Does Utilizing Immediate Crisis Intervention Tools Post Critical Incident Mitigate Short-Term Distress and or Long-Term Negative Psychological Impact on Responders in Complex Emergencies?

Responders to Complex Emergencies

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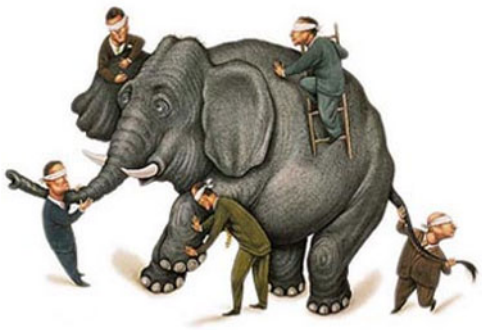
MAHA THESIS JOURNEY

In my decades of military and humanitarian service I witnessed firsthand innumerable tragedies. I often wondered how these horrific sights, unimaginable smells, and overwhelming emotions had not left me inconsolable, depressed, or suffering from posttraumatic stress disorder. No one leaves these scenes untouched, but I had become more resilient, appreciative of life, and resolved to continue to help others through such tragic moments. In hindsight, I see how peers, friends, and strangers had done some forms of acute psychological crisis intervention with me at the right times and mitigated the negative fallout from my experiences.

I endeavored to learn more about what acute psychological crisis intervention tools were effectively being used with relief workers deployed to complex emergencies around the world. To my surprise, research was almost nonexistent. Therefore, I expanded the search to include other responders, such as media personnel, peacekeepers, and United Nations program staff, who deploy to complex emergencies to assist the suffering or publicize their plight to the rest of the world. I discovered more research, but the methodological approaches and areas of focus were vast and often incomparable, leaving many gaps.

The literature review process was akin to the story of the blind men trying to describe an elephant by exploring only one very small part of the large animal. I realized that to answer my thesis question about whether immediate crisis intervention mitigates distress for responders, I would first have to take a step back and describe the whole problem.



Hence, my thesis journey began with describing the complex emergency landscape, the various types of responders, and the inherent stressors, as well as identifying typical critical incidents and some common negative reactions. Second, because virtually no research existed on crisis intervention for responders in complex emergencies, I had to study interventions that occur in other military, law enforcement, and disaster management settings to see what might be applicable and replicable. At the end of my journey, I was not able to fully answer my thesis question due to a lack of randomized controlled trials on crisis intervention with complex emergency responders. Nonetheless, I did paint the elephant so others can continue the journey.

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GLOSSARY

In research conducted across disciplines, cultures, and professions, words in the lexicon are often divergent in both structure and meaning. To ensure clarity throughout this paper, key terms are defined here.

Crisis intervention	According to George Everly and Jeffrey Mitchell, provision of "urgent psychological/behavioral care designed to first stabilize and then reduce symptoms of distress/dysfunction so as to achieve a state of adaptive functioning," or to provide a referral to the next level of care[1]
Critical incidents	Large or small scale incidents that are "beyond the range of 'normal' human experience, even in the context of humanitarian emergency work, because of their power to shock and traumatize staff involved"[2]
Critical Incident Stress Debriefing (CISD)	A seven-phase group crisis intervention component under the integrated approach of critical incident stress management (CISM)
Critical Incident Stress Management (CISM)	A multicomponent, comprehensive, systematic, and integrated range of crisis support services that are available before, during, and after critical incidents
Defusing	A small-group crisis intervention component under the integrated approach of CISM; practiced off-scene within twelve hours of a critical incident or traumatic event and designed specifically for emergency service personnel
First responders /Emergency service personnel	Police officers, fire fighters and emergency medical technicians within the United States; here called emergency service personnel to differentiate them from other responders who are discussed in this paper
Operational debriefing	Factual or evaluative briefing for military and paramilitary organizations following a particular operation, deployment, or incident
Psychological crisis	A reaction to a stressor that Caplan characterizes as having three main components; "1. Disruption to the balance between one's thinking and emotions, 2. A failure of one's usual coping mechanisms and 3. Evidence of significant distress, impairment or dysfunction"[3]

[1] T.C. Neil, J.E. Oney, B. Thacker and W. Reichart, *Emotional First Aid* (Louisville, KY: Kemper Behavioral Science Associates, 1994); George S. Everly, and Jeffrey T. Mitchell, *Integrative Crisis Intervention and Disaster Mental Health.*

[2] UNHCR, *Managing the Stress of Humanitarian Emergencies* (UNHCR Staff Welfare Section, Division of Human Resource Management UNHCR HQ, 2001, Reprinted 2005), 15.

[3] Jeffrey Mitchell, George Everly and Daniel Clark, *Strategic Response to Crisis,* (Ellicott City, MD: International Critical Incident Stress Foundation, 2006), 11; G. Caplan, *Principles of Preventive Psychiatry* (New York, NY: Basic Books, 1964).

Psychological First Aid (PFA)	According to the Institute of Medicine, "A group of skills identified to limit distress and negative health behaviors, PFA generally includes education about normal psychological responses to stressful situations and traumatic events; skills in active listing; understanding the importance of maintaining physical health and normal sleep, nutrition, and rest; and understanding when to seek help from professional caretakers"[4]
Responders	For this paper, United Nations peacekeepers and humanitarian program staff, the media, ICRC and nongovernmental organizations personnel
Psychological debriefing	Traditionally and with crisis intervention models, formal, structured discussion in groups about facts, thoughts, impressions, and reactions related to a critical incident; according to the Cochrane reviews, a single individual crisis intervention

[4] Institute of Medicine, "Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy," *The National Academy of Sciences*, (2003): 7.

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Undertaking such an intricate thesis topic in less than six months, while completing a full master's degree course load and balancing a plethora of competing demands, would not have been possible without the support of many:

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- All those who entrusted me with their personal stories of traumatic events from working in complex emergencies and for describing the needs and gaps in service.

- Colonel Charles Woods and others who taught me innumerable crisis intervention skills well over a decade ago, which have permitted me to be a candle's light during some of the worst times of people's lives; these precious moments have allowed me to combine personal experience with academic research while writing this thesis.

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- My thesis advisor, Dan Maxwell, who encouraged me and patiently helped me to weave the cross-disciplines and limited research into something tangible and understandable; in addition, Karen Jacobsen, who helped me conceptualize my thesis and reminded me that it is not just about the conclusion but also about the journey.

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- My husband, who gave endless love, support, and sacrifice of time over the last few months, and my parents, who taught me never to give up even when things seem insurmountable; they deserve a very special thanks.

We may not have found an empirically validated answer about the effectiveness of psychological crisis intervention with responders in complex emergencies, but we have laid a stronger foundation on which others someday hopefully will build.

PREFACE

Politically complex emergencies, "characterized by massive bloodshed and displacement, and often disease, malnutrition, and starvation,"[5] are prevalent around the world. In today's wars, civilians are no longer just potential victims of collateral damage, they are often the targets. "The tactic is scaring civilians; the tactic is killing or expelling civilians."[6] The Carnegie Commission reported that 90 percent of those killed in the conflicts of the 1990s were civilians, compared to 15 percent at the start of the twentieth century.[7] In 2010, the United Nations High Commissioner for Refugees reported that there were 27.5 million internally displaced persons and 15.4 million refugees in the world needing food, shelter, and health care.[8]

The increase in asymmetrical and unorthodox warfare, the rise of civilian casualties, the high number of internally displaced people, food security challenges, and natural disasters have created overwhelming needs that have exceeded the capacity of any one group to address and have required a "multiplicity of organizations" to respond.[9] The 2011 Global Humanitarian Assistance Report estimates humanitarian assistance to be a $16.7 billion industry employing several hundred thousand people.[10] Comprising United Nations (UN) peacekeepers, personnel from the International Committee of the Red Cross (ICRC), staff of nongovernmental organizations and UN humanitarian programs, and members of the media, these responders deploy with the earnest intent of assisting suffering people and publicizing their plight to the rest of the world. They are not left untouched by the experience.

This paper seeks to answer the question: Does utilizing immediate crisis intervention tools post–critical incident mitigate short-term distress and long-term negative psychological impact on responders in complex emergencies?

Part I opens with a description of the humanitarian landscape and the multifaceted players responding to complex emergencies.

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[5] Thomas G. Weiss, *Humanitarian Intervention: Ideas in Action* (Cambridge, UK: Polity Press, 2010), 62.
[6] *Women War and Peace: War Redefined,* PBS, 3:19-3:55. http://video.pbs.org/video/2165993549 (accessed February 1, 2012).
[7] Carnegie Commission on Preventing Deadly Conflict, P*reventing Deadly Conflict: Final Report* (Washington, DC: Carnegie Commission on Preventing Deadly Conflict, 1998), II.
[8] UNHCR, *2010 Global Trends* report. http://www.unhcr.org/4dfb66ef9.html (accessed January 1, 2012).
[9] T. G. Weiss, and P. J. Hoffman, "The Fog of Humanitarianism: Collective Action Problems and Learning-Challenged Organizations," *Journal of Intervention and State Building* No. 1, (2007): 55.
[10] GHA Report 2011, Global Humanitarian Assistance: A Development Initiative, 2011, 10. http://www.globalhumanitarianassistance.org/wp-content/uploads/2011/07/gha-report-2011.pdf (accessed March 1, 2012).

Chapter 1 illustrates the seismic shift in the war-related international humanitarian landscape, from Red Cross founder Henry Dunant's actions in the Battle of Solferino to modern-day complex political emergencies, in which nonstate actors target civilians. These conflicts lead not only to injuries, but also to food shortages, forced migration, and loss of livehoods. The chapter also describes how natural disasters can magnify the devastation in complex emergencies.

Chapter 2 describes the multiplicity of organizations responding to the humanitarian crises resulting from complex emergencies. It presents the evolution from Dunant's local volunteers to a $16.7 billion industry with a multiplicity of players. Specifically, this chapter discusses the mission, composition, and contribution of four types of complex emergency responders, including UN peacekeepers, media personnel, nongovernmental organizations/ICRC and UN programs.

Chapter 3 presents the dynamics of stress and subsequent reactions, and anatomizes the taxonomy of stressors inherent in complex emergencies, illustrating the demands placed on responders. Specifically, the chapter addresses personal/existential, environmental, organizational, and secondary stressors, all of which can contribute to cumulative stress. Nineteen types of critical incidents—that is, extreme stressors—within complex emergency settings are identified, and they are placed into two categories: critical incidents where responders or their colleagues were directly affected, and critical incidents arising from witnessing traumatic events directly affecting others. Understanding the stressors and subsequent reactions are essential in developing a response.

Chapter 4 discusses the mental health implications of working in complex emergencies. This chapter explores in detail the threats and actualities of the types of critical incidents described in Chapter 3. This chapter also describes in more detail the forms of temporary and long-term impairment that can arise from exposure to complex emergencies.

Part 2 examines the evolution of crisis intervention methodologies that have been adapted across professions. The examination reveals which crisis intervention principles, practices, and models may be applicable among responders working in complex emergencies.

Chapter 5 explores the anatomy and historical roots of crisis intervention strategies that have been developed to address acute and long-term impairment resulting from distress following a critical incident. The chapter describes crisis intervention methods used by the complex emergency responder population but notes that little research has been conducted in complex emergency settings. Therefore, the chapter places particular emphasis on the advancement of crisis intervention principles and models among military personnel, first responders, civilian crisis workers, and staff of disaster response organizations—all of whom deal with threats and critical incidents similar to those faced by responders to complex emergencies. The review of these other organizations and groups may help researchers to determine which models/approaches may be replicable and applicable to the complex emergency responder population. The chapter concludes with a review of the findings of a 2002 symposium that provided guidance on the relevance and effectiveness of various crisis intervention principles and models. The findings were reached through discussions, evaluations, and consensus among respective field experts; they solidified past conclusions and aided in the development of recommendations for moving forward.

Chapter 6 presents a strategic planning framework for determining, on the basis of the dynamics of various critical incidents, which crisis intervention models and approaches discussed in Chapter 5 may be beneficial for responders in complex emergencies. One example is that of a situational assessment planning framework and response for workers who have been involved in the critical incident of unearthing mass graves. The chapter details four crisis intervention components or approaches that may be relevant in addressing many of the nineteen types of critical incidents detailed in Chapter 3 and that incorporate the elements identified in the post-9/11 symposium discussed in chapter 5. Two of these four components are designed for individual crisis intervention: Psychological First Aid and SAFER-R. The other two components are designed for group crisis intervention: Defusing and Critical Incident Stress Debriefing.

Chapter 7 looks at three Cochrane Collaborative meta-analyses of studies of acute psychological debriefing and at the underlying randomized controlled trials that contributed to these analyses. The chapter gives particular emphasis to studies that cite renditions of the Critical Incident Stress Management components mentioned in Chapter 6,

critiques the methods employed in both the individual studies and the overall meta-analyses, and notes lessons from the research that are relevant for acute crisis intervention overall. Ideas are gleaned from the various methodologies employed in the studies and meta-analyses that may be helpful in the conduct of future randomized controlled trials of acute psychological crisis intervention with complex emergency responders. This chapter concludes with an assessment of the extent to which the Cochrane findings are relevant for similar crisis intervention components used with complex emergency responder populations.

Chapter 8 explains the operational implications flowing from the findings of the Cochrane reviews and discusses how these findings influenced the crisis intervention field, especially in the case of the many models and components that contain a debriefing element within their name or approach. The findings from the randomized controlled trials trumped decades of observational research conducted by experts in the field. This chapter emphasizes the implications that the Cochrane reviews' recommendation against debriefing had for the complex emergency field. Specifically, the chapter discusses the Sphere Handbook's warning on psychological debriefings and a decision by the United Kingdom's largest travel health clinic to discontinue debriefing with the aid workers they serve. Finally, the chapter discusses subsequent meta-analyses that used many of the studies cited in the Cochrane reviews, including one conducted by the National Institute of Clinical Excellence.

The paper's concluding statements address challenges and gaps, and make future recommendations for crisis intervention research on psychological support for responders in complex emergencies.

Battle of Solferino, Felice Cerruti-Bauduc, 1859

On the evening of June 24, 1859, following the Battle of Solferino, Henry Dunant, a businessperson from Geneva, Switzerland, came across a field littered with over 6,000 dead and 30,000 wounded soldiers. The wounded soldiers were suffering immensely, with no one to come to their aid. He described the scene of "poor wounded men, . . . ghostly pale, exhausted, badly hurt, . . . some who had gaping wounds already beginning to show infection, were almost crazed with suffering. They begged to be put out of their misery; and writhed with faces distorted in the grip of death's struggle."[11] Helping the physically wounded, let alone the psychologically wounded, was an afterthought in a strategy of war that resulted in thousands succumbing to their injuries. Aghast at the horrific scene, Dunant was propelled into action.

Humanitarianism's Inaugural Moment

Central to Dunant's actions following the Battle of Solferino in June 1859 were the ideals of neutrality and impartiality.[12] In what Michael Barnett and Thomas Weiss refer to as the "inaugural moment in war-related international humanitarianism,"[13] Dunant gained protected access to the injured under the ideal of tutti fratelli (all brothers now). Dunant galvanized local Italian women, tourists, and others to voluntarily tend both the Austrian and the French soldiers' wounds without regard for their nationality, race, religious beliefs, class, or political opinions.[14] Dunant's ideals would become some of the fundamental principles in the creation of the Red Cross and Red Crescent movement and would contribute significantly to the development of international humanitarian law and the laws of armed conflict.

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[11] Caroline Moorehead, *Dunant's Dream: War, Switzerland and the History of the Red Cross* (New York, NY: Carroll and Graf Publishers, Inc. 1998), 2-3.
[12] Peter Walker and Daniel Maxwell, *Shaping the Humanitarian World. Series on Global Institutions* (London, UK: Taylor and Francis, Inc. 2009), 22.
[13] Michael Barnett and Thomas G. Weiss, *Humanitarianism Contested: Where Angels Fear to Tread* (New York, NY: Routledge, 2011), 38.
[14] Caroline Moorehead, *Dunant's Dream: War, Switzerland and the History of the Red Cross*, 4-6.

Conflict in the Late Twentieth Century

Unfortunately, in the latter portion of the twentieth century seismic shifts occurred in the way conflicts were waged. International battles between sovereign nations fought by uniformed, professional soldiers with distinct front lines, as at Solferino, gave way to intrastate conflicts within weakened or failed states, with nonstate actors, including warlords and child soldiers, engaging in combat. These new kinds of fighters were very different from the professional warriors of the past, who were guided by codes of honor, laws of armed conflict, and rules protecting civilians. In today's wars, civilians are no longer just potential victims of collateral damage, they are often the targets. "The tactic is scaring civilians; the tactic is killing or expelling civilians."[15]

Following the Cold War, stockpiles of easy-to-use weapons were sold on the black market, allowing any belligerent group to wage war at a minimal cost. A half dozen children armed with AK-47s and rocket-propelled grenades now possessed the "equivalent firepower of an entire Napoleonic infantry"[16] and could ravage an entire village within an hour. Killing became "intimate"[17] as civilians were shot at close range or killed with the slice of a machete. Even more horrifying than the killings were the severe injuries to those who became the walking wounded, with amputations, branding scars, and severe disfigurement. These acts of terror invoked fear and helplessness among the general population.

Rapes of women and girls became common weapons of war and led to unwanted pregnancies, sexually transmitted diseases, and extreme demoralization. Today's battlefields have few front lines and no designated times of truce. Battles can ignite anywhere without warning by the spark of a word. Human rights abuses stain the fabric of these conflicts, and the effects on civilians are often "not temporary but protracted states of disorder,"[18] with disruption to food supplies, decapitation of health care infrastructure, internal displacement, and loss of livelihoods. All of these lead to complex emergencies.

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[15] *Women War and Peace: War Redefined,* PBS, 3:19-3:55. http://video.pbs.org/video/2165993549 (accessed February 1, 2012).
[16] P. W. Singer, *Children at War* (Berkeley, CA: University of California Press, 2006), 47.
[17] *Women War and Peace: War Redefined,* PBS, 4:00-4:30. http://video.pbs.org/video/2165993549 (accessed February 1, 2012).
[18] P. W. Singer, *Children at War*, 52-53.

Complex Emergencies

"Political complex emergencies, characterized by massive bloodshed and displacement, and often disease, malnutrition, and starvation,"[19] are prevalent around the world and require outside intervention for multiple stakeholders and responders. The Carnegie Commission reported that 90 percent of those killed in the conflicts of the 1990s were civilians, compared to 15 percent at the start of the twentieth century.[20] In 2010, the United Nations High Commissioner for Refugees reported that there were 27.5 million internally displaced persons and 15.4 million refugees in the world needing food, shelter, and health care.[21] Camps are set up to provide temporary shelter and food for the millions of refugees and internally displaced people. The populations of these camps can exceed ten thousand people on a few acres of land. Overcrowding and poor sanitation in the camps foster outbreaks of cholera, dysentery, measles, and meningococcal meningitis, resulting in high death rates.

A heart-wrenching process of triage and concerns for the security of staff occur when refugee camps rapidly grow beyond capacity, as did the Dadaab refugee complex in Kenya, where the population reached nearly half a million in 2011, exceeding the camp's capacity by 270 percent.[22] The majority of this population had fled famine, food shortages, and security concerns in neighboring Somalia.[23]

Somalis who were unable to cross over the borders into neighboring countries remained at the mercy of Al Shabaab, an armed group that controls population movement and limits access to outside responders. The UN and humanitarian agencies postulated that the lack of access contributed to tens of thousands of civilian deaths from malnutrition, starvation, and opportunistic diseases.[24]

A New York Times article states for every violent death resulting from the war in the Congo, sixty-two nonviolent deaths occur from the conditions created by the war.[25] It is

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[19] Thomas G. Weiss, *Humanitarian Intervention: Ideas in Action*, 62.
[20] Carnegie Commission on Preventing Deadly Conflict, P*reventing Deadly Conflict: Final Report*, II.
[21] UNHCR, *2010 Global Trends* report. http://www.unhcr.org/4dfb66ef9.html (accessed January 1, 2012).
[22] United Nations High Commissioner on Refugees. http://www.unhcr.org/refworld/country,,OCHA,,KEN,456d621e2,49a656866,0.html (accessed, January 1, 2012).
[23] United Nations High Commissioner on Refugees, 2012 UNHCR country operations profile – Kenya Working environment. http://www.unhcr.org/pages/49e483a16.html (accessed January 1, 2012).
[24] Clar Ni Chonghaile, "Al-Shabaab bans aid agencies in Somalia and raids offices." *Guardian* online, November 28, 2011. http://www.guardian.co.uk/world/2011/nov/28/al-shabaab-bans-aid-agencies-somalia, (accessed January 1, 2012).
[25] UN News Center, *"UN Condemns al-Shabab Raids and Humanitarian Aid Ban."* UN, August 26, 2011. www.un.org/apps/news (accessed January 1, 2012).

imperative for those assessing the negative consequences of war to expand their focus beyond those directly injured or killed and to include as victims those also affected by food shortages, forced migration, lack of health care, degraded infrastructure, and broken social support systems.

Natural Disasters

Natural disasters took the lives of 295,000 people, displaced millions, and caused an estimated $130 billion dollars in damage across the globe during 2010.[26]

Just into the new year, on the evening of January 12, 2010, a magnitude 7.0 earthquake devastated Haiti, an already fragile state suffering from environmental degradation, high unemployment, food shortages, and remnants of other natural and political disasters. The Haitian earthquake affected 3.5 million people, took the lives of 220,000, injured 300,000, and left at its peak 2.3 million homeless.[27]

Later, in July 2010, heavy monsoon rains flooded one-fifth of Pakistan's land area, affecting an estimated 20 million people.[28] Pablo Suarez of the Red Cross/Red Crescent Climate Centre states, "There are more disasters, there are more frequent disasters, there are more bizarre disasters."[29]

The increasing number of people living in extreme poverty, projected population growth, rapid urbanization, and displacement and other forced population movements will magnify the devastation flowing from future natural disasters. Some scientists theorize that natural disasters will increase in number and severity due to the effects of climate change.[30] Earthquakes, floods, droughts, tsunamis, and volcanoes wreak havoc on their own, but combined with preexisting dire circumstances, the damage from these events can become even more catastrophic, affecting the response of multiple organizations.

