more comprehensive service for affected workers, a service that should include easy access to individual counselling.

Conclusion

Psychological debriefings accelerate the recovery of normal people experiencing normal reactions to abnormal events. The process can be adapted to different groups affected by a disaster situation. The structured process of going through the facts, individuals' thoughts, then detailed impressions and their resulting reactions, before giving information pertaining to reactions and coping measures, is also a very useful method when employed in crisis intervention on the individual level. Those conducting PDs should be familiar with group processes, with normal reactions to extreme events, with post-traumatic stress disorders, and coping measures which help to integrate and process such events. If done by sensitive and knowledgeable personnel, there is a low potential for doing harm. By providing survivors, bereaved and helpers in disasters with rapid help, and by building on the internal strengths of the affected groups, we may prevent much of the unnecessary pain and agony experienced by these groups.

References

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