Rescuing the Rescuer: Critical Incident Stress Management

By Marie Nordberg - Associate Editor of Advanced Rescue Technology Magazine.

After more than a decade, Christopher Casey, EMT-P, still thinks about the holiday fire where eight children died in a three-family structure. He also recalls the 1990 accident in which two firemen were killed when their vehicle slammed into a tree while responding to a false alarm.

"That was an extended rescue that took several hours," says the Connecticut-based paramedic. "One fireman died before we got him out of the truck. To watch the process take place was very challenging. That event affected the whole community."

Former rescuer Jeff Mitchell, PhD, vividly remembers the China-doll-like face of a young woman who was hit and killed by a dump truck in Howard County, MD.

"Her eyes were fixed open, and, for a long time, that was hard for me to shake away," says Mitchell, president of the Ellicott City, MD-based International Critical Incident Stress Foundation. "It was clearly a dead person, and there was nothing that could be done for her, but the face was etched in my memory, and that image kept coming back again and again."

These are perfectly normal reactions to horrific situations, says Mitchell. Not being able to resolve those feelings, however, may lead to posttraumatic stress disorder (PTSD).

"I use the analogy of a light switch," says Mitchell. "If you turn on a switch, the lights come on; you turn it off, the lights go off. That's normal, as it's normal for human beings to have traumatic stress reactions. With PTSD, the light switch comes on, but it gets stuck in the 'on' position. Critical incident stress is a normal response of a healthy person to an abnormal event."

Tim Pelton, assistant chief with Cheshire Fire Department in East Berlin, CT, uses another analogy to explain critical incident stress.

"Think back to when you were 10 years old, and you fell off your bike and got hurt," he says. "Maybe you haven't thought of that in 30 years, but I just pulled it out of the file cabinet in your head, and it's right there. In emergency services and rescue folks, sometimes their file cabinet gets too full, and they get overwhelmed by significantly emotional events. CISM helps them park that stuff in the file cabinet.

"There are lots of triggers that queue up that file cabinet: visual, auditory, olfactory and so on," Pelton adds. "You might respond to an automobile accident where there's a car seat in back and a 2-year-old who looks just like your daughter. Visual trigger--you crash and burn because this kid could have been yours. The smell of a burned body, the odor of diesel exhaust or lights at an emergency scene can all open the file cabinet."

Rescuer Stress

Because extricating victims from a vehicle or recovering bodies from a downed aircraft require rescue personnel to use technical skills that may not result in physical contact with their victims, is there less emotional involvement than that experienced by EMS personnel? As a rescuer, are you less at risk for traumatic stress? Not at all, says Mitchell. "Medical providers typically get much closer to the victim," Mitchell admits, "and the rescue worker who is focused on tools or procedural tactics doesn't have to focus on the patient, as long as there is an EMT or paramedic to take care of him. But if the patient puts a hand on the rescuer's arm and says, 'Please don't let me die,' all boundary barriers are broken. Another thing that may have real impact is time exposure. The longer you're on the scene with a patient, the more he becomes a real person to you, and then it's much harder to continue without being affected."

Most rescue personnel like to think they can detach themselves emotionally from bad situations by functioning on "autopilot," says Marie Keogh, founder of Trumbull, CT-based Northeast Critical Incident Stress Management Services.

"All of their training comes to the surface, and they go to work at whatever they need to do. Unfortunately, it's the aftermath that takes its toll, when they're sitting back and reviewing what happened. That's when it's important for people to know about critical incident stress and how it may affect them."

What is CISM?

Prior to 1990, critical incident stress management was almost nonexistent, says Christopher Casey. The incident with the firemen peaked his interest in learning everything he could about it and sharing it with others.

"I guess you could say I learned the hard way, with alcohol abuse and other things," he says, "but better late than never. I learned there were alternative methods of dealing with the stress I was being exposed to and having to process as a paramedic, husband and father."

"I'll be overly chauvinistic and say that, 10 years ago, we had a male, macho boys club in emergency services," says Pelton, "and CISM was a hard issue to crack. But after you provide it once, it works forever and ever. The challenge is to make sure the first time works."

Under the umbrella term of critical incident stress management (CISM) are dozens of processes like defusing, debriefing and demobilization, explains Mitchell. The process takes a comprehensive, systematic and multi-component approach.

"That means there are components in place before people get traumatized, including education and systematic planning," he says. "You also have things going on during an incident, such as one-on-one field support, making sure

crews are properly rested, rotating crews from heavy work loads to light work loads to rest, and providing warmth, shelter and enough fluids to prevent dehydration in the field. The components that make up what happens after the traumatic experience include one-on-one defusings, debriefings and demobilization, if it's a large-scale disaster; family support services; follow-up services; and referrals for therapy, if necessary."