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[26] Munich Re, *Overall picture of natural catastrophes in 2010 – Very severe earthquakes and many severe weather events* (Munich Re, 01/03/2011. http://www.munichre.com/en/media_relations/press_releases/2011/2011_01_03_press_release.aspx (accessed January 1, 2012).

[27] OCHA, Haiti Jan 12th Earthquake Key Facts and Figures. ochaonline.un.org (assessed April 1, 2012).

[28] *The International Monetary Fund says the floods which have devastated Pakistan will present a massive economic and political challenge to its government and people,* Radionz.co.nz. http://www.radionz.co.nz/news/world/54885/pakistan-floods-seen-as-massive-economic-challenge-imf (assessed April 1, 2012).

[29] Pablo Suarez, Red Cross and Red Crescent Climate Centre speaking about Climate Adaptation at the 5th International Conference on Community Based Adaptation to Climate Change in Dhaka, Bangladesh. http://www.youtube.com/watch?v=3LjR85laZmc&feature=relmfu (accessed May 1, 2012).

[30] *Climate Change Report: Miami, Mumbai Must Prepare For Natural Disasters Now*, *Huffington Post* online: http://www.huffingtonpost.com/2012/03/29/climate-change-report-miami-mumbai_n_1385173.html (accessed May 1, 2012).

The increase in asymmetrical and unorthodox warfare, the rise of civilian casualties, the high numbers of internally displaced people, food insecurity challenges, and natural disasters have created an overwhelming need exceeding the capacity of any one group to address. A "multiplicity of organizations" is required to respond.[31] Dunant's ideal of assisting those in need has mushroomed into what the 2011 Global Humanitarian Assistance Report estimates to be a $16.7 billion industry.[32] This includes a plethora of new responders with multifarious objectives and varying ideas and principles working in arduous and sometimes dangerous conditions.[33] The primary responders discussed in this paper are from UN humanitarian programs, UN peacekeeping forces, international nongovernmental organizations (NGOs), ICRC, and media personnel.

United Nations Humanitarian Programs and Peacekeeping Forces

The United Nations comprises multiple humanitarian programs with mandates that include meeting the emergency needs of vulnerable populations.[34] Its World Food Programme, "the world's largest humanitarian agency fighting hunger worldwide," serves 90 million beneficiaries in 73 countries and annually provides an average of 3.7 million tons of food.[35] The UN High Commissioner for Refugees assists more than 10 million refugees and 14.4 million internally displaced people.[36] The United Nations Children's Fund (UNICEF) endeavors to improve the education, health, and rights of children in 190 countries.[37] The

[31] T. G. Weiss, and P. J. Hoffman, "The Fog of Humanitarianism: Collective Action Problems and Learning-Challenged Organizations," 55.
[32] GHA Report 2011 (Global Humanitarian Assistance: A Development Initiative, 2011) 10.
[33] T. G. Weiss, and P. J. Hoffman, "The Fog of Humanitarianism: Collective Action Problems and Learning-Challenged Organizations," 55.
[34] Kris Heggenhougen and Stella Quah, Leaning J Disasters and Emergency Planning, International Encyclopedia of Public Health, Vol. 2 (San Diego, CA: Academic Press; 2008), 204-215.
[35] World Food Programe: Our Work. http://www.wfp.org/our-work (accessed January 1, 2012).
[36] United Nations High Commissioner on Refugees. http://www.unhcr.org accessed (January 1, 2012).
[37] United Nations Children's Fund. http://www.unicef.org/about/who/index_introduction.html (accessed January 1, 2012).

combined effort of these multinational, multifaceted programs cover the four corners of the world as the programs continually navigate conflict, cultural and logistical divides.

As of November 30, 2011, the UN Department of Peacekeeping Operations had actively participated in sixteen peacekeeping operations throughout the world, including operations in Haiti, Côte d'Ivoire, Sudan, Syria, Afghanistan, and southern Asia's Timor-Leste.[38] A compilation of 121,272 troops, police, military observers, and civilians from 115 countries[39] make up this multinational mosaic that is charged with "assisting the Member States and the Secretary-General in their efforts to maintain international peace and security."[40]

Former UN secretary-general Dag Hammarskjöld noted that "Peacekeeping is not a soldier's job, but only a soldier can do it."[41] Representing around 82 percent of the peacekeeping force, [42] these soldiers do work that is in stark contrast to their training and experience. They are asked to be diplomatic, impartial, and neutral and to show restraint in the use of force in the face of unimaginable atrocities.[43] Intrapsychic conflict arises through "incompatible or opposing" impulses in many situations,[44] such as when a peacekeeper is unable to intervene to stop armed militias from ravaging an entire village, as happened in the Sudan, or is unable to stop genocide, as happened in Rwanda.

QUOTES FROM THE FIELD

"As a UN civil servant, I was not prepared for the inhumanity of man. My education at the University had taught me the legal provision of human rights and humanitarian law, and my subsequent work at UN headquarters guided me to an intellectual comprehension of humanitarian disaster areas. Neither taught me the dynamics of war. Those lessons can only be experienced the moment we face the gruesome reality of cruelty and desolation."

Transformed by the Front Line, by Yasmine Sherif (Danieli, 2002, 62)

"We are going to stay to bear witness to what the rest of the world does not want to see."

General Romeo Dallaire (*Hotel Rwanda,* film, 2004)

"The elastic band gets stretched but it never comes back to where it was before. You are never the same as before."

Peacekeepers and Peace-Builders Under Stress, by Bev Wright (Danieli, 2002, 11)

[38] UN Peacekeeping Operations Fact Sheet, November 30, 2011.
[39] Ibid.
[40] UN Peacekeeping: Department of Peacekeeping Operations. http://www.un.org/en/peacekeeping/about/dpko/ (accessed January 1, 2012).
[41] Thomas W. Britt and Amy B. Adler, *The Psychology of the Peacekeeper: Lessons from the Field* (Westport, CT: Preger, 2003), 79.
[42] UN Peacekeeping Operations Fact Sheet, November 30, 2011.
[43] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst* (Amityville, NY: Baywood Publishing Company, 2001), 31 (*Studies on Military Peacekeepers*, Jos M. P. Weerts, Wendy White, Amy B. Adler, Carl A. Castro, Gielt Algra, Inge Bramsen, Anja J.E. Dirkzwager, Henk M. van der Ploeg, Maaike de Vries and Ad Ziljlmans).
[44] Medical Dictionary, Free Online Dictionary defines intrapsychic conflict between incompatible or opposing wishes, impulses, needs, thoughts, or demands within one's own mind. http://medical-dictionary.thefreedictionary.com/intrapsychic+conflict (accessed January 1, 2012).

Having been forced to watch and not act, peacekeepers report feeling as though they were contributing to the atrocities. Former BBC war correspondent Martin Bell talked about the futility felt by the press and peacekeepers in Sarajevo: "They're watching the explosions, I am counting the explosions, we are making no difference."[45]

QUOTES FROM THE FIELD

"Modern air travel made it possible for me to be in Sarajevo, taking photographs of a front-line trench and city morgue in the morning and by evening be back in London drinking a glass of wine with a friend. That is a long way for the mind to travel."

Do Not Go If You Cannot Deal with the Consequences, by Gary Knight (Danieli, 2002, 283)

"If you were going to make really good images that day, something would have to happen; people would have to be hurt or killed."

Journalist Under Fire, by Anonymous (Feinstein, 2006, 26)

"Unlike other emergency responders who rush to tragedies to help, we run in to record. The ethics of our profession mandate that we do not intervene."

The Chance to Cry, by Frank Smyth (Danieli, 2002, 292)

"It's hard to wear a flak jacket when the people you are reporting are not."

Martin Bell, Former BBC Reporter, *Dying To Tell the Story,* film, (1998)

Nongovernmental, Humanitarian and Faith-Based Organizations

Scores of NGOs and faith-based organizations and the International Red Cross and Red Crescent Movement operate in almost every major complex emergency around the world. Humanitarian workers can be generalists or can be specialists working in any one of a broad range of disciplines. Missions include famine relief, response to natural disasters, refugee aid, human rights monitoring, and the unearthing, identification, and examination of mass graves. Some humanitarian workers implement specific relief efforts, while others work in development, education, peace building, economics, arms control, and election monitoring.[46]

Due to the diversity of agencies and organizations and the different methods of collecting and analyzing data, it is difficult to determine the total number of individuals currently working in this field.[47] In 2008 Abby Stoddard estimated that there were 595,000 humanitarian workers

[45] Kyra Thompson, Director, *Dying to Tell the Story (USA:* Turner Original Productions, VHS, 1998).
[46] Lisa McKay, updated by Dr. Rick Williamson, May 2011, *Helping the Helpers: Understanding, Assessing, and Treating Humanitarian Workers Experiencing Acute Stress Reactions* (Headington Institute, 2011), 4.
[47] Peter Walker, Feinstein International Center, Tufts University and Catherine Russ, RedR UK, "Professionalising the Humanitarian Sector A Scoping Study," Elrha, April 2010. https://wikis.uit.tufts.edu/confluence/download/attachments/36110654/Professionalising_the_humanitarian_sector.pdf?version=2 (accessed May 1, 2012)

and peacekeepers.[48] The majority of today's humanitarian workers are professionals whom Lisa McKay and Rick Williamson describe as "embracing this not only as a profession, but as a lifestyle and ultimately culture," unlike the "short term traditional volunteers of the past."[49] M. Janz and colleagues state that two-thirds of humanitarian personnel work in environments of security risk, and one-third work in hazardous-duty assignments.[50]

Some emergencies, like natural disasters, can provoke responses by myriad nontraditional humanitarian agencies and volunteers. This was evident with the thousands of organizations that responded to the 2010 earthquake in Haiti. In many instances nontraditional agencies are not adequately experienced in complex emergency response. They often lack psychosocial support mechanisms and are staffed with temporary workers or volunteers.

National Relief Workers

An estimated 90 percent of aid and relief workers are locals hired from the affected area. In high-threat areas, the percentage may increase due to security concerns and remote management. Local hires may participate in humanitarian work for personal reasons or as a means of obtaining employment to support a family when few other opportunities exist. Their incomes may make them targets for robbery, and their association with international agencies may make them targets for assault or murder.

Differences in culture, language, and remuneration may lead to friction between national and international staff.

QUOTES FROM THE FIELD

"After the war special doctors called psychologists came and told us we were suffering mental health problems. They made us sit in chairs and listen to facts, and tell them of events that had happened to us. This was very uncomfortable. In my village, when we think of such things we sing or dance, we tell stories of our ancestors or of the animals in the forest."

Helping the Helpers,
by Lisa McKay, updated by Rick Williamson
(The Headington Institute 2011, 65)

[48] Ibid., 11.
-A. Stoddard, A. Harmer, and V. Di Domenico, *Providing Aid in Insecure Environments: 2009 Update. Trends in Violence against Aid Workers and the Operational Response: Why Violent Attacks on Aid Workers Are on the Increase (*London, UK: HPG, ODI, 2009).
-A. Stoddard, A. Harmer, K. Haver, *Providing aid in insecure environments: trends in policy and operations. (*London, UK: HPG, ODI, 2006).
[49] Lisa McKay, updated by Dr. Rick Williamson, *Helping the Helpers: Understanding, Assessing, and Treating Humanitarian Workers Experiencing Acute Stress Reactions,* 4.
[50] M. Janz, C. Rogers, J. Slead, J. and A. Abifarin, *Risk and security essentials for humanitarian operations: Liberia.* In M. Janz and J. Slead (Eds.), *Complex humanitarian emergencies: Lessons from practitioners* (Monrovia, CA: World Vision, 2000), 66-91.

And if the situation worsens, evacuation is not usually an option for the locals or their families. McKay writes, "For locally hired national staff, it is their country and culture that is in the process of being ravaged by drought, epidemics and conflict. . . . It is their friends and family who are dying."[51] National workers may be experiencing a collective trauma as well as an individual one. A study of humanitarian aid workers in Darfur found a higher prevalence of burnout among the national staff.[52]

Media Personnel

The media are probably the greatest contributor to making the general public aware of conflicts and humanitarian crises throughout the world. According to Carlos Mavroleon, "It's not because the Marines are there you are hearing stuff, it is because we were there."[53] Over the last century, modern technology has brought images and stories from thousands of miles away into local living rooms. Media reporting has beckoned people to act in the face of gross human rights violations and merciless famine. It can force the United Nations to provide peacekeeping to protect innocent people from being slaughtered.

Media reports have improved the ability of aid and relief organizations to build capacity, to substantially grow their budgets, and to provide further services. Douglas Van Belle, Jean-Sébastian Rioux, and David Potter found that in 2004 one story in the New York Times could increase aid allocation by $375,000.[54] Philip Brown and Jessica Minty estimated that a minute of nightly news coverage increased daily relief agency donations by 13.2 percent, and a 700-word story in the New York Times or Wall Street Journal resulted in an 18.2 percent increase in donations following the Indian Ocean tsunami in 2004.[55]

In 1994 Kevin Carter committed suicide months after taking a Pulitzer prize winning photo of a starving boy and vulture during the famine in the Sudan. In his suicide

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[51] Lisa McKay, updated by Dr. Rick Williamson, *Helping the Helpers: Understanding, Assessing, and Treating Humanitarian Workers Experiencing Acute Stress Reactions,* 65.
[52] Saif Ali Musa and Abdalla A. R. M. Hamid, "Psychological problems encounter aid workers in Darfur," *Social Behavior and Personality: An International Journal 36,* No. 3, (2008): 407-416.
[53] Kyra Thompson, Director, *Dying to Tell the Story,* Carlos Mavroleon Interview.
[54] Douglas A. Van Belle, Jean-Sébastien Rioux and David M. Potter, *Media, Bureaucracies, and Foreign Aid: A Comparative Analysis of United States, the United Kingdom, Canada, France and Japan, Advances in Foreign Policy Analysis* (New York, NY: Palgrave Macmillan, 2004), 134.
[55] Philip Brown and Jessica Minty, "Media Coverage and Charitable Giving After the 2004 Tsunami," The William Davidson Institute, Working Paper, Number 855 (December 2006).

letter he wrote "I am haunted by the vivid memories of killing & corpses & anger & pain…of starving or wounded children."[56] Kevin Carter is not alone in these feelings. Seldom discussed is the psychological cost to the media personnel who witness and cover these horrifying scenes. A salient image that can instantly arouse a viewer's emotions can also cause a life-long negative imprint on the journalist's brain. The horrors of such scenes far exceed what is captured with the lens or on paper. A picture cannot encapsulate the deafening sounds and sickening smells; it cannot portray to the reader the helplessness the photographer felt while merely recording and being unable to respond to the suffering of the subject. The most disturbing scenes and most shocking stories will never be published because they go beyond the "threshholds of what the public could stomach."[57] However, media personnel and other complex emergency responders bear witness and must endure the stress that flows from what they have seen and experienced.

[56] Scott Macleod, "The Life and Death of Kevin Carter." *Time*, Volume 144, Issue 11, September 12, 1994, 70.
[57] Anthony Feinstein, *Journalist under Fire: The Psychological Hazards of Covering War (Baltimore, MD: Johns Hopkins University Press, 2006)*, 11.
* Kevin Carters suicide notes excerpts were from Kevin Carter: The Consequences of Photojournalism by Cinders posted online http://www.fanpop.com/spots/photography/articles/2845/title/kevin-carter-consequences-photojournalism (accessed November 1, 2011).

Determining appropriate crisis intervention methods is dictated by an understanding of the dynamics of stress and the taxonomy of stressors inherent in complex emergencies. C. P. Bryce asserts that the potential impact of a stressor is determined more by one's perception of the stressor than by its absolute qualities.[58] For example, if a relief worker comes across a snake, the perception that it is harmful and the worker's subsequent stress response may have nothing to do with whether the snake is indeed harmful.

Stress Dynamics

The pioneer of stress research, Hans Selye, defined stress as "the sum total of wear and tear on the body" as the body experiences a survival reaction, whether that reaction was promoted by a positive or negative stimulus.[59] It is the process by which the body physiologically prepares to respond, by "freezing," as recognized by J. A. Gray,[60] or with the "fight or flight" reaction described by physiologist Walter Cannon. The act of freezing is often the momentary initial response and is synonymous with hypervigilance or rapid situational awareness.[61] Fight or flight causes the sympathetic nervous system to galvanize the body's resources into addressing the situation or fleeing from it.[62] The parasympathetic nervous system is responsible for restoring the body back to normal functioning. [63]

Stress is an essential part of life. It comes in three types: eustress, distress, and neustress. Eustress is a positive motivating stress, while distress is often debilitating and can be pathogenic.[64] Neustress, seldom discussed, has neither a positive nor a negative effect on the body.[65] The factor that determines the type of stress is the individual person's perception. Responders may find working in dynamic and complex emergencies invigorating (they experience eustress), while the general public may find such

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[58] CP Bryce, *Stress Management in Disasters* (Washington, DC: Pan American Health Organization, 2001); Center for Disaster Epidemiology and Emergency Preparedness, *Surge, Surge, Support: Disaster Behavioral Health for Health Care Professions.* (Deep Center Disaster Epidemiology Emergency Preparedness, Miller School of Medicine University of Miami, http://www.deep.med.miami.edu/documents/Surge-Sort-Support_DBH%20for%20HC%20(textbook).pdf (accessed January 1, 2012), 84.

[59] George S. Everly, Jr., Victor Welzant and Jodi M. Jacobson, "Resistance and Resilience: The Final Frontier in Traumatic Stress Management," Chevron Publishing *International Journal of Emergency Mental Health*, Vol. 10, No. 4 (2008): 1.

[60] J. A. Gray, *The Psychology of Fear and Stress*, 2nd Edition (New York, NY: Cambridge University Press, 1988).

[61] H. Stefan Bracha, "Freeze, Flight, Fight, Fright, Faint: Adaptationist Perspectives on the Acute Stress Response Spectrum," *CNS Spectrums,* Volume 9, No. 9 (September 2004): 679-680.

[62] Dave Grossman and L. W. Christensen, *On Combat: The Psychology and Physiology of Deadly Conflict in War and in Peace,* 3rd Edition (Warrior Science Publications, 2008), 14-15.

[63] Ibid.

[64] George S. Everly, *Assisting Individuals in Crisis,* 4th Edition (Ellicott City, MD: The Johns Hopkins University and Loyola College in Maryland, International Critical Incident Stress Management Foundation, 2006), 99.

[65] Alan A. Mikolaj, *Stress Management for the Emergency Care Provider* (Saddle River, NJ: Prentice Hall, 2004), 2.

emergencies terrifying and unpleasant (they would experience distress). The perception of each stressor and subsequent reactions are individual experiences.

Distress can manifest itself negatively through cognitive, emotional, behavioral, physical, or spiritual impairment.[66] The tables below detail stress reactions as described by the International Critical Incident Stress Foundation,[67] UNHCR,[68] People In Aid,[69] Dart Center for Journalism and Trauma,[70] the National Guard Trained Crisis Responder course,[71] and the Headington Institute's Trauma and Critical Incident Care for Humanitarian Workers training materials.[72] The left-hand columns in the tables display some common reactions to distress. The right-hand columns show more severe impairment. The common distress reactions can be precursors to more pathogenic forms of impairment, depending on the timing, frequency, duration, and intensity of the reaction. The primary goal of acute psychological crisis interventions is to mitigate distress reactions.

Cognitive Distress	Severe Cognitive Dysfunction
— Time distortion — Confusion, loss of perspective — Inability to concentrate, distractibility — Diminished tolerance for ambiguity — Rigid, inflexible thinking — Difficulty in decision making and prioritizing — Guilt (survivor's, omission, commission) — Preoccupation or obsessions with event — Inability to understand consequences — Poor problem solving — Suspiciousness — Intrusive images — Blaming someone — Racing, circular thoughts	— Suicidal/ homicidal thinking — Paranoid thoughts — Disorientation — Persistent diminished problem-solving — Distressing recurrent dreams — Disabling guilt — Hallucinations — Delusions — Persistent hopelessness or helplessness — Psychogenic amnesia — Dissociation

[66] George S. Everly, *Assisting Individuals in Crisis,* 4th Edition, 99.
[67] Critical Incident Stress Information Sheets (Ellicott City, MD: International Critical Incident Stress Foundation, 2001).
[68] United Nations High Commissioner for Refugees: Staff Welfare Unit Career and Staff Support Services, *Managing the Stress of Humanitarian Emergencies, (July 2001,* Reprinted 2005*)* http://www.the-ecentre.net/resources/e_library/doc/managingStress.PDF (accessed January 1, 2012); International Federation of Red Cross and Red Crescent Societies, Managing Stress in the Field (International Federation of Red Cross and Red Crescent Societies, 2009).
[69] Debbie Lovell-Hawker, *Supporting Staff Responding to Disasters: Recruitment, Briefing and On-Going Care*, Third Edition (People In Aid, 2009).
[70] Dart Center for Journalism and Trauma, Online Learning, Self-Study Unit 1: Journalism and Trauma, II. Effects of Traumatic Stress http://dartcenter.org/content/self-study-unit-1-journalism-trauma-3 (accessed May 1, 2012).
[71] George S. Everly, Douglas J. Mitchell, Diane Myers and Charles E. Woods, National Guard Trained Crisis Responder (TCR) Course: *Terrorism and Disaster Response Trainer's Guide* (International Critical Incident Stress Foundation and Departments of the Army and the Air Force National Guard Bureau, 2002), 37-52.
[72] Lisa McKay, *Trauma and Critical Incident Care for Humanitarian* Workers Online Training Module (Headington Institute Care for Caregivers Worldwide, 2007), 16-19.