Signs of Stress

As in any stressful circumstance, people react differently to a situation, says Mitchell, and some are more emotional than others.

"Once you've completed your mission, the emotional stress may start off with you becoming angry, frustrated that the call didn't go as perfectly as you would have liked, it took too long, there were equipment failures, or you didn't have the right equipment," he says. "Maybe there were surprises during the mission, such as finding unfamiliar reinforcement rods and bars in a newer model car. All of those frustrations come out by people talking about how irritated they are. They may blame it on somebody else or on the equipment, or they may say, 'This got screwed up because of you.' They often aim their anger at people in their own organization--someone they normally have more respect for. Blaming the situation on somebody else when what's going on is beyond anyone's control is called diffuse aggression. That happens a fair amount in the rescue business."

There are also cognitive, physical, emotional and behavioral symptoms, says Mitchell.

"The immediate reactions after a stressful incident may be feeling distracted, or feeling like you're cut off from the rest of your group. You may have dreams or nightmares. If you had good visual contact with the injured party while you were attempting the rescue, you may have memories of the victim's eyes, what the blood was like and the gore. During a recovery operation, you may be able to

suppress your feelings while looking at massively destroyed bodies, but once the mission is complete, there's a replay of it where material that got stored in your brain gets replayed again and again, and you begin to focus on aspects of the incident that you weren't able to focus on while you were doing your job."

Cognitive symptoms include confusion, disorientation on the job, feeling that what you're doing is no longer important, and difficulty concentrating and remembering certain aspects of the event, says Mitchell. Physical symptoms may include hand tremors, chin and lip shakes, headache and stomach distress.

"From an emotional point of view," says Mitchell, "you'll see fear, imagining family members in place of the victim, or feeling sadness because you saw human life lost. Behavioral symptoms include withdrawal from contact with others, over-protectiveness (someone who goes home after an incident, locks up his child's bike and announces that the kid will never ride again), over-alertness to the environment and jumpiness. Those are short-term things. If it doesn't get resolved, either by yourself or with a little assistance, you move to long-term symptoms, and that brings you toward posttraumatic stress disorder."

According to Mitchell, there are six criteria for PTSD:

A horrific, horrible, grotesque, disgusting or frightening event.

Intrusive images--seeing the event again, hearing it, smelling it, tasting it. Seeing the face of an injured child floating in a bowl of soup or hearing a person's voice screaming for help.

Avoidance--avoiding places, conversations, people or experiences that even remotely remind them of an experience.

Arousal--having a hard time shutting down after emergency calls; constantly feeling on edge; looking over one's shoulder and expecting something to happen.

Symptoms that last longer than 30 days.

Significant disruption in normal life pursuits.

Mandatory Counseling?

Opinions differ on whether counseling should be mandated after a traumatic event. How helpful is it if participants are resistant from the outset? How responsible is a rescue agency when an employee who refuses help later develops PTSD?

"I personally feel that you can lead a horse to water, as the old saying goes, but you can't forcibly open someone's mind," says Casey. "I do believe there is limited value to mandatory debriefing, but mandatory in some bargaining agreements means you have to pay people a lot of money to come in for it."

Marie Keogh has mixed emotions.

"My theory is to do no harm, and I believe debriefings absolutely do no harm if done by a trained professional and those who believe in the process, but I don't like the term mandatory. People deal with things in their own way, and going through debriefing may not be their way."

Steve Fleming, EMT, a company officer with Poudre Fire Authority in Ft. Collins, CO, discovered that mandated debriefing elicited a negative response in many of the 130 firefighters in his department.

"We had a trailer fire where two small children died," explains Fleming, who is both a firefighter and trained debriefer. "The division chief, who is very pro-debriefing, pulled the two firefighters who were directly involved almost immediately, while they had a job they felt they still needed to do. We found out later that they were very bitter that they didn't get to finish the scene or bring closure to the job they felt they should have done. That incident led to a very

interesting and educational situation for us in how we viewed debriefing and how we came across to the troops.

"Anytime you put a mandate on just about anything for folks in emergency services, it gets to be a concern," Fleming adds. "Some things obviously have to be mandatory, but when it comes to emotions and feelings, there was a lesson to be learned in all of this. Since that point, we've had several situations where we've requested a debriefing team, but it's been run on a voluntary basis and has been better received."

Mitchell believes that the argument for or against mandatory is ove on either side.

"In the metropolitan Baltimore area, we have five counties and the city of Baltimore combined into one critical stress management team," he says. "In an average year, there are more than 70,000 emergency calls, of which only 25—30 result in debriefing or defusing. Out of that number, only two or three are mandated, usually for suicide of one of our own people, a line-of-duty death, a multi-casualty event, a serious wounding of one of our own during performance of duties, any event that is significantly threatening to personnel, or an event where there is a killing or wounding of an innocent party, such as running over a child while responding to a call. So the number of incidents that are mandated by policy are few, but they're of extreme significance. Mandating is done with the idea that we can get in early to help stabilize the situation and restore people before they are impacted in a way that becomes permanent."

Who should be responsible for making the mandate? Administration, says Mitchell.

"If you have an incident in your company where the employees are shaken, you'd better mandate counseling for them because, if you don't, you have a good chance of being sued for failing to provide help. The really important issue, of

course, is how you sell it. If I tell a group they have to go for help, the response will be, 'No way.' But if I say, 'Folks, this is a horrible event. We know some of you might not need this, but your presence would be helpful to others. We'd appreciate you being there for their benefit, so could you go to help your buddies out?' I'm never turned down, because people always reach out to help someone else. The whole issue with mandating is that some people have blown it into proportions it doesn't deserve."

Assuming counseling is available, who should take advantage of it? Is it more effective on a one-to-one basis or in group sessions? Is there a gender factor in how well counseling is accepted?

"Males do a much better job of openly denying that they're in trouble," says Mitchell. "People who have been in rescue for awhile build up a certain immunity to being traumatized, although I've seen cases where someone responds to 10,000 incidents and number 10,001 does them in. I've also seen some who build up a shell over the years and it takes more to penetrate, but I wouldn't want anyone to get too complacent. Ultimately, everyone is vulnerable to developing traumatic stress reactions. On a standard horrific case, almost everyone reacts, but some react for a brief period of time, some for a bit longer, and a few end up with full-blown PTSD."

As for one-on-one counseling vs. group therapy, each has its place, says Mitchell.

"What you don't want is a single-tactic approach to dealing with posttraumatic stress," he says. "If you take 15 personnel who have been through a horrible event and see them individually in a private office, each one will tell you, 'I'm your worst case, right? Nobody's got it as bad as me. I'm the only one you're calling in, right?' They're shocked when you tell them there are others, because they believe they're isolated and alone, and nobody else is going through what they are. When you put these people in a group and they hear each other say, 'This is

what I'm going through. This is what I'm feeling,' they suddenly realize they aren't the worst case.

"The other thing," says Mitchell, "is that group debriefing is not therapy--never has been, never will be. It's designed to do three things: stabilize the situation within a group; help to accelerate normal recovery processes; and identify individuals who might need more help. So both group and individual work have value--one is not better than the other. It's two different tactics within the overall strategy of CIS management."

"Within emergency services, people seem to be more comfortable in group settings," says Casey. "I guess they feel less threatened knowing their peers are experiencing the same things they are, and they're validated by the lack of uniqueness that they might have associated with it previously."

When scheduling a debriefing session, there seem to be two important factors to consider: Sessions should take place on neutral ground, and at least one "outsider" should be part of the debriefing team.

"I usually try to do debriefings away from the workplace so people aren't distracted," says Keogh. "We were called to a restaurant one time after several employees had been held at gunpoint. They wanted to have the debriefing there, so I asked if they had a separate room and was told that they did. When I got there, they had scheduled the debriefing in the same room where the people had been held hostage, so we moved everyone to the local fire station. You want to have someplace that is free from interruption and from stress."

Fleming is adamant about using impartial debriefers, which avoids personality clashes and embarrassment among coworkers.

"We've had some problems with debriefers trying to help coworkers who flat out didn't want to be helped," he says. "They were extremely devoted and committed

to the service, but we discovered that it was causing some real personality problems. Part of the reason I retired from our own department's CISD team was because I found out I did much better when we were called in by someone in an area I wasn't familiar with, and we were just there to facilitate the guidelines of the debriefing process."

Marie Keogh also prefers neutral facilitators for debriefing activities.

"It's good to have someone who doesn't know the individuals, who may be embarrassed to show their pain," she says. "They think they have to maintain a certain image in front of the people they work with every day, but if they're talking to someone outside the system, they might feel less embarrassed about their behavior."

Preincident Education

There are numerous ways to prepare yourself prior to a traumatic incident, both emotionally and physically, says Mitchell. Good training in the field is top priority, he adds.

"Become a good rescuer, know your skills and abilities, and be familiar with your rescue tools," he advises. "Get to know what resources are available to you and learn about posttraumatic stress so you'll recognize it when it happens.