Emotional Distress	Severe Emotional Dysfunction
— Anxiety — Detachment, feeling unreal — Negativism, cynicism — Anger, agitation, irritability — Diminished pleasure — Mood swings and outbursts — Overwhelming feelings — Posttraumatic Stress (PTS) — Helplessness or hopelessness — Fear, phobic avoidance, apprehension — Guilt — Emotional numbness	— Panic attacks — Depression, melancholy — Persistent flat affect — Infantile emotions in adults — Immobilizing depression — Posttraumatic Stress Disorder (PTSD) — Depression

Behavioral Distress	Severe Behavioral Dysfunction
— Impulsiveness, risk-taking — Decreased performance — Excessive talkativeness, prolonged silence — Intensified pacing — Excessive eating or limited eating — Alcohol or drug use — Hyperstartle — Compensatory sexuality — Sleep disturbance — Withdrawal — Crying spells — Excessive use of black humor — Hypervigilance — 1,000-yard stare — Reluctance to start or finish projects	— Violence — Antisocial acts — Self-medication — Immobility — Abuse of others — Lasting compulsive acts — Diminished personal hygiene — Persistent sleep disturbance

Physical Distress	Severe Physical Dysfunction
— Tachycardia or bradycardia — Headaches — Hyperventilation — Muscle spasms, muscle tremors or weakness — Psychogenic sweating or shivering — Dizziness or fainting — Indigestion, nausea, intestinal distress — Grinding of teeth — Extreme fatigue or exhaustion	— Chest pain — Persistent irregular heartbeat — Recurrent dizziness — Seizure — Recurrent headaches — Blood in vomit, urine, stool, sputum — Collapse, loss of consciousness — Numbness or paralysis — Inability to speak or understand speech

Spiritual Distress	Severe Spiritual Dysfunction
— Anger at God — Withdrawal from faith community — Crisis of faith — Loss of belief	— Cessation from practice of faith — Religious obsessions — Religious compulsions — Religious hallucinations or delusions

Notably, the reactions to stress are diverse and vary in duration and magnitude. Some individuals may not display any outward signs of distress.

The precipitators of stress can be grouped according to multiple typologies. Inherent in complex emergencies are personal and existential, enviromental, and organizational stressors, as well as secondary stress, which can result in cumulative or chronic stress.

Personal and Existential Stressors

Everyone has personal stressors related to their expectations, demands, plans, or beliefs. Responders often expect that they can make a difference,[73] that they can control every situation, and that they will be appreciated by everyone. These expectations can be crushed by the realities of complex emergencies.

Feelings of inadequacy in the face of overwhelming challenges can be ongoing.[74] Responders may feel guilty for choosing work over family and for missing weddings, funerals, and birthdays. Regret, over-eating, drinking, smoking, casual sex, and failing to exercise are responses to stress that add to a person's personal stress mix. Some responders are conflicted by a desire for something to happen so they can do their jobs and a desire for nothing to happen so people will not suffer. The most difficult personal stressors come when a responder's worldview is shattered. For example, a belief

QUOTES FROM THE FIELD

"The most overwhelming and gut wrenching challenge for me was more insidious: each day became a relentless series of life-and-death decisions. Decisions, for example, on where food and supplies could be delivered, which in turn determines who will eat, who would freeze, who would get shelter from the wind and the rain."

These Decisions Haunt Me Still,, by Kathleen Cravero (Danieli, 2002, 109)

"Even now I feel my whole approach to life has changed. Before I was an optimist, I thought. Humans were essentially good. Now I know that there is evil in the world."

Health Workers on the Front Line,,by Xavier Leus and Hilary Bower (Danieli, 2002, 81)

[73] United Nations High Commissioner for Refugees: Staff Welfare Unit Career and Staff Support Services, *Managing the Stress of Humanitarian Emergencies,* 8.
[74] Cynthia B. Eriksson, Jeff P. Bjorck, Linnea C. Larson, Sherry M. Walling, Gary A. Trice, John Fawcett, Alexis D. Abernethy and David W. Foy, "Social Support, Organizational Support, and Religious Support in Relation to Burn Out in Expatriate Humanitarian Aid Workers" *Mental Health, Religion and Culture*, 12:7 (2009): 672.

in a just world can be shattered when a responder witnesses the senseless death of a child.[75] Dena Rosenbloom and Mary Beth Williams state regarding exposure to trauma, "Basic beliefs can change quickly and dramatically, the way an earthquake can suddenly shift the course of a river. A belief may intensify, become absolute, reverse itself, or collapse altogether."[76] Personal and existential stressors interrelate and compound other forms of stressors.

Environmental Stressors

The complex emergency landscape, which can include armed conflict, famine, mass displacement, genocide, or large-scale natural disasters, is fraught with environmental stressors. Environmental stressors are forces in the human or natural environment that leads to a person's experiencing stress to a degree affecting psychological well-being.[77] Common environmental stressors often involve cultural and language differences, difficult living conditions, volatile and dangerous surroundings, harsh climate conditions, and exposure to sick and injured people and to corpses. Cultural and language differences can make it challenging to communicate, arrange services, and establish trust. It is also possible that responders will be rejected by the local population. A CDC report on Kosovo showed that 38 percent of international staff and 21 percent of national staff experienced hostility from the local population.[78]

QUOTES FROM THE FIELD

"Relief workers see the worst that life on the planet can inflict, slaughters, the brutal exploitation of other human beings, random and destructive natural disasters, famine, and hopeless, grinding poverty. Relief workers are thrown into crowded and chaotic settings with poor communication systems, and constantly changing circumstances."

Protecting the Protectors,
by Catherine A. Bertini
(Danieli, 2002, 65)

"Sustained automatic weapons firing close by caused the IDPs to panic. They hurled themselves and their babies over the razor wire that divided the compounds. From then on UNAMET compound was home to 1500-2000 IDPs."

The Evacuation Dilemma,
by Ian Martin
(Danieli, 2002, 25)

[75] Anthony Feinstein, *Journalist under Fire: The Psychological Hazards of Covering War*, 26.
[76] Lisa McKay, *Trauma and Critical Incident Care for Humanitarian Workers Online Training Module* (Headington Institute Care for Caregivers Worldwide, 2007), 13; Dena Rosenbloom, Mary Beth Williams, *Life After Trauma: A Workbook for Healing* (New York, NY: The Guilford Press, 1999), 67.
[77] U.S. Army Medical Department: U.S. Army Research Institute of Environmental Medicine. http://www.usariem.army.mil/pages/faq.htm (accessed January 1, 2012).
[78] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst, 245* (*Mental Health of Humanitarian Aid Workers in Complex Emergencies*, Barbara Lopes Cardozo and Peter Salama).

Living conditions can contribute to overall environmental stress. Accommodations can vary from tents to hotels. Those living in closer proximity to the people they serve often live in more arduous conditions. Access to running water or electricity can be intermittent. Small living spaces offer little privacy and make it harder to separate work time from personal time.[79] Personal items can be stolen, and resupply can be difficult. Traveling can be restricted and dangerous due to the presence of land mines and improvised explosive devices, the possibility of ambush, and the existence of checkpoints guarded by child soldiers or other armed groups.[80]

QUOTES FROM THE FIELD

"My heart beat in anguish, my mind wrestled with my fears about how to help these people. In that first morning, we witnessed thousands of corpses, covering every inch of the margin of the road. We stopped at roundabouts, and viewed people slipping rapidly to death."

Goal: A Champion of the Poor, by Andrew Spearman (Danieli, 2002, 191)

"It is not unusual for aid workers in the midst of open warfare, to suspend the laws of physics. Americans who would not walk alone at night in Central Park will venture into line."

The Dangers of Aid Work, by Barbara Smith Page (Danieli, 2002, 172)

Adding to the complexity can be hazardous roads, a scarcity of gas stations, poor signage, and unfamiliarity with the terrain. Security is a major concern in fluid and unpredictable conflict zones and where people are desperately struggling to meet their basic human needs. Overcrowding, malnutrition, poor sanitation, epidemic diseases, illnesses spread by insects, rabid animals and lack of health care create a Petri dish for the cultivation of physical ailments and illnesses that may not be responsive to vaccinations or cures.

UNHCR mentions the great anxiety among staff during the 1995 Ebola virus outbreak in Zaire (now the Democratic Republic of Congo).[81] The lack of protective gear can make it difficult to prevent transmission of diseases to responders while they rapidly tend to a mass influx of injured people. Evacuation of staff can be problematic in remote locations.[82] Intense heat without air conditioning, or frigid cold without heating can make

[79] Ibid., 243-245.
[80] Lisa McKay, updated by Dr. Rick Williamson, *Helping the Helpers: Understanding, Assessing, and Treating Humanitarian Workers Experiencing Acute Stress Reactions*, 17.
[81] United Nations High Commissioner for Refugees: Staff Welfare Unit Career and Staff Support Services, *Managing the Stress of Humanitarian Emergencies,* 14.
[82] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst, 243-245* (*Mental Health of Humanitarian Aid Workers in Complex Emergencies*, Barbara Lopes Cardozo and Peter Salama).

difficult work even more challenging.[83] Heat waves, long rains, and storms can cause a rapid deterioration in working and living conditions.

Sensory overload can occur amid the sights, smells, and sounds of a complex emergency. For example, responders might witness severe malnutrition; they may observe someone wasting away from marasmus or see edema in those with kwashiorkor. Other difficult experiences could include hearing the blood-curdling screams of those who have lost loved ones, the deafening silence of babies who can no longer cry, or artillery fire and small-arms discharge. The smells of feces, burning trash, and death can be deeply embedded in the mind and may not be extinguished over time.[84] Environmental stress can have a chronic or cumulative effect, magnifying a critical incident.

Organizational Stressors

Organizational stressors include factors related to management of the mission, supervision of the team, and conflicts among team members. Organizational stressors can degrade the crisis intervention response to a critical incident.[85] "The work at headquarters is very much part of humanitarian action. Without a headquarters, the field cannot work and without the field, headquarters is worthless," reported Manuel Bessler, former head of the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) in Pakistan.[86]

QUOTES FROM THE FIELD

"In the aftermath of tragedy, many things go wrong. Organizations and people become confused and chaotic. They overreact, they underreact, they take action too quickly, or they fail to act at all."

Healing Is an Individual Process,
by Kathleen Cravero
(Danieli, 2002, 101)

Disconnects can exist between policy and practical application. Undefined roles, mission ambiguity, unfulfilled expectations, poor communication, conflicting ideals, and lack of support from leadership can exacerbate a stressful environment among

[83] E.A. Brusher, "Combat and Operational Stress Control." *International Journal of Emergency Mental Health* 9, No. 2 (2007): 61-63; T.W. Britt and A.B. Adler, "Stress and Health During Medical Humanitarian Assistance Missions." *Military Medicine,* 164 (1999): 275–279.
[84] N. A., Kline, J. L., and Rausch, "Olfactory precipitants of flashbacks in posttraumatic stress disorder: Case reports." *Journal of Clinical Psychiatry*, 46 (1985): 383-384.
[85] Cynthia B. Eriksson, Jeff P. Bjorck, Linnea C. Larson, Sherry M. Walling, Gary A. Trice, John Fawcett, Alexis D. Abernethy and David W. Foy, "Social Support, Organizational Support," 7.
[86] Swissinfo.ch. http://www.swissinfo.ch/eng/politics/foreign_affairs/Humanitarian_aid_unit_gets_new_head.html?cid=30154804 (accessed January 1, 2012).

responders.[87] As Cheryl Regehr and Ted Bober argue, sometimes "the requirements of the job do not match the capabilities, resources, or needs of the workers."[88] Lars Weiseth notes some of the primary causes of burnout among humanitarian staff; they include interference from top management, unwanted organizational change, unrealistic expectations, and organizational policies.[89] Kaz de Jong, with Médecins Sans Frontières Holland, and Sian Kelly, with Save the Children UK, indicate that job stressors result when workers are challenged with creating order out of chaos while managing high expectations from both headquarters and beneficiaries.[90] A. J. W. Taylor mentions the duplicity between the words and actions of politicians who decide peacekeeping operation goals.[91] Further organizational stressors include overwhelming work hours, shift work, inadequate remuneration, limited career progression opportunities and the disparity in practices related to and benefits for national staff. [92]

Team conflicts occur when heterogeneous groups of expatriates and national staff are suddenly expected to function as a team in a dynamic and stressful environment with limited resources.[93] Beyond

QUOTES FROM THE FIELD

"On a number of occasions, I have been in danger because of administrative problems and delays in making payments, which I have no control over. We often throw people into the field without adequate support or means to honor obligations and this can be very dangerous in some countries."

Health Workers on the Front Line, by Xavier Leus and Hilary Bower (Danieli, 2002, 81)

"In the Arab world, the amount of respect you show a person in his or her death is soothing balm to his family and his colleagues. But very often the first concern of our organization is for the type of contract a person is on, which then governs the response."

Health Workers on the Front Line, by Xavier Leus and Hilary Bower (Danieli, 2002, 82)

[87] Deborah Manning and April Preston, "Organizational Stress: Focusing on Ways to Minimize Distress," *CUPA-HR Journal,* Vol. 54 No. 2, (Summer 2003).
[88] Cheryl Regehr, *In the Line of Fire: Trauma in the Emergency Services* (New York, NY: Oxford University Press, 2005), 6.
[89] Lars Weiseth, *Stressors Causing Burnout: Frustrated Goals and Expectations* (UN Department of Humanitarian Affairs Training Couse, 1993).
[90] The Headington Institute, *Dealing with the Stress of Humanitarian Work* (*InfoSud Human Rights Tribute*, 23 Aug 2010).
[91] A.J.W. Taylor, "Occupational Stress and Peacekeepers," *The Australasian Journal of Disaster and Trauma Studies*, Volume: 2004-1, (2004): 3.
[92] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst, 243-245* (*Mental Health of Humanitarian Aid Workers in Complex Emergencies*, Barbara Lopes Cardozo and Peter Salama).
[93] Lisa McKay, *Understanding and Coping with Traumatic Stress* Module 1. Headington Institute, 2007. http://headington-institute.org/Portals/32/resources/English_Translation_Understanding_and_coping_with_traumatic_stress_final.pdf (accessed January 1, 2012).

internal organizational conflicts, interagency conflicts and competition exist[94] with other NGOs, journalists, and UN programs. Jonathan Shay asserts that ethical leadership and unit cohesion protect the minds and spirits of service members in combat.[95] Conversely, unethical leadership or the absence of camaraderie may damage the mind and spirit.

Organizational policies can influence mental health outcomes for responders.[96] Organizational stressors degrade safety, trust, and the dependability of staff and need to be addressed before a critical incident situation. Mitigating the stress beforehand will lead to responses that are more effective.

Vicarious Traumatization and Compassion Fatigue

William Hazlitt stated, "Man is the only animal that laughs and weeps; for he is the only animal that is struck by the difference between what things are and what they might have been."[97] Working in humanitarian crises day after day, witnessing firsthand the immense suffering of innocent civilians, and hearing tales of traumatization and personal tragedy can inflict upon the responder reactions and symptoms similar to what the primary victim is experiencing.[98]

The Netherlands Centre for Social Development warns aid workers about the dangers of countertransference reactions with clients. They note that

QUOTES FROM THE FIELD

"Aid workers can sometimes be struck by an overwhelming despair brought on by the feeling that a few individuals cannot do enough to satisfy such a huge need"

Goal: A Champion of the Poor, by Andrew Spearman (Danieli, 2002, 191)

"You function under pressure in the present by postponing your relief to the future. That kind of pressurized living and working builds tensions which have to be released at some point, when you leave the frontlines"

Transformed by the Front Lines, by Yasmine Sherif (Danieli, 2002, 62)

[94] United Nations High Commissioner for Refugees: Staff Welfare Unit Career and Staff Support Services, *Managing the Stress of Humanitarian Emergencies,* 12.
[95] Hayden A. Duggan and Tom Greenhalgh, *From Battlefield to Street: One Uniform to Another*; Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York, NY: Scibner, 1994).
[96] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst, 250-252* (*Mental Health of Humanitarian Aid Workers in Complex Emergencies*, Barbara Lopes Cardozo and Peter Salama); Center for Disease Control and Prevention: Global Health-Global Disease Detection and Emergency Response: IERH Scientific Publications: Mental Health in Aid Workers: Fact Sheet: http://www.cdc.gov/globalhealth/gdder/ierh/Publications/mentalhealth_aidworkers_pib.htm (accessed January 1, 2012).
[97] Timothy Dietz, *Scenes of Compassion: A Responder's Guide For Dealing With Emergency Scene Emotional Crisis* (Ellicott City, MD: Chevron Publishing , 2009), 39.
[98] Antares Foundation, *Antares Foundation on Critical Incident Stress* Workshops Slides. http://www.antaresfoundation.org/guidelines/antares_workshop_critical_incidents_2010.pdf (accessed January 1, 2012).

interacting or listening to dramatic stories of suffering can force aid workers to contemplate their own vulnerabilities, such as "fear of dying."[99] Research studies have found numerous instances of compassion fatigue and vicarious traumatization, otherwise known as secondary traumatization, among international and national aid workers, media, and UN peacekeepers.[100]

Secondary traumatization comes with bearing witness to other people's tragedies. Siddharth Ashvin Shah, Elizabeth Garland, and Craig Katz found that all of the aid workers they studied who were employed as informal "barefoot" counselors in India, helping victims of sexual assault and or other violence, showed symptoms of secondary traumatization. Saif Ali Musa and Abdalla A. R. M. Hamid mention high levels of secondary traumatization in aid workers serving in Darfur, with a higher prevalence in the Sudanese staff.[101] Relief workers who are personally affected by the crisis they are responding to may experience higher levels of distress, potentially leading to secondary traumatic stress or other ailments.[102]

Compassion fatigue, generally known as too-tired-to-care or tired-of-caring, occurs when a person becomes emotionally exhausted by what they have witnessed or experienced.[103] In a field where relief, recovery, and development efforts progress in minuscule steps in comparison to the overall need, it can be hard for responders to stay encouraged with a belief that what they are doing truly makes an impact.[104] Lives saved are overshadowed by lives lost. And the articles written and pictures taken rarely make it to press in societies more concerned with pop culture than with current affairs.

QUOTES FROM THE FIELD

"Listening, taking statements and testimonies . . . women particularly the sexual violence . . . It is almost as if we were the victims … at this moment we want to avoid people as our pain has hardened and we are feeling numb."

Secondary Traumatic Stress, by Humanitarian Aid Worker Organization Director, India (Shah, Garland and Katz, 2007, 61)

[99] Mental Health and Psychosocial Support Network, *Prevention of Professional Burn-out with Care Workers: Self-Care and Organizational Care,* 7. http://lastradainternational.org/lsidocs/807%20admira_work_for_care_2005_module_13_prevention.pdf (accessed January 1, 2012).
[100] Siddharth Ashvin Shah, Elizabeth Garland, and Craig Katz*, "Secondary Traumatic Stress: Prevalence in Humanitarian Aid Workers in India,"* Sage Publications *Traumatology*, Volume 13 No. 1, (March 2007): 59-70.
[101] Saif Ali Musa and Abdalla A. R. M. Hamid, "Psychological problems encounter aid workers in Darfur," 415.
[102] Howard B. Smith, "Providing Mental Health Services to Clients in Crisis or Disaster Situations," *Vistas: Compelling Perspectives on Counseling* (2006).
[103] C. R. Figley, *Compassion Fatigue. Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized.* (New York, NY: Brunner/Mazel,1995).
[104] Headington Institute, *Humanitarian Workers and Traumatic Stress. http://headington-institute.org/Default.aspx?tabid=1331* (accessed January 1, 2012).

Cumulative Stress

Cumulative stress is the destructive accumulation and culmination of multiple stress factors. It deteriorates individual coping mechanisms and can lead to significant impairment and dysfunction, including burnout, if left unattended. The consequences of burnout for an organization are staff attrition, work conflicts, scapegoating, lack of initiative, and increased sick leave.[105] UNHCR warns that when cumulative stress goes unmanaged it erodes the effectiveness of both staff and programs.[106] "Idealism can become cynicism, optimistic enthusiasm can become pessimism."[107] Chronic low-level personal, environmental, and organizational stressors can be more insidious than high-level critical-incident stressors.[108] Marie Diamond uses the frog analogy. When a frog is dropped into a pot of boiling water, it will immediately jump out. Conversely, if a frog is placed into a pot of water that is heated gradually to boiling, it will not realize the danger until it is too late.[109] Elana Newman, who surveyed 800 photojournalists, found that "witnessing death and injury takes its toll, a toll that increases with exposure."[110]

While cumulative stress can have critical incidents as its source, it is difficult to separate sources and to associate each symptom of stress with its origins in a preceding stressor incident. The Headington Institute found that the greater the number and intensity of traumatic events that relief workers have experienced in the past, the greater their chance of experiencing traumatic stress reactions when they are subsequently exposed to sufficient stressors. [111] Furthermore, as the time of exposure to a stressor event lengthens, the risk of distress increases.[112] When a system is already compromised by cumulative stress, the shock of a critical incident can have greater negative impact, and recovery time can be lengthened.

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[105] United Nations High Commissioner for Refugees: Staff Welfare Unit Career and Staff Support Services, *Managing the Stress of Humanitarian Emergencies,* 13.
[106] Ibid., 9.
[107] Kevin M Gilmartin, *Emotional Survival for Law Enforcement: A Guide for Officers and Their Families* (Tucson, AZ: E-S Press, 2002), 3.
[108] Peter Salama, *The Psychological Health of Relief Workers: Some Practical Suggestions,* Humanitarian Practice Network, 1999, http://www.odihpn.org/humanitarian-exchange-magazine/issue-15/the-psychological-health-of-relief-workers-some-practical-suggestions (accessed January 1, 2012).
[109] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst, 103* (*What aid workers and Frogs have in common*, Marie Diamond).
[110] Joe Hight and Frank Smyth, *Tragedies and Journalists*. Dart Center for Journalism and Trauma, A Resource Center for Journalist who cover Violence. http://dartcenter.org/content/tragedies-journalists-6 (accessed January 1, 2012).
[111] Headington Institute, *Understanding and Coping with Traumatic Stress, Part Five: Risk and Protective Factors,* Headington Institute. http://headington-institute.org/Default.aspx?tabid=1790 (accessed January 2012).
[112] Ibid.

A college professor once asked the class, "How heavy is a glass of water?" The professor received several answers but the professor replied, "The weight doesn't matter, it depends on how long you try to hold it. . . . The longer you hold it the heavier it becomes, that is until you put it down and rest." Stress is the same way. If we carry stress especially after a critical incident, the stress can become increasingly heavy, if not dealt with properly.[113]

Critical Incidents

The stressors arising from critical incidents are sometimes referred to as extreme stress or traumatic stress. According to UNHCR, critical incidents can be "large or small scale, but are thought of as being beyond the range of 'normal' human experience, even in the context of humanitarian emergency work, because of their power to shock and traumatize staff involved."[114] George Everly and Jeffrey Mitchell define critical incidents as "stressful events having the potential to overwhelm one's usual coping mechanisms which results in psychological distress and an impairment of normal individual, as well as collective, adaptive functioning."[115]

QUOTES FROM THE FIELD

"I was confronted with many situations in which, to any 'reasonable' outsider, the abnormal had become normal."

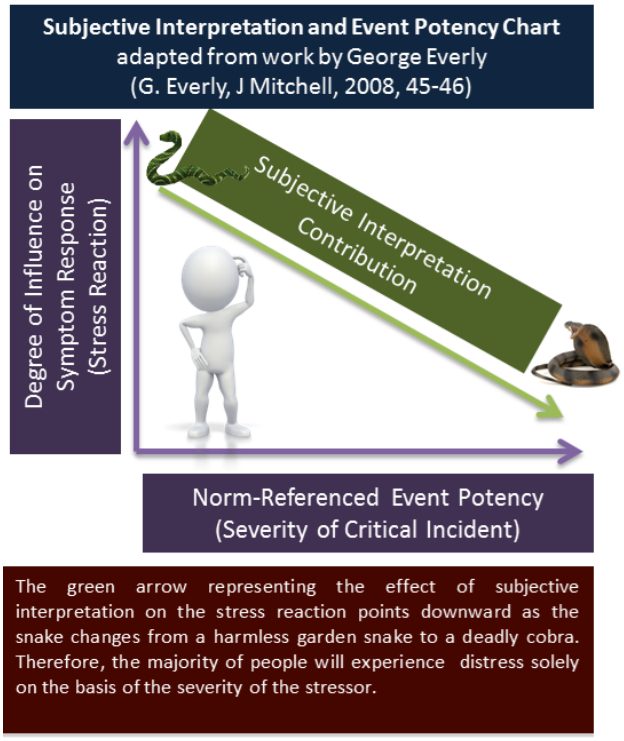
What Aid Workers and Frogs Have in Common, by Marie Diamond (Danieli, 2002, 103)

One does not have to be present at a critical incident to feel its effects. Those who share a personal connection with the people directly involved may also experience some impairment.[116] This is key because NGOs, media organizations, and UN programs are staffed from relatively small occupational communities. Thus, reactions to specific critical incidents, such as deaths in the line of duty, can have an extensive rippling effect. This was evident in Chechnya in 1996 when five International Red Cross medical staff members

[113] Cops Alive, Critical Incident Stress Management. http://www.copsalive.com/critical-incident-stress-management/ (accessed January 2012).
[114] United Nations High Commissioner for Refugees: Staff Welfare Unit Career and Staff Support Services, *Managing the Stress of Humanitarian Emergencies,* 15.
[115] George S. Everly, Jr. and Jeffrey T. Mitchell, *Integrative Crisis Intervention and Disaster Mental Health* (Ellicott City, MD: Chevron Pub Corp 2008).
[116] United Nations High Commissioner for Refugees: Staff Welfare Unit Career and Staff Support Services, *Managing the Stress of Humanitarian Emergencies,* 18.

were killed in their hospital compound just before Christmas, and concern and grief spread throughout the humanitarian community.[117]

Critical incidents can produce short-term distress or longer-term psychological impairment. Often short-term reactions are known as "normal reactions to abnormal situations." It is difficult to determine which types of critical incidents result in psychological crises and require crisis intervention for the responder population because their occupations often require them to do things or be exposed to things the public generally considers abnormal,[118] such as working in a refugee camp, seeing the injured or dead, living in an unsecure environment, or witnessing mass destruction.[119] One may infer that many of the organizational or environmental stressors inherent in complex emergencies are critical incidents. UNHCR notes that many staff have not received any support after previous critical incidents, and therefore a stress-burden reaction may compound a subsequent critical incident.[120]



C. P. Bryce asserts that the potential impact of a stress is determined more by one's perception of the stressor rather than its absolute qualities,[121] but George Everly believes that the perception variable changes with the severity of the stressor.[122] In his Subjective Interpretation and Event Potency model, Everly explains that the milder or more common a stressor is, the more one's perception contributes to the stress reaction.[123] Conversely, the more severe

[117] United Nations High Commissioner for Refugees: Staff Welfare Unit Career and Staff Support Services, *Managing the Stress of Humanitarian Emergencies,* 14.
[118] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst, 101-103* (*What aid workers and Frogs have in common*, Marie Diamond).
[119] Ibid.
[120] United Nations High Commissioner for Refugees: Staff Welfare Unit Career and Staff Support Services, *Managing the Stress of Humanitarian Emergencies.*
[121] Center for Disaster Epidemiology and Emergency Preparedness, *Surge, Surge, Support: Disaster Behavioral Health for Health Care Professions,* 84.
[122] George S. Everly, *Assisting Individuals in Crisis,* 4th Edition, 96.
[123] Ibid.

and abnormal the stressor is, the less one's subjective interpretation or perception of the stressor contributes to the overall stress reaction.[124]

To conduct research on individuals' reactions to distress, it is therefore necessary to first analyze and assess the potency of the critical incident. The Critical Incident History Questionnaire has been used with career urban law enforcement personnel to assess cumulative exposure to critical incidents using quantitative measures along with the traditional qualitative narratives.[125] Of the 662 narratives studied, 70.7 percent involved personal threats to life followed by duty-related violence. These involved encounters with sexual or other physical assault, exposure to civilian death, exposure to an injured officer, engagement in dangerous action, and presence during a life-endangering disaster.[126] Identifying critical incident events where individual perceptions play less of a role in determining the reaction is paramount in designing, planning, and measuring a crisis intervention response. However, it appears that no such research has commenced with the complex emergency responder population.

Research on Complex Emergency Critical Incidents

Over the last twenty years, On-Site Academy, located in Gardner, Massachusetts, has treated firefighters, police officers, military, medical personnel, and aid workers who have experienced severe impairment following critical incidents. On-Site Academy conducted anecdotal research with military service members that yielded a list of critical incidents it referred to as the "9 Deadly Combat Sins."[127] Jeffrey Mitchell conducted similar research using surveys of law enforcement professionals.[128] Yet no comprehensive list appears to exist for peacekeepers, UN program staff, media employees or NGO personnel working in complex emergencies.

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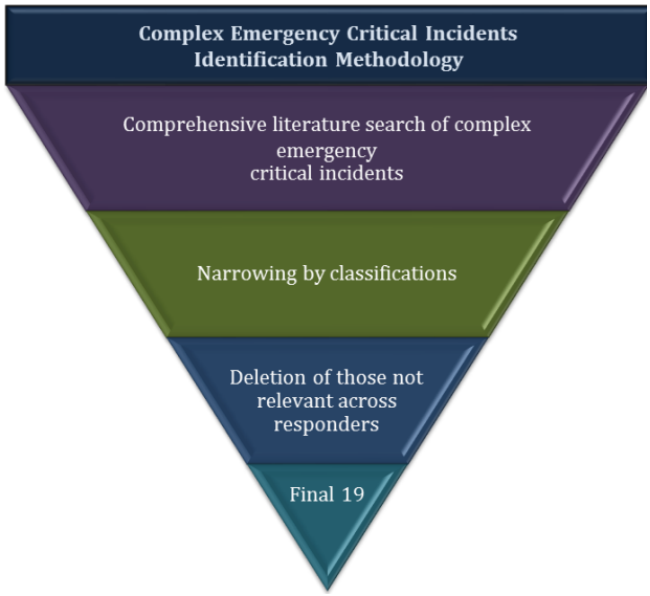
[124] Ibid.
[125] Shannon E. McCaslin, Cynthia E. Rogers, Thomas J. Metzler, Suzanne R. Best, Daniel S. Weiss, Jeffrey A. Fagan, Akiva Liberman and Charles R. Marmar, "The Impact of Personal Threat on Police Officers' Response to Critical Incident Stressors," *The Journal of Nervous and Mental Disease*, Volume 194, No. 8 (August 2006): 591-594.
[126] Ibid., 593-594.
[127] Hayden A. Duggan and Tom Greenhalgh, *From Battlefield to Street: One Uniform to Another* Course, PowerPoint's, 21.
[128] J. Mitchell, and G. Bray, *Emergency Services Stress: Guidelines for Preserving the Health and Careers of Emergency Services Personnel*. (Englewood Cliffs, NJ: Prentice Hall, 1990) 29; Hayden A. Duggan and Tom Greenhalgh, *From Battlefield to Street: One Uniform to Another* Course, PowerPoint's, 19.



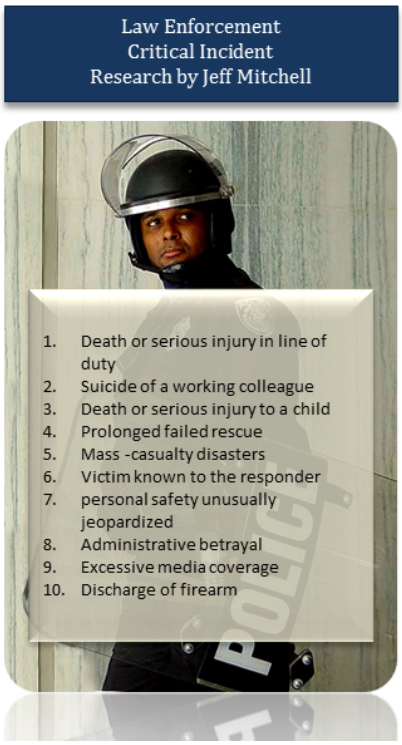
The present author examined hundreds of interviews, stories, personal accounts, and research on situations causing temporary distress or long-term impairment across the four complex emergency responder populations[129] and developed a list of ninety-three incidents (see Appendix). The author then sorted the list and organized the incidents into categories such as Injury, Death, and Targeting of Children. Next, the author deleted incidents that were not relevant to all four responder populations. For example, killing someone was an extreme stressor that only peacekeepers had experienced. Two categories with a total of nineteen critical incidents emerged from this process. One category included incidents in which responders or colleagues were directly affected (10 incidents); the other category included critical incidents in which responders witnessed traumatic events happening to others (9 incidents).

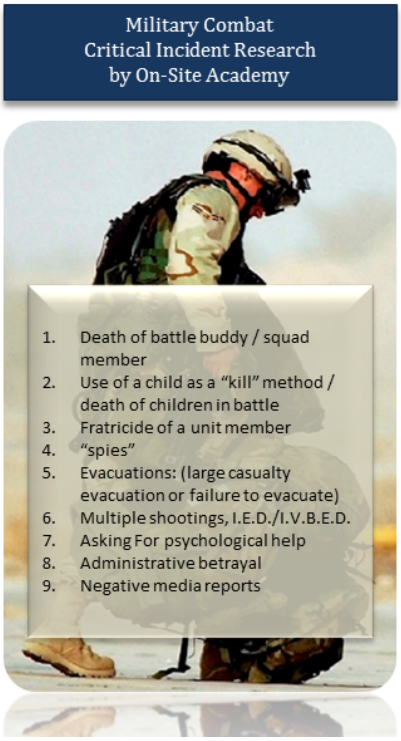
The charts on the next page display these two categories. Additionally, On-Site Academy's and Mitchell's lists of incidents in the military and law enforcement professions are shown for the purpose of comparison. Deaths and injuries in the line of duty, administrative betrayal, and injuries to children were among the top critical incidents shared among the complex emergency responders as well as military and law enforcement professionals. Sexual assault or rape of responders was found in a small portion of the literature review and was classified under threatened or actual assault or battery for this study. However, further research may reveal more sexual assault cases, in which case a twentieth type of critical incident will be identified. This may be important because crisis intervention for sexual assault may differ from intervention for other types of assaults.

Only media and peacekeeping personnel mentioned attempted or completed suicide by responders. Nonetheless, given the stigma and secrecy around suicide, as well as

[129] *Note Bibliography listing for literature review.

literature that shows relief workers having suicidal ideations, one can surmise that attempted or completed suicide does occur among them as well and will result in a critical incident.





Although the identification of nineteen types of complex emergency critical incidents begins to lay the groundwork for the identification of potential crisis intervention responses, it is not a substitute for empirical evidence. If the most effective responses are to be crafted and measured, it is imperative that future research be conducted using Critical Incident History Questionnaires or other instruments to measure cumulative exposure to critical incidents among the responder population.

Inherent in complex emergencies are a plethora of personal, environmental, and organizational stressors that, when combined, result in insidious chronic or cumulative stress. Over time, these stressors can affect individuals' initial reactions to critical incidents as well as their ability to effectively respond and recover thereafter. Hence teaching individuals to manage routine, chronic, and cumulative stress is imperative in combating the potential fallout from a critical incident.

Furthermore, the identification of ninety-three complex emergency critical incidents in which subjective interpretation plays less of a role in the reaction was a key to this section. Narrowing the list of critical incidents from ninety-three down to nineteen provides for a more manageable list for use in strategic planning and in the design and effective measurement of comprehensive crisis intervention responses that address the unique characteristics of each type of incident.

Working amid complex emergencies poses multiple dangers to emergency responders, as well as to residents of the area where the emergency is occurring. When responders are exposed to ongoing or repeated primary or secondary trauma, the threat to their mental health increases.

Threats

Ellen Connorton and her colleagues discuss the physical and emotional dangers of working in global complex emergencies and humanitarian settings, as well as the mental health implications of ongoing primary and secondary trauma exposure.[130] They note elevated rates of trauma as compared to the general population and mention a greater manifestation of posttraumatic stress disorder (PTSD), depression, and anxiety.[131] Brian Gushulak notes that more than 35 percent of long-term humanitarian workers felt that their health had deteriorated during missions.[132] Peter Salama refers to humanitarian workers as a new type of war veteran returning from the battlefield.[133] Unarmed aid workers sometimes serve in areas where national governments will not send their own armed troops.[134]

Lisa McKay and her colleagues state that at least "25% of humanitarian workers in complex emergencies

QUOTES FROM THE FIELD

"When the objective is to drive out or exterminate other ethnic groups, humanitarians may be attacked simply because they are inconvenient obstacles or witnesses. It is clear that it doesn't matter that you're supposed to be a health worker in a hospital—in complex emergencies nowhere is risk free."

Helping the Helpers, by Lisa McKay, updated by Rick Williamson (Headington Institute, 2011, 17)

"The hazards of the job are such that they may not be killed, but they can be crippled, weakened, with broken marriages.

The all-inclusive human condition we call stress eats away at you silently and insidiously, undermining your mental and physical stability."

Protecting the Protectors, by Catherine A. Bertini (Danieli, 2002, 65)

[130] Ellen Connorton, Melissa J. Perry, David Hemenway and Matthew Miller, "Humanitarian Relief Workers and Trauma-related Mental Health," Oxford University Press on behalf of the Johns Hopkins Bloomberg School of Public Health, *Epidemiologic Reviews* Vol. 34, No. 1 (2012): 145.
[131] Ibid.
[132] Brian D. Gushulak, *Advising Travelers with Specific Needs: Humanitarian Aid Workers*, Center for Disease Control and Prevention. http://wwwnc.cdc.gov/travel/yellowbook/2012/chapter-8-advising-travelers-with-specific-needs/humanitarian-aid-workers.htm, (accessed January 1, 2012).
[133] Peter Salama, *The Psychological Health of Relief Workers: Some Practical Suggestions,* Humanitarian Practice Network, 1999, http://www.odihpn.org/humanitarian-exchange-magazine/issue-15/the-psychological-health-of-relief-workers-some-practical-suggestions (accessed January 1, 2012).
[134] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst, 67* (*Protecting the protectors*, Catherine A. Bertini).

can expect to undergo a life-threatening experience."[135] Donald Bosch notes, "As missions become more dangerous, stress is simply an inevitability."[136] Pascale Blanchetière warns that the protective coping mechanisms aid workers develop to deal with the stressors of working in complex emergencies can become detrimental to their long-term well-being, resulting in chronic psychopathology and social dislocation.[137] She discusses the consequences of distancing attitudes, black-and-white thinking, and self-destructive behavior.[138] Anthony Feinstein writes that "For all its allure and excitement," the job of a war journalist is "practiced at a cost of both emotional equilibrium and physical health."[139]

Critical Incidents from Direct Impact

Responders working in armed conflict areas continue to be kidnapped, assaulted, and murdered despite the UN Security Council calling for their protection with Resolutions 1738 (2006) in regard to journalists and Resolution 1502 (2003) pertaining to UN personnel and humanitarian workers.[140] The Centers for Disease Control and Prevention conducted a study on 285 international and 325 national workers from twenty-two international aid organizations serving in Kosovo during 2000.[141] Over 7 percent of those surveyed had experienced the murder of a colleague, 6 percent had been taken hostage, and 20 percent had been robbed. Over a third had been verbally or physically threatened. These experiences are considered precursors to PTSD by the

CDC Findings on Traumatic Stressors in Kosovo

Traumatic Stressor	International Staff (% affected)	Local Staff (% affected)
Verbal or physical threat to life	36%	37%
Handling dead bodies	26%	23%
Murder of coworker	7%	7%
Taken hostage	6%	6%
Attacks on vehicles or convoys	15%	11%
Assaults and robberies	20%	17%

[135] Lisa McKay updated by Dr. Rick Williamson, *Helping the Helpers: Understanding, Assessing, and Treating Humanitarian Workers Experiencing Acute Stress Reactions,* 39.
[136] The Headington Institute, *Dealing with the Stress of Humanitarian Work.*
[137] Lynne McCormack, Stephen Joseph and Martin S. Hagger, "Sustaining a Positive Altruistic Identity in Humanitarian Aid Work: A Qualitative Case Study," *Traumatology* 15, No. 2 (2009): 109-118.
[138] Ibid.
[139] Anthony Feinstein, *Journalist under Fire: The Psychological Hazards of Covering War*, 4.
[140] UN Security Council, *Security Council Condemns attacks against journalist in conflict situations, unanimously adopting resolution 1738* http://www.un.org/News/Press/docs/2006/sc8929.doc.htm (accessed January 1, 2012).
[141] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst, 245* (*Mental Health of Humanitarian Aid Workers in Complex Emergencies*, Barbara Lopes Cardozo and Peter Salama).

American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR). Agencies are sometimes faced with the moral dilemma of risking the physical and psychological safety of their staff or failing to serve people in desperate need.

In 2008, Larissa Fast reported that intentional violence was a leading cause of death among humanitarian workers.[142] Over 1,000 humanitarian workers have died in the line of duty since the 1990s.[143] Both the United Nations and the media have reported an increase in staff killed during 2011. According to the International Federation of Journalists, over 100 journalists were killed in 2011. United Nations personnel who died were most often killed by explosives.[144]

Sadly, responders have even been targeted by the people whom they seek to help. Such was the case of Red Cross water supply engineer Ricardo Munguia, who was killed on March 27, 2003, while working in Afghanistan.[145] The person who authorized Munguia's killing and his executioner both wore prostheses provided by the Red Cross.[146] Line-of-duty deaths are often cited among the most traumatic incidents for fire and law enforcement communities, and one can postulate that this is similar for the complex emergency responder population. Feelings of disbelief, shock, profound guilt and thoughts such as "it could have been me" and "thank God it was not me" are common initial reactions articulated from the front lines to headquarters and to loved ones back home.

QUOTES FROM THE FIELD

"The militias are on the way and I am sure they will do their best to demolish this office. These guys act without thinking, and they can kill a human as easily and painlessly as I kill mosquitoes in my room."

Are You Still There?–Reply,
by Carlos Caseres
(Danieli, 2002, 6)

"In places where everyone carries a gun, disagreement can be fatal."

Health Workers on the Front Line,
by Xavier Leus and Hilary Bower
(Danieli, 2002, 81)

Kidnappings of humanitarian workers have increased fourfold since 2005.[147] Economic gains and political leverage are acknowledged to be among the foremost

[142] Larissa Fast, *Attacks against Aid Workers (*University of Notre Dame Kroc Institute for International Peace Studies) http://kroc.nd.edu/newsevents/quickquestions/attacks-against-aid-workers-76 (accessed January 1, 2012).
[143] Aid Worker Security Database (AWSD). https://aidworkersecurity.org/ (accessed January 1, 2012).
[144] Abby Stoddard, Adele Harmer and Katherine Haver, "Aid Worker Security Report 2011: Spotlight on Security for National Aid Workers: Issues and Perspectives," (Humanitarian Outcomes AWSD Research Team, August 2011): 7.
[145] Fiona Terry, "The International Committee of the Red Cross in Afghanistan: Reasserting the Neutrality of Humanitarian Action" *International Review of the Red Cross*, Vol. 93 No. 881 (March 2011).
[146] Ibid.
[147] Abby Stoddard, Adele Harmer and Katherine Haver, "Aid Worker Security Report 2011: Spotlight on Security for National Aid Workers: Issues and Perspectives," 7.

reasons.[148] The 2011 Aid Worker Security Report states that nearly one hundred humanitarian workers were kidnapped and were subsequently released or able to escape in both 2009 (94) and 2010 (87).[149] Time in captivity can span days or months. Six UN workers kidnapped in Yemen were released on February 2, 2012, after two days in captivity,[150] and two aid workers were rescued on January 24, 2012, in Somalia following three months in captivity.[151] Both peacekeepers and journalists have been kidnapped in Libya, Sudan, and other locations. Not all kidnap victims are released; some are killed, and others are never found. The unknown whereabouts of colleagues can perpetuate ongoing psychological crises.