"Historically, we have found that as we've increased the number of education programs, as well as the number of immediate defusings and one-on-one counseling to emergency operations personnel, the number of debriefings has declined. They don't stop, but the need declines if you've done other things well. People call for help earlier, and help responds faster so they get rid of the effects of the experience, which helps them stay healthy and on the job longer."

Preincident education is paramount, says Keogh.

"The whole theory of CISM is definitely that preincident education is top priority, and that's what we try to do here in Connecticut. When volunteer firefighters or others experience disturbing feelings, they can say, 'This is normal. They said this might happen.' Before an incident, we tell them to practice good life skills. Since Type A personality is so prominent in emergency services, we need to teach relaxation skills and how to communicate openly. We also educate family members, and tell them to give the emergency worker time and space, and to say, 'I know you had a really bad call. I'm here if you want to talk about it, and I understand if you don't.' We tell people to exercise and do things in moderation, and tell them that alcohol is not something to be used when you're going through an incident."

In light of the high number of divorces in emergency services, family education is critical, says Steve Fleming.

"My big push right now is to educate spouses and significant others about the stresses we experience," he says. "Personally, I can tell you that my wife could never quite feel comfortable with my schedule, the risks and having children, and I feel very strongly that spouses need to be educated as much as our employees. A few years ago, our fire department's union got spouses together and had them form a support group, which is especially important during a prolonged operation so they have a way to keep updated on what's going on, and they realize that others are going through the same situation."

As part of pre-incident education, says Tim Pelton, his debriefing teams focus on how to look for signs of stress in a coworker.

"It usually comes down to one concept--significant change in behavior," he says. "Take the guy who is very gregarious, always joking or back-slapping, and he's suddenly shut down, locked out, sitting in a corner and staring at the wall. Or, the meekest, kindest person in your outfit becomes violent and verbally abusive. That's a big, red flag."

Conclusions

Although there is still some resistance to counseling, even long-time employees who think they've seen it all are beginning to see the value in post-incident defusing and debriefing, says Casey.

"A lot of old-timers come up to us and say, 'Gee, I wish you'd been around 27 years ago when we had this terrible accident,'" he says. "They are debriefing themselves many years later. I talked to one paramedic who used to drive 30 miles out of his way to avoid a particular accident site. Left untreated, it does terrible things."

Keogh has seen similar reactions.

"I frequently run into one of the old 'dinosaurs,' who says, 'I don't need this, but I'll be here to see you kids through it.' Then, during the debriefing, he'll bring up a car accident that happened 30 years ago, and he recalls every detail. But I think the new management in fire departments and EMS are well educated in this area and know when to call for help."

"One thing that's helped me over the years is having a good relationship with the people I work with," says Fleming. "We do have the 'firehouse talks,' and that's been a big benefit, but not everyone gets along, so you just need to be open and educated in the beginning and feel comfortable talking about stressful situations. It's also important to have a supportive administration, which offers different ways and means of counseling. Some people really benefit from organized CIS debriefings, and others don't feel comfortable in a group environment, so administration needs to work with all options, including an employee-assistance program so someone can have a confidential visit with a counselor.

"We're even careful about the name we use for our team," he adds. "CISD is what they do, but many of the past events that weren't critical incidents still

needed to be talked about. Our people know what CISD means, but we just try to offer a chance to meet and talk about anything. As far as who should or shouldn't go to counseling, it's all in their own perception."

Talking it out is absolutely essential, agrees Pelton.

"I can't stress enough the need to talk," he says. "I don't care if you talk to your steering wheel, your dog, your partner or your spouse. Part of the whole macho image in emergency services is having this mindset about not taking your work home to the family, but our entire team tells people, 'When you've had a tough call, your kids know as soon your foot hits the door that something is different with Mom or Dad. They aren't sure what and don't understand all the ins and outs, but we strongly encourage everyone to talk to their spouse and kids about the call. The more you talk about an event, the easier it is for you to park it in the right spot. It's having the attitude of, 'I gotta suck it in; I gotta keep it in my gut; I can't talk about it,' for fear of being a wimp or not 'one of the boys' that's self-defeating.

"Look at emergency services folks having heart attacks at age 59 and cirrhosis at age 56," says Pelton. "They're chewing up their bodies over 20 years of service because they didn't park stuff and it literally ate away at them. Every time you talk about an incident, it takes a little more of the load off your shoulders."

Critical incident stress management is good management, concludes Mitchell.

"Good management is taking care of your most important resource: your personnel," he says. "CISM is not a magical thing. It's all about keeping healthy people healthy and strong, and keeping functional people functional."

Marie Nordberg is associate editor of Advanced Rescue Technology Magazine.