Also on the rise is the use of improvised explosive devices (IEDs).[152] In 2009 the World Food Programme offices in Islamabad, Pakistan, were bombed. In 2011, a bombing of the United Nations office in Nigeria killed eighteen people. Explosives are seemingly everywhere in places like Afghanistan and Pakistan, with roadside IEDs, IEDs carried in vehicles including ambulances, suicide bombers, and small incendiary devices placed in objects like Coke cans and children's dolls. The 2011 Aid Worker Security Report talks about multi-wave attacks, which involve attackers blasting their way into compounds followed by armed combatants.[153] Lethal injuries resulting from these attacks can include burns and result in amputations and disfigurement. The unpredictable and unrestrained nature of explosives promulgates fear and causes psychological trauma far beyond those directly targeted. It is an embodiment of the ancient Chinese proverb by Sun Tzu, "Kill one person, and frighten ten thousand."

Coming face to face with his worst nightmare, a professional peacekeeping soldier may have to make a split-second decision about whether to shoot a child soldier who looks like his eleven-year-old son.[154] This child may be brandishing a fully loaded AK-47 and may be about to kill innocent civilians. British peacekeeper Phil Ashby refers to child soldiers as

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[148] Ibid.
[149] Ibid.
[150] CNN: Middle East, U.N., Aid Workers Kidnapped in Yemen Released. http://edition.cnn.com/2012/02/02/world/meast/yemen-aid-workers/index.html (accessed March 1, 2012).
[151] CNN: U.S. Special Forces Rescue Somalia Aid Workers. http://articles.cnn.com/2012-01-25/africa/world_africa_somalia-aid-workers_1_special-forces-aid-workers-special-operations-troops?_s=PM:AFRICA (accessed March 1, 2012).
[152] Abby Stoddard, Adele Harmer and Katherine Haver, "Aid Worker Security Report 2011: Spotlight on Security for National Aid Workers: Issues and Perspectives," 7.
[153] Ibid.
[154] R. Dallaire and I. Beah, *They Fight Like Soldiers, they Die Like Children: The Global Quest to Eradicate the use of Child Soldiers* (New York, NY: Walker and Co, 2011), 1-3.

"savage little hooligans with no sense of right or wrong or value for life, armed with high velocity rifles and normally high as kites."[155] Yet they are still children.

Child soldiers are not indigenous to any one country. The United Nations estimates there are a quarter million child soldiers, or combatants under the age of eighteen, serving in around thirty armed conflicts worldwide in combat or combat-support roles.[156] Many people are aware that approximately 800,000 people were murdered during the Rwandan genocide, but few realize that children, even girls, were among the killers.[157] In 2002, a fourteen-year-old sniper caused the first American combat fatality in Afghanistan, that of Special Forces Sergeant First Class Nathan Chapman.[158] The thought of children as belligerents is inconceivable to most people. It creates intrapsychic conflict for responders who are negotiating with armed children for access to humanitarian space or who are witnessing children threatening or harming others.

Easily overlooked as a potential critical incident, betrayal by colleagues or leadership can be among the most psychologically damaging events in complex emergencies. In Dante's Divine Comedy those who betray others are relegated to the lowest depths of hell.[159] Julie Fitness states, "Betraying another person or group of people implies unspeakable disloyalty, a breach of trust, and a violation of what is good and proper."[160] Bosch notes the importance of aid workers feeling that their contributions matter. "When that is undermined by a sense of betrayal," he writes, "it is demoralizing to the very soul."[161]

Sometimes leaders inadvertently disregard the needs of staff in the chaos of competing demands, miscommunication, or limited resources. This unresponsiveness can often feel like administrative betrayal. Shirley Brownell describes an incident following an ambush in Somalia: "What struck me as particularly tragic throughout this ordeal was that the UN administration seemed more interested in recovering its stolen vehicle than in

[155] Phil Ashby, "Child Combatants: A Soldier's Perspective," *The Lancet,* 360 (December, 2002), s12.
[156] United Nations Report of the Special Representative of the Secretary-General, *Children and Armed Conflict*, Sixtieth Session Promotion and protection of the rights of children (2005), 2.
[157] L. Sharlach, "Gender and Genocide in Rwanda: Women as Agents and Objects of Genocide," *Journal of Genocide Research* 1, no. 3 (1999): 387.
[158] P. W. Singer, *Children at War,* 25.
[159] Julie Fitness, *Betrayal, Rejection, Revenge, and Forgiveness: An Interpersonal Script Approach*. (Macquarie University, 2001) 2; Dante Alighieri, *Divine Comedy* (Edison, NJ: Chartwell Books, Inc., 2006).
[160] Julie Fitness, *Betrayal, Rejection, Revenge, and Forgiveness: An Interpersonal Script Approach,* 2.
[161] The Headington Institute, *Dealing with the Stress of Humanitarian Work.*

showing any caring and concern about the pain, suffering, and death of its civilian staff."[162] Multiple examples similar to the ambush in Somalia appeared throughout the literature, showing that when a critical incident, such as line-of-duty deaths, was related to subsequent ineffective agency response, the poor response appeared to be more psychologically damaging to responders.

There is currently no quantitative research on administrative betrayal, but qualitative stories appear throughout the literature. It is imperative for leadership to maintain open dialogue during deployments and, if needed, to provide some form of after care upon staff members' homecoming or movement to subsequent assignments; such actions could prevent feelings of betrayal and lessen potential distress experienced by staff.

QUOTES FROM THE FIELD

"I have seen in my career I thought all of the atrocities until the moment that I was faced with atrocities against women and girls and in particular sexual violence. I was not prepared for that kind of violence. It was beyond belief."

Patrick Cammaert,
retired major general,
former commander UN
peacekeeping operations
(*War Redefined,* PBS, 2011)

"I struggled to find a way to understand and regain my footing as a man, as a doctor and as a putative humanitarian. And I still struggle now when I confront memories of that time, memories that are no longer unspeakable, but still unbearable."

An Imperfect Offering,
James Orbinski, M.D.,
past president of Médecins Sans
Frontières (Orbinski, 2008, 163)

Critical Incidents from Witnessing the Suffering of Others

Critical incidents derived from witnessing traumatic events experienced by others, involve events such as injury, torture, and death. Mary Kaldor reports that "in contemporary war, civilians are targets. The tactic is scaring civilians. The tactic is killing or expelling civilians or raping women."[163] Studies of British and Canadian peacekeepers serving in Bosnia from 1992 to 1995, revealed that 70 to 90 percent experienced direct threats on their lives. However, these individuals found witnessing the ethnic cleansing, torture, rape, and mutilation of others to be more distressing than threats on their own lives.[164]

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[162] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst, 25* (*An Ambush in Somalia,* Shirley N. Brownell).
[163] *Women War and Peace: War Redefined,* PBS, 3:19-3:55. http://video.pbs.org/video/2165993549 (accessed February 1, 2012).
[164] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst,* 37 (*Studies on Military Peacekeepers*, Jos M. P. Weerts, Wendy White, Amy B. Adler, Carl A. Castro, Gielt Algra, Inge Bramsen, Anja J.E. Dirkzwager, Henk M. van der Ploeg, Maaike de Vries and Ad Ziljlmans.); C. Lamerson and E.Kelloway, "Towards a Model of Peacekeeping Stress: Traumatic and Contextual Influences," *Canadian Psychology*, 37:4 (1996): 195-204; G. Passey and D. Crockett, *Psychological Consequences of Canadian UN Peacekeeping* (Government of Canada Publication, Ottawa, 1999); P. Roberts, W*ar in*

"Stupid deaths," as they are called by Paul Farmer and others, are deaths that are preventable.[165] Children should not die from the measles when a vaccine exists; nor should they die from cholera because of lack of access to clean water. Lack of dignity for the dead occurs when bodies are left to decompose on the street or dumped into mass graves.

The challenge of passively monitoring atrocities against others appears throughout the literature under review, predominately in individual narratives. Karesh Jetly describes how taking action gives responders a sense of control."[166] Conversely, inaction involves a loss of control and can result in feelings of helplessness and destroyed altruism.[167] Few are left untouched after witnessing heinous acts inflicted on others or after witnessing the consequences of such acts. The suffering of women and children is particularly troubling. The responders may incur psychological wounds that run deep. However, some wounds may not manifest themselves until months or years later when something triggers the memory of them. This may potentially alter research findings regarding the distress potency of a particular critical incident.

Psychological Casualties

War and other complex emergencies have psychological as well as physical casualties.

In addition to physical risks and cumulative stressors that are inherent in development work, there is evidence that prolonged exposure of aid workers to extreme human suffering, and exposure to violence towards themselves, their co-workers, or the communities they are attempting to assist, can have a severe psychological impact on workers.[168]

Peace: A Field Study in Bosnia of Troops in a Siege Under Fire, presentation at the 16th Annual Meeting of the International Society for Traumatic Stress Studies, San Antonio, Texas, USA, November 16-19 2000.

[165] *While Paul Farmer has used the "*stupid deaths*" in presentations, the term has been commonly used in responder circles and therefore its origin cannot be determined.

[166] Hayden A. Duggan and Tom Greenhalgh, *From Battlefield to Street: One Uniform to Another* Course, PowerPoint's, 104.

[167] Ibid.

[168] J. Guy, *Humanitarian Aid Personnel and Chronic Traumatic Stress,* Headington Institute. www.headington-institute.org/Default.aspx?tabid=1331 (accessed March 1, 2012).

It is well documented that the number of individuals experiencing psychological distress during disasters greatly exceeds the number of individuals who are physically injured.[169] Roughly, 80 percent of casualties are psychological, and 20 percent are physical, especially in disasters where the "boundaries of exposure are unclear."[170] The ratio can range from 4:1 to 50:1, depending on the cause of the event.[171] D. Myers notes that "following the Sarin gas attacks in Tokyo, 12 people died and 900 received medical treatment, but 9000 people presented with psychological complaints; a ratio of 1:10."[172] F. Norris, M. Friedman, and P. Watson contend that acts of mass violence produce "severe psychological impairment in a higher proportion of survivors than do natural disasters."[173] The nature of the stressors, their cumulative effects, and the likelihood of exposure to further critical incidents all affect the chance that responders to complex emergencies may become psychological casualties.

Lack of research and varying data collection methods make it difficult to conduct meta-analyses on the mental health of complex emergency responder populations. However, research performed on symptomatology shows higher rates of PTSD among relief workers compared to the general U.S. and European populations.[174] Kaz de Jong estimates that 3 to 4 percent of Médecins Sans Frontières workers develop severe mental illnesses such as depression while working in the field.[175] Bosch list flashbacks, intrusive thoughts, and paranoia as some of the indicators that parts of the brain—such as the hippocampus, which acts as the brain's "shock absorber"—are not fully operating.[176] Anthony Feinstein and his colleagues found that war journalists have PTSD rates

[169] Center for Disaster Epidemiology and Emergency Preparedness, *Surge, Surge, Support: Disaster Behavioral Health for Health Care Professions,* 120.
[170] Ibid.
[171] George Everly, Fostering *Human Resilience in Crisis: A Primer on Psychological Body Armor and Psychological First Aid and Resilient Leadership,* (Ellicott City, MD: Chevron Publishing Corp., 2011), 22.
[172] D. Myers, *Weapons of Mass Destruction and Terrorism. The Ripple Effect from Ground Zero* (Washington, DC: American Red Cross, 2001) 23; George S. Everly, Douglas J. Mitchell, Diane Myers and Charles E. Woods, National Guard Trained Crisis Responder (TCR) Course: Terrorism and Disaster Response Trainer's Guide, 78.
[173] Center for Disaster Epidemiology and Emergency Preparedness, *Surge, Surge, Support: Disaster Behavioral Health for Health Care Professions,* 131; F. Norris, M. Friedman and P Watson, "60,000 Disaster Victims Speak, Part 2: Summary and Implications of the Disaster Mental Health Research," *Psychiatry*, 65 (2002b): 204-260.
[174] Ellen Connorton, Melissa J. Perry, David Hemenway and Matthew Miller, "Humanitarian Relief Workers and Trauma-related Mental Health,"145.
[175] The Headington Institute, *Dealing with the Stress of Humanitarian Work.*
[176] Ibid.

comparable to those of combat veterans, as well as higher levels of depression than the general population.[177]

Roméo Dallaire speaks articulately about his own battle with PTSD following peacekeeping missions during the Rwandan genocide.[178] He writes, "I plunged into a disastrous mental health spiral that led me to suicide attempts, a medical release from the Armed Forces, and a diagnosis of post-traumatic stress disorder."[179] A meta-analysis of twelve studies on the prevalence of PTSD among peacekeepers, conducted by Fernandes Souza and colleagues, showed PTSD cases in the range of 5 to 25.8 percent.[180] However, as with other studies of responder populations, variations in study methodologies and psychometric tests impede the establishment of concrete findings.[181]

Connorton and colleagues mention the lack of assessment of relief workers upon their return home; without such assessment, after-care problems and needs are not likely to be adequately acknowledged or addressed.[182] M. McCreesh states that up to 60 percent of British relief workers experience stress responses during their reintegration phase.[183] In complex emergencies, responders are often on temporary assignments and move from one area of operation to another, then return home when a contract has ended. Others' assignments end abruptly due to security situations. This type of transilience, together with other factors, makes it difficult to provide routine assessments of responders for PTSD, depression, or other long-term psychological impairments. It is imperative, especially following assignments with critical incidents, that humanitarian workers are provided with uniform methodological screenings and follow-ups. Furthermore, it is recommended that longitudinal studies of the results of those screenings be conducted. Without such studies,

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[177] Anthony Feinstein, John Owen and Nancy Blair, "A Hazardous Profession: War, Journalists, and Psychopathology," *Am J Psychiatry,* 159 (2002): 1570-1575.

[178] *The Invisible Veterans* - LGen Roméo Dallaire (Ret.) - Part 1-3 http://www.youtube.com/watch?v=Az48iVOSE6M&feature=results_video&playnext=1&list=PL2BE9D43730529711 (accessed January 1, 2012).

[179] Roméo Dallaire, *Shake Hands with the Devil: The Failure of Humanity in Rwanda* (New York, NY: Carroll and Graf Publishers, 2005), 5

[180] Wanderson Fernandes Souza, Ivan Figueira, Mauro Mendlowicz, Eliane Volcham, Cara Marques Portella, Ana Carolina Feraz Mendonca-de-Souza and Evandro Silva Freire Coutinho, "Posttraumatic Stress Disorder in Peacekeepers A Meta-Analysis," *The Journal of Nervous and Mental Diseases*, Volume 199, No. 5, (May 2011): 309- 310.

[181] Ibid.

[182] Ellen Connorton, Melissa J. Perry, David Hemenway and Matthew Miller, "Humanitarian Relief Workers and Trauma-related Mental Health," 153.

[183] Centre for Intercultural Learning Canadian Foreign Service Institute: *Staff Reintegration Following High-Risk Missions Good Practices in Supporting International Development and Aid* http://www.dfait-maeci.gc.ca/cfsi-icse/cil-cai/pdf/staff-2009-eng.pdf (accessed January 2012); McCreesh M., *Re-Entry Syndrome*, 2003 www.aidworkers.net?q-node/263, No longer online.

it is very difficult to illustrate the scope of problems, including the delayed onset of psychological impairment, and to effectively assist those in need.

Part One Summary

Although a consortium of United Nation programs, NGOs, universities, and professionals have collaborated to identify mental health issues and provide psychosocial support to service populations, comparably little empirically validated research has been done on interventions to support the responder population. This is not because a need does not exist. Data is scarce because of the complexity of conducting research in a dynamic environment, where it is difficult to control for multiple variables that can affect the outcome. These variables include innate resilience, the brain's natural ability to heal following trauma, subjective interpretation of the critical incident, cumulative stress demand, and myriad of possible stress reactions. People in Aid, the Antares Foundation, and the Headington Institute have made a concerted effort to establish guidelines and recommendations for staff care for relief worker organizations;[184] however, limited resources and competing demands in responder organizations can inhibit the operationalizing of these recommendations. According to the 2007 Interagency Guidelines on Mental Health and Psychosocial Support in Emergency Settings, "The provision of support to mitigate the possible psychosocial consequences of work in crisis situations is a moral obligation and responsibility of organizations exposing staff to extremes."[185]

In order for responders to do their work successfully, they must not burn out or suffer from other forms of impairment. Future research must concentrate on solidifying an understanding of the dynamics of complex emergency critical incidents through the use of Critical Incident History Questionnaires or comparable instruments. Uniform methodological and longitudinal studies on responder stress reactions are imperative to illustrate the scope of the problem and to support the design of an appropriate framework to address the needs.

Part 2 of this paper looks at crisis intervention models and approaches that attempt to decrease the frequency of psychological casualties experienced by responders in the current humanitarian landscape.

[184] Ibid., 4.
[185] Interagency Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007). http://www.who.int/hac/network/interagency/news/iasc_guidelines_mental_health_psychososial.pdf (accessed January 1, 2012).

Often crisis intervention is confused with psychotherapy even though the context, objectives, and practices are dramatically different. Jeffrey Mitchell uses a medical first aid analogy to describe crisis intervention: "Just as medical first aid is not a replacement for definitive medical care and surgery, crisis intervention is not psychotherapy; nor is it a substitute for psychotherapy. . . . It's more about support than it is about cure."[186]

Anatomy of Crisis Intervention

The National Guard Trained Crisis Responder course highlights some key differences between crisis intervention and psychotherapy: Crisis intervention concentrates on prevention and mitigation of stress reactions, while psychotherapy often focuses on repair and growth.[187] Crisis intervention takes place rapidly and in close proximity to the stressors, while the psychotherapy response is delayed and in a remote location. [188] The main efforts of crisis intervention focus on the present, whereas psychotherapy often also concentrates on the past and future.[189]

A "psychological crisis" is a reaction to a stressor, such as trauma, disaster, or another critical incident.[190] Crisis intervention is the response to the psychological crisis. Caplan characterized a psychological crisis as having three main components:

1. Disruption to the balance between one's thinking and emotions
2. A failure of one's usual coping mechanisms
3. Evidence of signficant distress, impairment or dysfuction[191]

The goals of crisis intervention are also threefold, according to Mitchell and his colleages:

1. Assess the nature and severity of a crisis reaction (triage)
2. Stabilize the situation
3. Reduce the distress associated with an acute crisis response[192]

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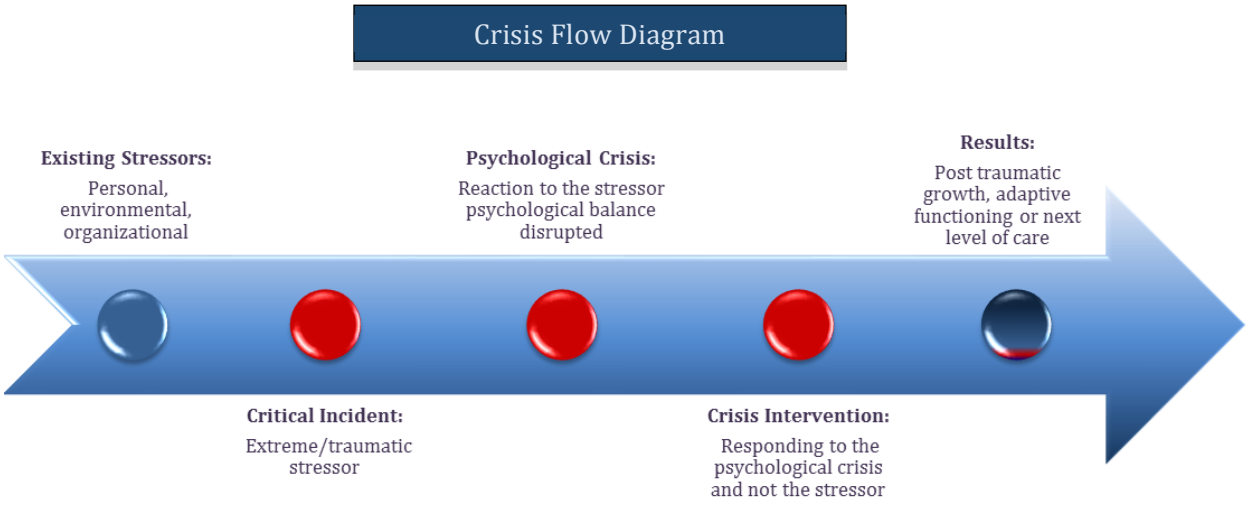
[186] Jeffrey T. Mitchell, "Major Misconception in Crisis Intervention," *International Journal Emergency Mental Health*, Volume 5, No. 4, 2003): 121.
[187] George S. Everly, Douglas J. Mitchell, Diane Myers and Charles E. Woods, National Guard Trained Crisis Responder (TCR) Course: Terrorism and Disaster Response Trainer's Guide, 78.
[188] Ibid.
[189] Ibid.
[190] V. R. Volkman and J. Durkin, *Traumatic Incident Reduction and Critical Incident Stress Management: A Synergistic Approach, (*Loving Healing Press, 2006), 122.
[191] Jeffrey Mitchell, George Everly and Daniel Clark, *Strategic Response to Crisis,* (Ellicott City, MD: International Critical Incident Stress Foundation, 2006), 11; G. Caplan, *Principles of Preventive Psychiatry,* (New York, NY: Basic Books, 1964).
[192] Jeffrey Mitchell, George Everly and Daniel Clark, *Strategic Response to Crisis,* 11.



The goal of crisis intervention is to focus on a person's psychological reaction to a critical incident and not on the incident itself. D. A. Alexander believes that "resilience rather than psychopathology is the norm."[193] It is well documented that some people, when faced with traumatic stressors, will maintain or return to normal adaptive functioning on their own[194] and may even experience posttraumatic growth.[195] Other people may benefit from various crisis intervention techniques designed to assist them in returning to normal adaptive functioning. A third group of people may experience severe dysfunction beyond what can be addressed through the selected crisis intervention technique. These people will need to be referred to the next levels of psychological or medical care. George Everly states that "the direct implementation of crisis intervention tactics is predicated upon evidence of human distress and/or dysfunction, not merely the occurrence of an event" stressor.[196] Determination of the most effective crisis intervention technique is predicated upon knowledge of the targeted individuals' and groups' needs.

[193] Muhammad Sami Bilal, Mowadat Huassain Rana, Sajid Rahim, Sohail Ali, "Psychological Trauma in a Relief Worker: A Case Report. from Earthquake-Struck Areas of North Pakistan," Department of Psychiatry, Military Hospital, Rawalpindi, Pakistan, *Prehospital and Disaster Medicine*, Vol. 22, No. 5 (2007): 459; D.A. Alexander, *Psychiatric Sequelae of Trauma*. In: Greaves I, Porter K (Eds): Key Topics in Trauma. (Oxford, 1997), 249-257.
[194] Carol S. North, Laura Tivis, J. Curtis McMillen, Betty Pfefferbaum, Jann Cox, Edward L. Spitznagel, Kenneth Bunch, John Schorr, and Elizabeth M. Smith, "Coping, Functioning, and Adjustment of Rescue Workers After the Oklahoma City Bombing," *Journal of Traumatic Stress*, Vol. 15, No. 3 (June, 2002): 171-172.
[195] Tzipi Weiss and Roni Berger, *Posttraumatic Growth and Culturally Competent Practice: Lessons Learned from Around the World* (Hoboken, NJ: John Wiley and Son Inc, 2010).
[196] George S. Everly, "Five Principles of Crisis Intervention: Reducing the Risk of Premature Crisis Intervention," *International Journal of Emergency Mental Health* 2, No. 1 (Winter, 2000): 1-4.

Crisis Intervention History

Crisis intervention is often referred to as acute psychological care, psychological first aid, or emotional first aid. Everly and Mitchell define crisis intervention as providing "urgent psychological/behavioral care designed to first stabilize and then reduce symptoms of distress/dysfunction so as to achieve a state of adaptive functioning," or providing a referral to the next level of care.[197] Although debate lingers over the exact origins of crisis intervention, a wide variety of professions significantly contributed to the established collection of crisis intervention methodologies. Throughout different periods, these professions have borrowed and adapted many of each other's techniques. Crisis intervention methods became prevalent worldwide and are multicomponent in nature.

Given the scarcity of existing data and literature on crisis intervention within the complex emergency responder population, this chapter focuses on military organizations, emergency service personnel, civilian crisis workers, and disaster response teams who deal with threats and critical incidents such as those noted in the following table. The review of crisis intervention models employed by these organizations and groups is for the purpose of gauging what crisis intervention models or approaches may be appropriate for the complex emergency responder population.

[197] T.C. Neil, J.E. Oney, B. Thacker and W. Reichart, *Emotional First Aid* (Louisville, KY: Kemper Behavioral Science Associates, 1994); George S. Everly, and Jeffrey T. Mitchell, *Integrative Crisis Intervention and Disaster Mental Health,* 7-8.

Critical Incidents Across Professions

	Critical Incident Type	Military	Law Enforcement, Fire, and Medical	Civilian Crisis Work	Disaster Response
Direct Impact to Responder Population	Death or serious injury in line of duty	X	X		
	Kidnapping; hostage taking; abduction	X			
	Severe Injury or Illness	X	X		X
	Bombings ; IED attacks; mine, grenade, or other explosions	X			
	Actual or threatened assault or battery	X	X	*	
	Triage; making life and death decisions	X	X		X
	Evacuation or unfinished business	X			X
	Administrative betrayal	X	X		
	Attempted or completed suicide of a colleague	X	X	X	X
	Children as belligerents	X	X		
Witnessing the Suffering of Others	Injury, death, or targeting of children	X	X	X**	X
	Women as targets for harm, including rape	X	X	X	
	Heinous mutilations or torture	X	X		
	Unearthing, identifying, and examining mass-grave bodies	X	X		X***
	Monitoring atrocities passively	X			
	Witnessing gross human rights violations	X	X		
	Lack of dignity for the dead	X			X
	Needless "stupid deaths“	X	X		X
	Mass casualties	X	X		X

Notes:

*Although civilian crisis workers may not be targets of assaults and threats, they deal with populations that have been targets, such as victims of crime.

**Witnessing injury, death, or targeting of children is akin to witnessing cases of severe child abuse or neglect for civilian crisis workers

***Unearthing, identifying, and examining mass-grave bodies is akin to collecting and identifying bodies in crime scenes or disasters

Military Contribution to Core Acute Crisis Intervention Principles

In the United States Civil War, Jacob Mendes Da Costa observed a correlation between tachycardia contributing to anxiety and hypervigilance among uninjured front-line soldiers. Da Costa referred to this as "the irritable heart of a soldier."[198] Cathartic ventilation and other techniques helped to mitigate war-related distress during the Franco-Prussian War (1870-1871).[199] Cathartic venting via small group crisis intervention was used following the D-Day invasion in World War II.[200] During the Russo-Japanese War (1904-1905), medical professionals were closer to the front lines, allowing them to better assist the soldiers experiencing psychological distress. It was discovered that if a soldier could be treated closer to the front while simultaneously receiving the emotional support of comrades, that soldier would return to duty quicker than soldiers who had been completely removed from the front in order to receive treatment.[201]

Marc Crocq and his colleagues believe that the use and success of forward operating treatment centers during the Russo-Japanese War, World War I, and the Vietnam War were precursors to and informed significantly the acute psychological briefings used among disaster victims today.[202] Given the security concerns, limited access, and the need for complex emergency responders to continue fieldwork following a critical incident, it may be advantageous for responder organizations to adopt and or continue using the forward operating treatment center concept that has been beneficial to the military during war.

During World War I, trench warfare, high-explosive shells, and machine guns appeared to shock the warriors' central nervous systems, resulting in cases of blindness, deafness, and paralysis with no given physiological cause. This gave rise to the terms shell-

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[198] Nicholas L. Rock, James W. Stokes, Ronald J. Koshes, Joe Fagan, William R. Cline and Franklin D. Jones, War Psychiatry: U.S. Army Combat Psychiatry (Office of The Surgeon General United States of America, 1995), 153.
[199] Carla Frayne, *The Verdict Is In: CISM Endorsed By The U.N,* Emergency Support Network: http://www.emergencysupport.com.au/articles/verdictcism.asp (accessed January 1, 2012); Adapted from Jeffrey T. Mitchell, "From Controversy to Confirmation: Crisis Support Services for the Twenty-First Century," *International Journal of Emergency Mental Health*, Vol. 10, No. 4, (2008).
[200] Atle Dyregrov, *Psychological Debriefing: A Leaders Guide for Small Group Crisis Intervention* (Ellicott City, MD: Chevron Publishing, 2003), 6.
[201] Ilona Meagher, *Moving a Nation to Care: Post –Traumatic Stress Disorder and America's Returning Troops* (Canada: Ig Publishing, 2007), 15; Marc-Antoine Crocq and Louis Crocq, "From Shell Shock and War Neurosis to Posttraumatic Stress Disorder: A History of Psychotraumatology," *Dialogues in Clinical Neuroscience*, Vol 2 . No. 1 (2000): 50; A. Kardiner, H. Spiegel, *War Stress and Neurotic Illness.* (New York, NY: Paul B. Hoeber Inc., 1947).
[202] Marc-Antoine Crocq and Louis Crocq, "From Shell Shock and War Neurosis to Posttraumatic Stress Disorder: A History of Psychotraumatology," 52.

shocked and traumatic war neurosis.[203] The symptoms of shell-shock did not appear to be caused by having to kill, but rather, as Ulrich Ziemann notes, by the anxiety and fear cause by witnessing the injury or death of comrades and hearing the constant noise of shelling.[204] In his 1915 review of eighty-eight cases, French psychiatrist Emmanuel Régis reached comparable findings and described the "etiological role" of a soldier witnessing the killing of his comrades.[205] The psychological effects from exposure to violence continue to be evident today in research done on peacekeepers, media, relief workers.[206]

Studies of cases from World War II have indicated that group morale, unit cohesion and strong leadership can play a significant role in palliating "combat stress causalities."[207] Whether the benefits of unit cohesion can apply equally to responders to complex emergencies remains to be seen. It is possible that while responders work as individuals or in small groups on particular operations, the network of colleagues throughout the world can play a supportive role when needed, as was seen after the murders of relief workers in Chechnya. [208]

Simple rest and relaxation (or rest and recuperation), known today in military and emergency service circles as R&R, comprises a warm shower, a hot meal, and a good night's sleep, all of which contribute significantly to the rejuvenation of soldiers. German First Aid stations during World War II provided milk and chocolate to soldiers who had undergone a traumatic event.[209] Abraham Maslow's Hierarchy of Needs pyramid emphasizes the importance of addressing biological needs before progressing to higher-level needs.[210] The Salvation Army recognizes the value of simplicity when working with disaster victims, as is

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[203] *Psychiatric Lessons of War, War Psychiatry*, 9; Ilona Meagher. *Moving a Nation to Care: Post –Traumatic Stress Disorder and America's Returning Troops* (Ig Publishing Canada, 2007),16.
[204] B. Ulrich, Ziemann, *Frontalltag im Ersten Weltkrieg. Wahn und Wirklichkeit. (*Frankfurt, Germany: Fischer, 1994),102-103.
[205] Marc-Antoine Crocq and Louis Crocq, "From Shell Shock and War Neurosis to Posttraumatic Stress Disorder: A History of Psychotraumatology," 49.
[206]C. B Eriksson, H Vande Kemp, R Gorsuch, S, Hoke, and D. W. Foy, "Trauma Exposure and PTSD Symptoms in International Relief and Development Personnel," *Journal of Traumatic Stress*, 14 No. 1 (2001): 205–219; I. Bramsen, A.J.E. Dirkzwager, and H.M. Van der Ploeg, "Predeployment Personality Traits and Exposure to Trauma as Predictors of Posttraumatic Stress Symptoms: A Prospective Study of Former Peacekeepers," *American Journal of Psychiatry, 157, No.* 7 (2000): 1115–1119; Katharine M. Putman, Jeanette I. Lantz, Cynthia L. Townsend, Autumn M. Gallegos, Amy A. Potts, Rebecca C. Roberts, Emily R. Cree, Marina de Villagra, Cynthia B. Eriksson, David W. Foy, "Exposure to Violence, Support Needs, Adjustment, and Motivators Among Guatemalan Humanitarian Aid Workers," *Am J Community Psychol*, 44 (2009): 109–115; Elana Newman, Roger Simpson and David Handschuh, "Trauma Exposure and Post-Traumatic Stress Disorder among Photojournalists," *Visual Communication Quarterly*, 10:1, (2003): 4-13.
[207] *Psychiatric Lessons of War*, War Psychiatry, 11-12.
[208] United Nations High Commissioner for Refugees: Staff Welfare Unit Career and Staff Support Services, *Managing the Stress of Humanitarian Emergencies,* 14.
[209] Marc-Antoine Crocq and Louis Crocq, "From Shell Shock and War Neurosis to Posttraumatic Stress Disorder: A History of Psychotraumatology," 52.
[210] NATO Joint Medical Committee, *Psychosocial Care for People Affected by Disasters and Major Incidents: A Model for Designing, Delivering and Managing Psychosocial Services for People Invovled in Major Incidents, Conflict, Disaster and Terrorism* (NATO, 2008), I-49.

evident in their slogan: "soap, soup, and salvation." Various complex emergency responder organizations provide respite areas or R&R to their personnel.[211] Islamic Relief provided televisions to their staff to watch during their downtime when they were deployed for the Haiti earthquake response,[212] while other humanitarian organizations organized sports, games, and exercise opportunities to "alter stress-addled brains."[213]

A dramatic increase in psychological casualties, combined with the success of forward treatment in close proximity to the front line, led to the identification of five core principles for treatment of the psychological wounds of war. These treatment principles, first identified by Thomas Salmon in 1917, are immediacy, proximity, expectancy, simplicity, and centrality.[214] Immediacy requires immediate to early intervention, before symptoms transform into more chronic or pathogenic variants. Proximity involves bringing emotional support systems as close to the battlefield as possible. Providing treatment at or near the battlefields reduces the frequency of instances where soldiers feel guilty about leaving comrades behind or conflicted about leaving a peaceful area to return to the front lines. The principle of expectancy refers to an approach in which the patient is advised that his ailments may be temporary and that he has the capacity to recover. The practice of simplicity involves addressing the basic human needs of the affected person, rather than attempting to provide intense counseling that might require the person to divulge and deal with past traumas or inadequacies. Centrality requires provision of services apart from traditional mental health

[211] Centre for Intercultural Learning Canadian Foreign Service Institute: *Staff Reintegration Following High-Risk Missions. Good Practices in Supporting International Development and Aid.* http://www.dfait-maeci.gc.ca/cfsi-icse/cil-cai/pdf/staff-2009-eng.pdf (accessed January 2012); McCreesh M., *Re-Entry Syndrome*, 2003 www.aidworkers.net?q-node/263, No longer online. Good Practices in Supporting International Development and Aid http://www.dfait-maeci.gc.ca/cfsi-icse/cil-cai/pdf/staff-2009-eng.pdf (accessed January 1, 2012).
[212] The Headington Institute, *Dealing with the Stress of Humanitarian Work.*
[213] Ibid.
[214] Marc-Antoine Crocq and Louis Crocq, "From Shell Shock and War Neurosis to Posttraumatic Stress Disorder: A History of Psychotraumatology," 50.

institutions in order to lessen the stigma felt by those seeking assistance for their mental health needs.[215] The literature review showed that many complex emergency responders chose not to seek mental health care through traditional channels due to the associated stigma; [216] they may have benefited from care from nontraditional channels.

In later iterations, these five crisis intervention principles changed, but the core focus on proximity, immediacy and expectancy—or "PIE"[217]—remained. The "BICEPS" principles currently used by the United States Army are brevity, immediacy, centrality/contact, expectancy, proximity, and simplicity.[218] The principles of pragmatism ("goal-directed and action-oriented" responses) and innovation ("creative and flexible" responses) from other disciplines are also incorporated.[219] Threads of the crisis intervention principles learned in the military have been woven into almost all acute crisis intervention methodologies across multiple disciplines.

Critical Incident Stress Management for Emergency Services

As a graduate student in psychology and a paramedic and firefighter in the 1970s, Mitchell saw the psychological impact certain traumatic incidents had on emergency service personnel. In 1983, using earlier established crisis intervention treatment principles from the military, Mitchell developed a group crisis intervention component known as Critical Incident Stress Debriefing (CISD) to address the unique concerns of police officers, firefighters, and others in emergency services. Semantic confusion over the CISD process within the literature occurred initially when Mitchell used the term CISD to describe both a multicomponent crisis

[215] Laurence Miller, Wounded Warriors: Stress and Crisis Management for Military and Law Enforcement Personnel (The Crisis Management and Traumatic Stress Report, A Publication of the National Center for Crisis Management, 2008), 11.
[216] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst,* 18 (*Peacekeepers in Peace-Builders Under Stress,* Sue Downie); 55 (*Caring for Staff in UNHCR,* Soren Jessen-Petersen).
[217] Laurence Miller, Wounded Warriors: Stress and Crisis Management for Military and Law Enforcement Personnel, 11-12.
[218] E.A. Brusher. "Combat and Operational Stress Control." 111-122.
[219] George S. Everly and Jeffrey T. Mitchell, *Integrative Crisis Intervention and Disaster Mental Health,* 99.

intervention approach and a specific group crisis intervention component.[220] By 1997, the multicomponent, comprehensive, systematic, and integrated range of crisis support services was renamed Critical Incident Stress Management (CISM),[221] which covers a spectrum of critical incident time frames from pre-incident, through during-incident, to post-incident. The CISD group crisis intervention component kept its original name. The primary focus of CISM is to prevent or mitigate dysfunction brought on by exposure to critical incidents through a wide array of components, such as defusing, demobilization, pre-crisis preparation, and SAFER-R Individual Crisis Intervention.

Pre-crisis preparation is an important component in CISM. It helps to set expectations, improve coping mechanisms, and educate responders on techniques they may employ when they are subjected to high levels of stress. Dave Grossman refers to "stress inoculation" as key in helping people to prepare for traumatic incidents, address them, and rapidly regain balance afterward.[222] The International Red Cross uses psychological support teams to provide psychological preparedness services to their staff prior to deployments.[223] According to Ron Avery, "prior success under stressful conditions acclimatizes you to similar situations and promotes future success."[224] The Headington Institute's "high-fidelity stress exposure training" helps prepare staff for likely stressful situations they may encounter.[225]

Exposure to mass casualties, seriously injured children, or a colleague's death in the line of duty can have an overwhelming impact on responders. The use of trusted fellow police officers to aid their colleagues in distress following a shooting in Los Angeles, California, led the way to one of the first peer-support crisis interventions outside the

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[220] George S. Everly and Jeffrey T. Mitchell, "The Debriefing "Controversy" and Crisis Intervention: A Review of Lexical and Substantive Issues," *International Journal of Emergency Mental Health*, Vol. 2, No. 4 (2000): 213.

[221] George Everly and Jeffrey Mitchell, *Critical Incident Stress Management (CISM): A New Era and Standard of Care in Crisis Intervention* (Ellicott City, MD, Chevron, 1997); Carla Frayne, *The Verdict Is In: CISM Endorsed By The U.N,* http://www.emergencysupport.com.au/articles/verdictcism.asp (accessed January 1, 2012); Adapted from Jeffrey T. Mitchell, "From Controversy to Confirmation: Crisis Support Services for the Twenty-First Century*," International Journal Of Emergency Mental Health*, Vol. 10, No. 4, (2008).

[222] Dave Grossman and L. W. Christensen, *On Combat: The Psychology and Physiology of Deadly Conflict in War and in Peace 3rd Edition*, 30-49.

[223] Centre for Intercultural Learning Canadian Foreign Service Institute: *Staff Reintegration Following High-Risk Missions Good Practices in Supporting International Development and Aid.* http://www.dfait-maeci.gc.ca/cfsi-icse/cil-cai/pdf/staff-2009-eng.pdf (accessed January 2012); McCreesh M., *Re-Entry Syndrome*, 2003 www.aidworkers.net?q-node/263, No longer online.

[224] Dave Grossman and L. W. Christensen, *On Combat: The Psychology and Physiology of Deadly Conflict in War and in Peace*, *3rd Edition,* 35.

[225] The Headington Institute, *Dealing with the Stress of Humanitarian Work.*

military.[226] It has been acknowledged that people experiencing a psychological crisis would prefer to seek help from others in their same occupation who understand their culture, rather than from outsiders. Peer-support crisis intervention was later replicated by hospitals, fire services, international aid organizations, and schools. The UNHCR developed a strong Peer Support Personnel Network of around 100 trained staff members based in duty stations around the world.[227] World Vision International has ninety peer supporters in fifty countries who are trained in CISM.[228] Médecins Sans Frontières in Holland found that staff were concerned that talking with their peers about stress reactions would affect future assignments.[229] Therefore, they created a volunteer peer support network independent of the agency's administration.[230]

In 2007, CISM was adopted by the United Nations General Assembly. Due to controversy over nomenclature because some terms have multiple meanings or are not translatable, alternative names were given for the demobilization, defusing and critical incident stress debriefing components of CISM.[231] For example, the name CISD has been replaced with Powerful Event Group Support (PEGS), demobilization was replaced with Rest, Information, and Transition Services (RITS), and defusing was replaced with Immediate Small Group Support (ISGS). Only the names changed; the interventions remained the same. Some of the NGOs working in relationship with the United Nations have also elected to use the newer CISM component nomenclatures. The People in Aid 2011 comprehensive manual on debriefing aid workers and missionaries uses Critical Incident Debriefing as their rendition of CISD.[232]

Critical Incident Stress Debriefings were conducted with Singapore media personnel following the December 26, 2004, Asian tsunami, which claimed thousands of lives. Twelve

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[226] Robyn Robinson, *Establishing and Maintaining Peer Support Programs in the Workplace* (Ellicott City, MD: Chevron Pub Corp., 2003), 6.
[227] United Nations High Commissioner for Refugees: Staff Welfare Unit Career and Staff Support Services, *Managing the Stress of Humanitarian Emergencies,* 29.
[228] Benjamin Porter and Ben Emmens, *Approaches to Staff Care in International NGO's* (People In Aid/InterHealth September 2009), 33. http://www.interhealth.org.uk/editpics/File/Approaches%20to%20Staff%20Care%20in%20International%20NGOs.pdf accessed May 1, 2012.
[229] Centre for Intercultural Learning Canadian Foreign Service Institute: *Staff Reintegration Following High-Risk Missions Good Practices in Supporting International Development and Aid.* http://www.dfait-maeci.gc.ca/cfsi-icse/cil-cai/pdf/staff-2009-eng.pdf (accessed January 1, 2012); McCreesh M., *Re-Entry Syndrome*, 2003 www.aidworkers.net?q-node/263, No longer online.
[230] Ibid.
*Note the crisis intervention approach MSF PNP uses is not listed in the literature but one can surmise is may be akin to a psychological first aid approach.
[231] George S. Everly and Jeffrey T. Mitchell, *Integrative Crisis Intervention and Disaster Mental Health,* 207-217.
[232] Debbie M. Lovell-Hawker, *Debriefing Aid Workers and Missionaries: A Comprehensive Manual, 8th Edition, (London, England:* People In Aid, June 2011), 20-38.

media personnel who worked between four and twelve days in the affected area were divided into two groups, with each group receiving a CISD within 1 week of returning home.[233] The sessions lasted approximately two hours and were conducted by trained mental health professionals. The participants indicated the benefit of being included with a group of peers who shared similar experiences. Fifty percent of the participants rated the overall debriefing as having a high value, and 41.7 percent rated the debriefing as having a moderate value.[234] Thus 91.7 percent of the participants expressed that hearing the experiences of others had either high or moderate value for them (66.7% high and 25% moderate). [235] Seventy-five percent of the participants reported placing either a moderate or a high value on being notified about potential post disaster symptoms. Finally, 88.3 percent of the participants found a moderate or high value in discussing coping strategies. [236]

CISM was also integrated into the U.S. military.[237] One example is the Dover Air Force Base mortuary's use of CISDs after personnel processed the remains of 248 service members killed when their airplane crashed over Newfoundland while they were en route home after serving in a multinational peacekeeping mission in Sinai.[238] Further occupational groups that have employed the CISM model include the Federal Aviation Administration, the Secret Service, the Federal Bureau of Investigation, and the Massachusetts Department of Mental Health in the United States, as well as the Swedish National Police, Icelandic rescue teams, and various Red Cross components.[239]

Learning from the CISM model and earlier-established crisis intervention treatment principles, others developed crisis intervention models to address cumulative stress and multiple critical incident exposure. The U.S. Army created the "Battlemind Psychological Debriefing" in 2007 to help troops prepare for and subsequently address multiple stressors

[233] S.S. Sin, A. Chan, C.Y. Huak. "A Pilot Study of the Impact of the Asian Tsunami on a Group of Asian Media Workers," *International Journal Emergency Mental Health,* Vol. 7, No. 4 *(*2005): 299-305.
[234] Ibid., 301-303.
[235] Ibid.
[236] Ibid.
[237] Secretary of the Air Force, Air Force Instruction 44-15A Critical Incident Stress Management, July, 1999. http://www.calguard.ca.gov/csc/Documents/afi44-153.pdf (accessed January 1, 2012).
[238] Theresa Humphrey, "The Armed Forces' Mortuary Base: Debriefings Ease Stress of Dealing with Dead" *Los Angeles Times* (October 23, 1988).
[239] Raymond B. Flannery and George Everly, "Crisis Intervention: A Review," *International Journal of Emergency Mental Health*, Vol. 2, (2000): 121.

related to deployments in combat zones.[240] These debriefings occur over multiple time frames: Time-driven debriefings occur during the deployment to address the cumulative effects of stress. Event-driven debriefings occur following specific traumatic incidents. Post-deployment debriefings take place upon service members' return home. [241] Amy Adler and her colleagues found that 1,060 service members "with high levels of combat exposure who received Battlemind debriefing reported fewer posttraumatic stress symptoms, depression symptoms, and sleep problems than those in stress education."[242]

Similar frameworks were considered by Debbie M. Lovell-Hawker and her colleagues to address the deployment challenges of responders in complex civilian emergencies.[243] However, she is careful not to "over-debrief" personnel with too many meetings and thereby diminish the value of the debriefings.[244] On-Site Academy created the R.E.S.T.O.R.E. protocol for military debriefing to assist those who have been exposed to multiple critical incidents over a deployment.[245] Rather than debriefing each critical incident separately, R.E.S.T.O.R.E concentrates on key elements of the overall experience.[246] The debriefing focuses on participants' first impression of the deployment, followed by their hardest experience, and ending with their last impression.[247] Given that responders in complex emergencies are at times exposed to cumulative stress and multiple critical incidents, crisis intervention models like R.E.S.T.O.R.E. and Battlemind may prove valuable in helping them to process their deployments.

Acute Crisis Emergencies in Civilian Population

An important contribution to the established collection of crisis intervention methodologies for civilians experiencing critical incidents was research conducted by Eric Lindemann and Gerald Caplan on grief reactions following the 1942 Cocoanut Grove

[240] Amy B. Adler, Paul D. Bliese, Dennis McGurk, Charles W. Hoge and Carl Andrew Castro, "Battlemind Debriefing and Battlemind Training as Early Interventions With Soldiers Returning From Iraq: Randomization by Platoon," *Sport, Exercise, and Performance Psychology*, Vol. 1, (2011): 66–83.
[241] Ibid.
[242] Ibid.
[243] Debbie M. Lovell-Hawker, *Debriefing Aid Workers and Missionaries: A Comprehensive Manual, 8th Edition,*; Debbie M. Hawker, John Durkin and David S. J. Hawker, "To Debrief or Not to Debrief Our Heroes: That is the Question*," Clinical Psychology and Psychotherapy Clinical. Psychology Psychotherapy 18*, No. 6 (December 2010).
[244] Ibid., 36.
[245] Hayden A. Duggan and Tom Greenhalgh, *From Battlefield to Street: One Uniform to Another* Course, PowerPoint's, 152-161.
[246] Ibid., 155-156.
[247] Ibid.

nightclub fire in Boston, which took the lives of 493 people within 15 minutes.[248] Researchers witnessed the complexity of the grieving process resulting from unexpected, "unnatural,"[249] and mass deaths from the perspective of the survivors and those who were connected with the survivors. Lindemann and Caplan opened a community mental health center and employed caretakers and clergy members to tend to immediate needs in the initial stages of grief.[250] Pastoral crisis counseling transformed into pastoral interventions and later proliferated to address individuals and groups in spiritual distress.[251] Shortly after the 9/11 attacks in New York City, the American Red Cross presented data showing that people were more likely to seek help from spiritual leaders than from mental health professionals.[252]

In the 1950s, community mental health programs grew and expanded to include suicide prevention centers. In their research, Edwin Shneidman and Norman Farberow dealt with the immediate concerns of those experiencing suicidal thoughts.[253] In the 1960s and 1970s, access to mental health programs was greatly improved by the advent of walk-in centers and telephone hotlines. The importance of providing immediate guidance and support anytime and anywhere was established.

The establishment of walk-in centers and telephone hotlines staffed partially by trained volunteers without clinical backgrounds multiplied the number of people available to provide intervention. As was the case with early military and first-responder peer intervention, it was accepted that paraprofessionals using problem-solving and emotional de-escalation techniques, outside of hospitals and with the guidance of mental health professionals, would be able to address the immediate needs of the crisis and prevent further damage.[254]

In 1986, the National Organization for Victims Assistance (NOVA) began using crisis intervention methods with crime victims and their families through crisis response

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[248] Barbara Rubel, "Sudden Loss: Impact of a grief-crisis intervention immediately after a sudden violent death on the survivor's ability to cope." *Illness, Crisis and Loss*, Vol. 7, No. 4, (October 1999): 390-401.
[249] G. Sprang and J. McNeil, "Post-homicide Reactions: Grief, mourning and post- traumatic stress disorder following a drunk driving fatality," *OMEGA--Journal of Death and Dying* 37, No. 1 (1998*): 46.*
[250] Donna C. Aguilera, *Crisis Intervention: Theory and Methodology,* Eighth Edition (St. Louis. MO: Mosby, 1998).
[251] George S. Everly, "The Role of Pastoral Crisis Intervention in Disasters, Terrorism, Violence, and Other Community Crises," *International Journal of Emergency Mental Health, Vol.* 2, No. 3 (2000): 139.
[252] * American Red Cross data from the 2001 Ripple Effect Conference in New York City, showed people were more likely to seek help from a spiritual leader than mental health professionals.
[253] George S. Everly and Jeffrey T. Mitchell, *Integrative Crisis Intervention and Disaster Mental Health,* 12-13.
[254] Ibid.

teams.[255] This program has been nationally recognized for its skills and protocol in mitigating trauma reactions following critical incidents.[256] Elements of NOVA crisis intervention may help lessen the distress experienced by responders to complex emergencies who have been targeted by belligerents.

With the advent of modern technology like smart phones, applications are now being developed for understanding the dynamics of distress, coping mechanisms, and relaxation techniques that can be employed with the touch of a finger. The U.S. Department of Veteran Affairs created a smart-phone app called PTSD Coach, which helps individuals to learn and manage symptoms that may occur following a traumatic event.[257] Perhaps a similar crisis intervention app can be created that enables complex emergency responders to access help, confidentially, anytime and anywhere the need arises.

Psychological First Aid Immediately Following Disasters

In 1952 F. C. Thorne first discussed the need for something akin to physical first aid to address the immediate psychological casualties of an emergency, rather than traditional in-depth, longer-term therapy.[258] Thorne stated, combined with catharsis to vent the emotions "reassurance is probably the first aid method par excellence."[259] In 1954, the American Psychiatric Association published an article about psychological first aid in community disaster settings and urged the creation of a "Psychological First Aid" (PFA) intervention that would assist disaster workers.[260] The National Center for PTSD and the National Child Traumatic Stress Network determined that as an evidence-informed, flexible, and culturally adaptive means of intervention, PFA was applicable to in-field settings.[261] Similar to PIE, BICEPS, and CISM, PFA has the core goal of immediately assisting civilians affected by disasters or acts of terrorism by reducing the initial distress and

[255] National Organization for Victims Assistance (NOVA). http://www.trynova.org/help-crisis-victim/overview (accessed January 1, 2012).
[256] Ibid.
[257] Mobile App: PTSD Coach, United States Department of Veteran Affairs. http://www.ptsd.va.gov/public/pages/PTSDCoach.asp (accessed January 8, 2012).
[258] F.C. Thorne, "Psychological First Aid," *Journal of Clinical Psychology* Vol. 8 No. 2, 1952): 210-211; George S. Everly and Jeffrey T. Mitchell, *Integrative Crisis Intervention and Disaster Mental Health,* 165-166.
[259] Ibid.
[260] *Psychological First Aid in Community Disasters* (American Psychiatric Association, 1954); George S. Everly and Jeffrey T. Mitchell, *Integrative Crisis Intervention and Disaster Mental Health*, 166.
[261] M.A. Husson and J.A. Uhernik, *Psychological First Aid: An Evidence Informed Approach for Acute Disaster Behavioral Health Response;* G. R. Walz, J. C. Bleuer, and R. K. Yep, *Compelling Counseling Interventions* (Alexandria, VA: American Counseling VISTAS Association, 2009), 271-280.

promoting adaptive functioning. PFA uses an eight-pronged approach of contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social support, provision of coping information and establishment of linkages with collaborative services.[262]

Originally PFA was to be conducted by mental health professionals, but eventually it was expanded so it could be practiced by anyone competently trained in PFA techniques. The U.S. Substance Abuse and Mental Health Services Administration created training materials to teach emergency service personnel to provide basic psychosocial support.[263] Often formal PFA training can be completed within a few hours. The implementation of rapid training was a major force multiplier, increasing the available pool of trained laypersons, who are essential in environments where resources are lacking and medical infrastructure is damaged.

The Sphere Handbook, which discusses minimum standards in humanitarian response, refers to PFA as "Basic, non-intrusive pragmatic care with a focus on listening but not forcing talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing company from significant others; and protecting from further harm."[264] In August 2011 the World Health Organization, the War Trauma Foundation, and World Vision International released a publication titled Psychological First Aid: Guide for Fieldworkers. This guide, available in multiple languages and endorsed by twenty-four large international agencies, was intended for both their service populations and colleagues who might be experiencing distress.[265] Stefan Germann, director of global health partnerships at World Vision International, reported that the guide "will enable us to rapidly scale up basic psychological first aid for adults and children throughout all our development and humanitarian emergency programming in almost 100 countries around the world."[266] This sixty-four–page PFA publication is an excellent resource for providing

[262] Ibid., 274-275.
[263] Substance Abuse and Mental Health Administration, Psychological First Aid for First Responders Tips for Emergency and Disaster Response Workers NMH05-0210. http://store.samhsa.gov/shin/content//NMH05-0210/NMH05-0210.pdf (accessed January 1, 2012).
[264] The Sphere Project, *The Sphere Handbook 2011: Humanitarian Charter and Minimum Standards in Humanitarian Response* (United Kingdom, Practical Action Publishing, 2011), 335. http://www.sphereproject.org/resources/download-publications/?search=1&keywords=&language=English&category=22 (accessed January 1, 2012).
[265] World Health Organization, *Psychological First Aid: Guide for Field Workers* (World Health Organization, 2011). http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf (accessed January 1, 2012).
[266] Ibid.

basic psychosocial support to clientele, but the section set aside for addressing the needs of field staff is brief.

PFA is being marketed to and used throughout organizations working within complex emergencies and disaster settings as an evidence-informed[267] (formerly referred to as evidence-based in some circles) approach, and yet as of 2009, no formal systematic review of its effectiveness had been conducted.[268] A cursory online search turned up no randomized controlled trials conducted between 2009 and January 2012. Many of the interventions listed throughout this chapter similarly lack systematic review. The majority of approaches and models were created, evolved, and were adapted on the basis of observation, consensus, and sometimes indirect evidence.

In 2009, Jonathan Bisson and Catrin Lewis were commissioned by the World Health Organization to perform a systematic review of PFA. They conducted an online bibliographic database search using the terms Psychological First Aid and PFA through sixteen medical, social science, and science databases, including the Cochrane Central Register of Controlled Trials and the Cochrane Database of Systematic Reviews.[269] Bisson and Lewis note that their research "revealed no RCTs, observational or any other empirical study of PFA" but just "description, commentary, expert opinion or discussion of PFA."[270] They state that "The absence of quantitative data containing evidence to support PFA makes it impossible to determine whether it is effective or not following traumatic events." However, they do cite indirect evidence that PFA addresses peritraumatic dissociation and that perceived poor social support often correlates with increased rates of PTSD.[271] Bisson and Lewis contend, "It therefore seems reasonable to advocate the use of interventions based on the principles of PFA."[272]

Evidence-Based Early Psychological Intervention

The American Red Cross and the U.S. Departments of Defense, Justice, Health and Human Services, and Veterans Affairs convened a symposium shortly after 9/11 to assess

[267] Ibid.
[268] Jonathan I Bisson and Catrin Lewis, "Systematic Review of Psychological First Aid," Commissioned by the World Health Organization, July 2009), 4.
[269] Ibid., 5.
[270] Ibid.
[271] Ibid., 13.
[272] Ibid., 14.

evidence-based early psychological interventions for victims and survivors of mass violence. They subsequently created and published a 315-page report of their findings.[273] Participants from around the world, representing think tanks, academia, victim advocacy groups, and mental health agencies, attended and debated the best practices for early crisis intervention applied within four weeks following violence or disasters.[274] Given the scarcity of literature and randomized controlled trial research on early interventions, the symposium participants used the consensus process, "combining what is known from research and expert opinion as a way to examine the evidence in the field and provide guidance"[275]

Matters discussed at the symposium were interventions, key operating principles, and timing, screening, and follow-up processes. Equally important were the role of current research and evaluation, ethical dilemmas, and key questions still unanswered. Participants determined that the term debriefing should only refer to operational debriefings and not be used to refer to or describe psychological debriefings or the CISM Critical Incident Stress Debriefing component.[276] This was a critical decision because a great deal of confusion had arisen in research and studies that used the terms interchangeably.

The symposium established that early intervention should be conducted soon after the incident, within a hierarchy of needs including survival, safety, security, food, shelter, and health. Consensus formed around the idea that crisis intervention is multicomponent in nature, with preparation, planning, education, training, service provision, and evaluation being the key components to any early intervention.

Overall, the group agreed that the following nine key elements should be included in any acute psychological crisis intervention model. Practitioners should:[277]

- address basic human needs, such as food, safety, and communication with loved ones;
- mitigate further harm through PFA to reduce physiological arousal and deescalate emotions through communication;

[273] National Institute of Mental Health, *Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence.* A Workshop to Reach Consensus on Best Practices (Washington, D.C.: U.S. Government Printing Office *NIH Publication,* No. 02-5138, 2002).
[274] Ibid., 5.
[275] Ibid.
[276] Ibid., 7.
[277] Ibid., 6-7, 13-14.

- conduct noninvasive needs assessment, analyzing scope of services being provided and addressing gaps;
- observe the environment for triaging those most affected and reduce external stressors, including media, toxins, rumors, and other threats to the well-being of victims and emergency service personnel;
- disseminate accurate and timely information through physical presence, flyers, or website postings;
- provide technical assistance, consultations, and training to build the community's capacity to respond;
- foster resilience and recovery by connecting participants with natural support systems and teaching coping skills or enhancing each individual's coping mechanisms; and
- after triage assessment, refer those in need of the next level of care;
- involve mental health professionals who use psychotherapy, pharmacotherapy, or hospitalization to reduce or ameliorate symptoms or improve functioning.

Crisis Intervention Development Summary

The development and evolution of successful acute crisis intervention was based primarily on observation, agreement on best practices, and indirect evidence rather than on randomized controlled trials. A collection of core crisis intervention principles developed by the military have been adopted or adapted into crisis intervention models or approaches for emergency services, disaster response, civilian crisis hotlines, and a host of other venues. Many of these models and approaches may be effective with responders working in complex emergencies, given the similarities in critical incidents experienced by the groups, but the rapid advancement of early interventions and the unpredictable, dynamic environments in which the models are employed make it difficult to conduct randomized controlled trials. Therefore, on the effectiveness of early interventions there is very little published scientific research of the sort that for some is the sole standard of solid empirical evidence to demonstrate the value and success of the various crisis intervention techniques. However, observational findings such as the ones listed in this chapter,

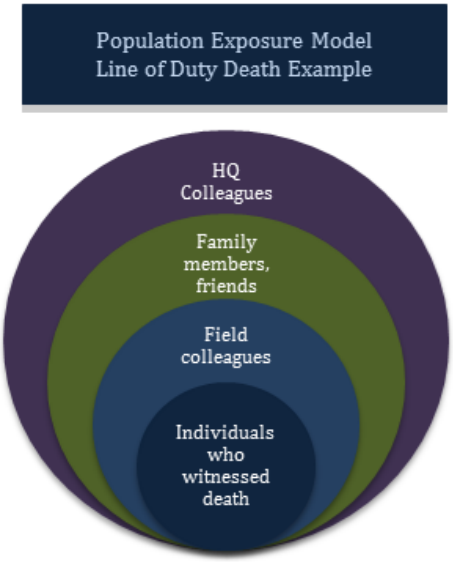
analyzed and agreed upon by experts within the field, serve as stronger indicators of crisis intervention models' efficacy than the results of randomized controlled trials conducted outside a complex emergency setting.

A common myth exist that "one crisis intervention fits all". Determining which models or approaches would be effective on the basis of different circumstances requires a situational assessment.

Strategically Determining the Critical Incident Response

The five T strategic planning framework (Target, Type, Timing, Theme, and Team) formulated by the International Critical Incident Stress Foundation (ICISF) has proven effective for determining which responses are appropriate to which population following critical incidents. Notably, more psychological causalities than physical casualties often follow in critical incidents, especially those involving some form of threat violence or actual violence.[278] A line-of-duty death affects not only the person killed, but also those who witnessed the death or assisted in the recovery and those have a personal connection with the fallen outside the field periphery.

Concentric circles representing a population exposure model[279] are beneficial in targeting and prioritizing populations that may require some form of intervention. On the basis of a needs assessment, the appropriate type of intervention can be determined. For example, a defusing is applicable to those who have directly witnessed the death, but a family support service is more germane to family members and close friends at home. The extremes of too-little–too-late or too-much–too-early are essential for practitioners to keep in mind when considering the timing of the intervention.



Understanding of overarching themes is necessary for operationalizing interventions. For example, the dynamics of human-made disasters, including violence and

[278] D. Myers, *Weapons of Mass Destruction and Terrorism. The Ripple Effect from Ground Zero*; George Everly, *War on Terrorism" and the Battlefield of the Mind* (International Critical Incident Stress Foundation and Loyola College in Maryland).
[279] U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Mental Health Services, *Mental Health Response to Mass Violence and Terrorism* (U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Mental Health Services, 2004), 8, 11.

acts of terrorisms, can differ from the dynamics of natural disasters.[280] People's belief in a just world where good overrides evil can be shattered. The incomprehensible act of a human being intentionally perpetrating horrific acts upon others, especially children can erode a person's ability to trust others. The kidnapping of colleagues or the inability to find or identify bodies of coworkers can result in recurrent waves of traumatic stress instead of just one tidal wave. After a careful assessment of the targeted population and the proposed types and timing of interventions, along with an evaluation of overarching themes, it will become clear what sort of team is appropriate to provide psychological support services. Teams can comprise peers, clergy, mental health professionals, and others whom the target population sees as creditable. Assembly of the team is based on the intervener's expertise and the accessibility and receptiveness of those in need. Employing the five T framework, combined with a more in-depth assessment of the incident and subsequent reaction will aid in assessing the appropriate response.

**Note: Threat is sometimes used as an additional category or subset of Theme*

Example of Situational Assessment

Using the ICISF strategic response planning framework, a population exposure model, and established crisis intervention practices from other professions, this author created a crisis intervention response plan for all nineteen types of complex emergency critical incidents identified in chapter 4. Below is an example of the response to the critical incident of unearthing mass graves. Although few humanitarian workers are subjected to this type of work, it is one of the most complex critical incidents for which to devise a response plan, given the multiphase nature of shift rotation, the diverse populations involved, sensory exposure, and the potency of the event, all of which make it an excellent example to analyze here.

[280] Ibid., 9-10.

The merciless slaughters of babies still clutched in their mothers' arms; churches barricaded and subsequently set on fire, burning alive those who sought sanctuary; young boys and men gunned down by the thousands, then dropped into shallow graves: these are a few of the situations forensic scientists investigate. While armies of relief workers attend to the needs of living, another army of workers deploys to give a voice and names to the dead.[281]

In order to provide evidence of atrocities to criminal tribunals or other judicial bodies, organizations like Physicians for Human Rights take on the incomprehensible task of unearthing, examining, and identifying remains. Meticulous screening and preparation of staff prior to deployments have helped to mitigate, but not necessarily stop psychological morbidity. Forensic scientists experienced in conducting meticulous autopsies are relegated to more rudimentary approaches because of field conditions and the large number of bodies.[282] Identification may be impossible due to the lack of surviving family members who can provide DNA evidence. For the family members of those few who are identified, the hope that their loved one has somehow escaped a horrific end is destroyed. Invariably many questions go unanswered even upon completion of the mission.[283]

Target. The first element in a situational assessment-planning framework is determination of which target populations need services. The responder populations in possible need of crisis intervention services prior to, during, or following excavation or examination of corpses are not limited to forensic and ballistic experts, entomologists, archaeologists, and practitioners in other scientific disciplines. [284] Equally important are heavy equipment operators who move the bodies, media who film the carnage, and peacekeepers and security guards. Anyone involved in this process, regardless of how small a part they play, should be monitored for levels of distress. A population exposure model aids in the creation of homogenous groups for various interventions and prevents cross-contamination of stressors. For example, someone who worked in a location where

[281] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst,* 258 (*Surviving With The Dead: Forensic Investigations In The Service of Human Rights,* William D. Haglund and Susannah M. Sirkin).
[282] Ibid., 256-265.
[283] Ibid., 265.
[284] Ibid., 256-265.

multiple children were discovered would not participate in the same intervention group as those working with the family members of the missing.

Themes. Themes to consider during the unearthing of mass graves include sensory exposure to the remains; the large number of dead, including women, children, and the elderly; gross disfigurement or decomposition of bodies; escalated emotions of loved ones or the local population; lack of closure, and the violation of responders' core beliefs. Cultural diversity of local staff must be taken into account.

Timing. Responders' extensive work hours and other competing demands may limit their availability for crisis intervention. Deployments can last from days to months, and ongoing daily exposure is likely. Constant rotations of staff may require multiple sessions and kinds of intervention components. Because post-deployment intervention components occur at a distance from the stressors, they may be more effective than the field components for some of the targeted population.

Teams. Intervention teams can be made up of peers, managers, other responder populations serving in the area, clergy, mental health professionals, or others whom the target population trusts and sees as having credibility. External interveners may find accessibility to the geographical area where responders are working extremely difficult; therefore, peers may provide the best support. Where internet connections are accessible, modern technology such as smart-applications on stress management techniques and the use of Skype can help counter geographical challenges.

Potential Crisis Intervention Models and Approaches for Unearthing Mass Graves

Pre-Crisis	Ongoing	Shift Disengagement	Post-Crisis
☐ Stress Inoculation	☐ Psychological First Aid	☐ Demobilization	☐ Defusing
☐ Stress Management	☐ Peer Support	☐ Rest and Relaxation	☐ Critical Incident Stress Debriefing
☐ Crisis Preparation	☐ Crisis Management Briefing	☐ Respite Center	☐ Post Deployment Debriefing
	☐ SAFER-R Individual Crisis Intervention		

Follow-up and Referral as Needed

Types of Models, Components, or Approaches. Given the diversity of the targeted population and other challenges, a multicomponent, comprehensive, systematic, and integrated range of crisis support services may be most effective for mitigating distress from working with mass graves. Sometimes crisis intervention components will serve solely to "psychologically triage"[285] an individual exhibiting severe impairment. Understanding the working conditions and providing a situational assessment-planning framework will help in determining an appropriate crisis intervention response.

A Closer Look at Four Crisis Intervention Components

Four of these crisis intervention tools—Psychological First Aid (PFA), Critical Incident Stress Debriefing (CISD), SAFER-R Individual Crisis Intervention, and defusing) have been recommended as an integrated response in over half of the nineteen types of critical incidents identified earlier. Comprehensively understanding the elements and objectives of specific interventions is pivotal for conducting research that measures their efficacy.

Each of these four crisis intervention components met key elements that the post-9/11 symposium on evidence-based early psychological interventions determined should be included in any acute psychological crisis intervention model. Two of the components are designed for individual crisis intervention: PFA and SAFER-R Individual Crisis Intervention. The other two components are designed for group crisis intervention, defusing and CISD. The creators of SAFER-R, CISD, and defusing recommend that participation be both voluntary and confidential.

None of these crisis intervention components is a panacea, but each is one component in a continuum of care. SAFER-R Individual Crisis Intervention, defusing and CISD all fall under the umbrella of Critical Incident Stress Management (CISM). None of these intervention components are meant to be a replacement for psychotherapy or psychotropic drugs, but they can all contribute greatly a determination of whether to refer those in need to the next level of care.

[285] George S. Everly and Jeffrey T. Mitchell, "The Debriefing "Controversy" and Crisis Intervention: A Review of Lexical and Substantive Issues, 212.

Four Crisis Intervention Components/Approaches

	Intervention Type	Format		Symptom Mitigation	Phases	Timing
		Individual	Group			
	PFA	X		X		Anytime
CISM System	SAFER-R	X		X	5	Anytime after initial impact
	Defusing		X	X	3	Post-crisis within 12 hours
	CISD		X	X	7	Post-crisis 1-10 days, or 3-4 weeks after mass disaster

Possibly the earliest point in a psychological continuum of care,[286] PFA can be done anytime, anywhere by anyone who has participated in a few hours of training. Many people already have these skills and have practiced PFA before learning the approach. There is no formal structure, and there are no phases to progress through. The Johns Hopkins Preparedness and Emergency Response Learning Center uses the acronym RAPID to characterize the core components of PFA: Reflective Listening, Assessment, Prioritization, Intervention, and Disposition.[287] Referred to as compassionate and encouraging care, the RAPID model of PFA seeks to address the basic human needs. The Institute of Medicine describes PFA as:

> A group of skills identified to limit distress and negative health behaviors, . . . PFA generally includes education about normal psychological responses to stressful situations and traumatic events; skills in active listing; understanding the importance of maintaining physical health and normal sleep, nutrition, and rest; and understanding when to seek help from professional caretakers.[288]

[286] George S. Everly and Jeffrey T. Mitchell, *Integrative Crisis Intervention and Disaster Mental Health,* 167.
[287] *Psychological First Aid (PFA),* Johns Hopkins Bloomberg School of Public Health, Preparedness and Emergency Response Learning Center. http://www.jhsph.edu/preparedness/training/pfa.html (accessed December 2011).
[288] Institute of Medicine, "Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy," 7.

Considered an "elaborated model of PFA," SAFER-R uses the PFA approach but allows for expansion when necessary.[289] An individual crisis intervention component under the integrated approach of CISM, SAFER-R can be used by a trained individual on-scene during an acute crisis or disaster situation, or anytime or anywhere following the initial impact.[290] George Everly and Jeffrey Mitchell define the goals of SAFER-R as "to mitigate the acute distress of the individual in crisis and to facilitate access to follow-up mental health assessment and treatment, if needed." SAFER-R is a structured individual crisis intervention following five progressive steps: [291]

1. Stabilization of the situation
2. Acknowledgment of the crisis
3. Facilitation of understanding
4. Encouragement of adaptive coping
5. Restoration of adaptive, independent function, or referral to the next level of care.

A small group crisis intervention component under the integrated approach of CISM, defusing is done off scene within twelve hours of a critical incident or traumatic event that has the capacity to overwhelm a person's usual coping mechanisms.

This small group intervention, designed specifically for emergency service personnel, should include only those who worked together prior to the incident and on the same tasks related to the traumatic event.[292] The small group comes together under a trained facilitator to briefly discuss the experience before they have time to rethink and possibly misinterpret the incident.[293] Mitchell and Everly explain that defusing comprises three segments:[294]

[289] George S. Everly, George S. Everly and Jeffrey T. Mitchell, *Integrative Crisis Intervention and Disaster Mental Health,* 174.
[290] Ibid.
[291] Ibid., 174-179.
[292] Jeffrey T. Mitchell and George S. Everly, *Critical Incident Stress Debriefing: An Operations Manual for CISD, Defusing and Other Group Crisis Intervention Services* (Ellicott City, MD: Chevron, 2001), 121-122.
[293] Ibid., 122.
[294] Ibid., 128-134.

1. Introduction: Establish rapport, discuss process, set expectations and ground rules
2. Exploration: Invite participants to discuss the experience of the event in a conversational and not investigative manner.
3. Information: Normalize and demedicalize the crisis reactions and teach basic personal stress management and coping techniques.

The average time for a defusing is forty-five minutes, and it is not intended to go beyond an hour. Defusing differs from CISD in that it does not delve deeply into emotions because people may still be in shock. Similar to defusing a bomb, the intervention defuses the reaction caused by a critical incident or traumatic stress before it explodes into something larger.[295] Not all situations can be defused, but as in the case of a bomb, is better to attempt to defuse it than to let it explode when individuals' well-being is at risk. Mitchell and Everly write that the main goals of defusing are:

— a rapid reduction in the intense reaction to a traumatic event;
— a "normalizing" of the experience so people can return to their routine duties as quickly as possible;
— a reestablishment of the social networks of the group so people do not isolate themselves from each other, but instead see that their reactions are similar to one another's; and
— an assessment of the personnel to determine if a full debriefing is necessary. [296]

Other objectives of defusing are to equalize the information about the incident, to provide practical support and stress survival information, to help restore any cognitive process disrupted by the event, and to create links for additional support.[297]

A group crisis intervention component under the integrated approach of CISM, CISD is used one to ten days following a critical incident event, or three to four weeks following a

[295] Ibid., 123.
[296] Ibid.
[297] Ibid., 123-124.

mass disaster.[298] The primary goal of CISD is to facilitate psychological closure, ameliorate symptoms, and if necessary, provide follow-up or referrals to the next level of care.[299] Trained individuals, including mental health professionals and occupational peers, facilitate CISD in a seven-phase, one-to-three hour intervention within a small homogeneous group.[300] The seven phases of CISD described by Alan Mikolaj are:[301]

1. Introduction: Establishment of rapport, discussion of process, setting of expectations and ground rules
2. Fact: Factual structuring that allows a more complete picture of the events to unfold
3. Thought: A shift from fact to thought process, in which cognitive reactions are solicited
4. Reaction: Emotional reaction emergences, cathartic venting if needed;
5. Symptoms: Recognition and verbalization of physical and psychological symptoms or reactions
6. Teaching: Normalization and demedicalization of crisis reactions and teaching of basic personal stress management and coping techniques
7. Reentry: Reinforcement of constructive coping mechanisms, identification of dysfunctional ones, answering questions, and provision of psychological closure; assessment of need for follow-up or referrals may take place

Determining Which Crisis Intervention Tool to Use

The ability to complete a strategic planning framework (such as the five T approach) around the various types of critical incidents will assist agencies in effectively responding to rather than poorly reacting to a crisis. Knowledge of the objectives and elements involved in each crisis intervention model, component, or approach helps to determine which interventions may be useful with complex emergency responders. PFA, SAFER-R,

[298] Ibid., 5-8.
[299] Ibid.
[300] Jeffrey T. Mitchell and George S. Everly, *Critical Incident Stress Debriefing: An Operations Manual for CISD, Defusing and Other Group Crisis Intervention Services*, 5-8.
[301] Alan A. Mikolaj, *Stress Management for the Emergency Care,* 85-86.

defusing, and CISD are only a few of the crisis intervention tools organizations can employ. Virtually no random controlled trials have been conducted on these interventions within complex emergency settings, but some have been conducted with civilians in trauma; these may contribute to the body of knowledge about which tools to employ in complex emergency settings.

Many have argued that more robust scientific studies, such as randomized controlled trials (RCTs), are needed to determine the effectiveness of the various crisis interventions. The Cochrane Collaborative performed three meta-analyses of RCTs in the early intervention realm. In 1998, Jonathan Bisson, Suzanna Rose, and Simon Wessely conducted a systematic review of single-session psychological interventions following trauma to determine the overall effectiveness of early psychological interventions, which they referred to as debriefings. The 1998 meta- analysis reviewed nine RCTs. Subsequently, two updates were done, first in 2002, with the addition of two more RCTs, and again in 2006 with the addition of four RCTs. The similar findings in all three iterations of the Cochrane review led Bisson, Rose, and Wessely to advocate against the use of routine early crisis interventions.[302]

Studies Used for Cochrane Review

The RCTs for the Cochrane meta-analyses were identified in key word searches of multiple relative databases, including MEDLINE, PsychLit, using the terms psychological debriefing, stress debriefing, critical incident stress debriefing, and crisis intervention.[303] Studies were then narrowed down to those consisting of single-session interventions for individuals within one month of exposure to a trauma.[304] The interventions had to involve "some form of emotional processing/ventilation, by encouraging recollection/reworking of the traumatic event, accompanied by normalization of emotional reaction to the event."[305] Studies were excluded if they were conducted on children, psychiatric patients, people being treated for posttraumatic stress disorder (PTSD), or psychology students; if they dealt with perinatal grief; or if they involved crossover designs.[306]

Several factors and tools were used to assess the outcomes across many of the RCTs. To determine the rates of PTSD, the Impact of Event Scale (IES) or a comparable tool was

[302] S. Rose, J. Bisson, and S. Wessely, A Systematic Review of Single-Session Psychological Interventions ('debriefing') Following Trauma *Psychotherapy and Psychosomatics* 72, No. 4 (2003):176-; S. Wessely, S. Rose and J Bisson, "A Systematic Review of Brief Psychological Interventions (debriefings) for the Treatment of Immediate Trauma Related Symptoms and the Prevention of Post-Traumatic Stress Disorder, Cochrane Review," (Oxford, UK: *Cochrane Library*, Issue 3, Updated Software).
[303] S. Rose, J. Bisson, R. Churchill, S. Wessely, "Psychological Debriefing for Preventing Post-traumatic Stress Disorder (PTSD) (Review)," *Cochrane Database System,* Issue 1 (2009): 1.
[304] Ibid., 1.
[305] Ibid., 4.
[306] Ibid., 1-42.

used.[307] The Hospital Anxiety and Depression Scale (HADS), the Brief Symptom Inventory (BSI), and the twenty-two–item Langer Psychiatric Screening Inventory were used to measure general psychological morbidity.[308] Depression was measured using the Hospital Anxiety and Depression Scale—Depression Subscale (HAD-D), the Beck Depression Scale, and the Postnatal Depression Scale.[309] The Hospital Anxiety and Depression Scale—Anxiety Subscale (HAD-A), the Spielberg State-Trait Anxiety Inventory, Gottschalk-Gleser Content Analysis Scale for anxiety, and other tools measured the rate of anxiety.[310]

The Cochrane studies summary chart below briefly describes the RCTs that were the object of the three meta-analyses conducted in 1998, 2002, and 2006. Over half of the studies were partially or completely unpublished at the time of the respective meta-analysis findings, a fact that makes peer review challenging. Cochrane review authors Bisson and Rose conducted two of the studies within the meta-analyses, and one of these found that the intervention caused harmful effects.[311] Over half the studies in the meta-analyses involved at least one of the components within the Critical Incident Stress Management (CISM) model, usually an adaptation of Critical Incident Stress Debriefing (CISD).

Review	Date	Studies	Authors	Title
1st Cochrane report	1998	9	Jonathan Bisson, Suzanna C. Rose, Simon Wessely	A systematic review of brief psychological interventions for the treatment of immediate trauma related symptoms and the prevention of post-traumatic stress disorder
2nd Cochrane report	2002	11	Jonathan Bisson, Suzanna C. Rose, Simon Wessely	Psychological debriefing for preventing post-traumatic stress disorder
3rd Cochrane report	2006	15	Suzanna C. Rose, Jonathan Bisson, Rachel Churchill, Simon Wessely	Psychological debriefing for preventing post-traumatic stress disorder

[307] Ibid., 4.
[308] Ibid.
[309] Ibid.
[310] Ibid.
[311] J. I. Bisson, P. L. Jenkins, J. Alexander, and C. Bannister, "Randomized Controlled Trial of Psychological Debriefing for Victims of Acute Burn Trauma," *The British Journal of Psychiatry* 171, No. 1 (1997): 79.

The Cochrane Review Studies							
Date	**Pub/ Unpub**	**Authors**	**Focus of Study**	**CISM Element** (often adapted)	**1998 Review**	**2002 Review**	**2006 Review**
1996	P/U	J. Bisson, P. Jenkins, J. Alexander, C. Bannister.	Burn unit: victims of acute burn trauma	√	√	√	√
1979	P	S. Bordow, D. Porritt	Hospital: male inpatients after road traffic accidents		√	√	√
1979	P	B. Bunn, A, Clarke	Anxious relatives of seriously injured or ill hospital patients		√	√	√
2001	P	K. M. Campfield and A. M. Hills	Civilian victims of robbery in the workplace	√			√
1999	P/U	L. Conlon, T. Fahy, R. Conroy	Hospital-setting trauma clinic			√	√
	U	L. Dolan, D. Bowyer, C. Freeman, K. Little	Hospital trauma clinic: Life-threatening and near life-threatening experiences, such as assaults, house fires, and accidents.	√	√	√	√
1996	P/U	M. Hobbs, R. Mayou, B. Harrison, P. Worlock	Psychological debriefing for victims of road traffic accidents		√	√	√
1998	P	T. Lavender, S. A. Walkinshaw	Midwives in hospital postpartum ward		√	√	√
1996	P/U	C. Lee, P. Slade, V. Lygo	Gynecology ward: women following early miscarriage	√	√	√	√
2004	U	B. T. Litz, A. B. Adler, C. A. Castro, K. Wright, J. Thomas, M. Suvak	Group debriefing with platoons deployed on peacekeeping mission	√			√
2003	P	S. R. Priest, J. Henderson, S. F. Evans, R. Hagan	Maternity hospital: stress debriefing after childbirth	√			√
1999	P	S. Rose, C. R. Brewin, B. Andrews, M. Kirk	Individual psychological debriefing for victims of violent crime	√	√	√	√
2002	U	M. E. Sijbrandij et al.	Trauma victims in emergency department and trauma unit	√			√
2000	P	R. Small, J. Lumley, L. Donohue, A. Potter, U. Walderstrom	Midwife-led debriefing to reduce maternal depression following operative birth			√	√
1996	P/U	G. Hobbs, G. Adshead	Trauma victims following vehicle accidents, dog bites, assaults		√	√	√

Randomized Group Trials Meta-Analyses, 1998 and 2002

The Cochrane review evaluated findings from eleven studies of individual crisis interventions in randomized controlled trials (RCTs) within predominantly medical settings in Australia, Ireland, and the United Kingdom. Out of the eleven randomized controlled studies in the 2002 iteration of the Cochrane review, two studies were cited in which the debriefing subjects did worse "in terms of reduced psychological distress when compared to the non-debriefed group,"[312] three studies reported positive outcomes for the debriefing subjects, and six studies demonstrated no difference. The traumatic experiences studied involved burn patients, motor vehicle accidents, women experiencing miscarriages,[313] women who just gave birth,[314] victims of crime,[315] and families of seriously ill or injured patients.[316] Two studies exhibiting negative outcomes were the J. I. Bisson, P. L. Jenkins, J. Alexander, and C. Bannister study of acute burn patients and the M. Hobbs, R. Mayou, B. Harrison, and P. Worlock study of motor vehicle accident victims. A more detailed look at the two studies involving negative outcomes is critical for determining how their weighted outcome contributed to the overall 1998 and 2002 Cochrane review findings.

Bisson, Jenkins, Alexander, and Bannister conducted their study on acute burn patients admitted into the Welsh Regional Burns Unit. The ages of the patients ranged from sixteen to sixty-five. Average inpatient hospital stays ranged from 13.2 days for the control group to 18.4 days for the intervention group.[317] The facilitators for the burn patient debriefings employed an adaptation of the Mitchell component of CISD, but instead of employing group intervention as intended by Mitchell, the facilitators conducted their debriefings with individuals or couples.

The study of the burn patients does not mention the nature or degree of the burns, vital details for predicting the potential level of psychological distress. For example, a burns

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[312] Debbie M. Lovell-Hawker, *Debriefing Aid Workers and Missionaries: A Comprehensive Manual,* 8th Edition.
[313] C. Lee, P. Slade, V Lygo, "The influence of psychological debriefing on emotional adaption in women following early miscarriage: A preliminary study," *Br JMed Psychol* 69, No. 1 (1996): 47.
[314] T. Lavender, SA Walkinshaw, "Can midwives reduce postpartum psychological morbidity? A randomized trial," *Birth 25, No. 4, (*1998): 215–219; R. Small, J. Lumley, L. Donohue, A. Potter, U. Walderstrom, "Midwife-led debriefing to reduce maternal depression following operative birth: A randomized controlled trial," *BMJ* 321 *(*2000): 1043–1047.
[315] S. Rose, J. Bisson, "Brief early psychological interventions following trauma: A systematic review of the literature," *J Trauma Stress* 11 (1998): 697–710.
[316] T. Bunn, A. Clarke, "Crisis intervention: An experimental study of the effects of a brief period of counseling on the anxiety of relatives of seriously injured or ill hospital patients," *Br J Med Psychol* 52, No. 2 (1979): 191–195.
[317] J. I. Bisson, P. L. Jenkins, J. Alexander, and C. Bannister, "Randomized Controlled Trial of Psychological Debriefing for Victims of Acute Burn Trauma," 79.

that cover a large part of the body, that reach deep tissues, or that disfigure the face or hands are not comparable to more minor burns on the back or thighs. Nothing is written in the study regarding the extent of physical pain or the medications the patients have been taking or the effects medications may have on the cognitive functioning of the burn patients.

Bisson, Jenkins, Alexander, and Bannister do mention that the debriefing group "had higher initial questionnaire scores and more severe dimensions of burn trauma than the control group, both of which were associated with a poorer outcome.[318] Significant past traumas within the intervention group were almost double those of the control group. Analysis of covariance found that "initial questionnaire scores were superior predictors of poorer outcomes than recipients of psychological debriefing."[319] It appears that equivalent group membership was not reached between the control and intervention groups. Furthermore, the mean time of debriefings was 44.3 minutes, with a standard deviation of 17.4 minutes, falling below the minimum of one to three hours recommended in the CISD component protocol. Bisson, Jenkins, Alexander, and Bannister indicate a additional study limitation in their observation: "Despite a sample size of greater than 100, the power of the results was below 60% on follow-up."[320]

Given the researchers' indications of all of the limitations of the study, including the poor match between the control and intervention groups, failure to maintain the integrity of the CISD component, and the low return on results, it is difficult to understand how Bisson, Jenkins, Alexander, and Bannister can definitively conclude, on the front page of their study, that their research "seriously questions the wisdom of advocating one-off intervention post trauma."[321]

Mayou, Ehlers, and Hobbs analyzed the effects of one-hour individual debriefings conducted on motor vehicle accident patients between the ages of sixteen and sixty-five, one to two days following their admission to the John Radcliffe Hospital in the United Kingdom. Findings showed that the accident victims who were psychologically debriefed

[318] Ibid., 78.
[319] Ibid., 80.
[320] Ibid.,
[321] Ibid., 78.

did worse than those receiving only standard medical care.[322] The initial facilitators of the motor accident debriefings were clinical nurses and social workers trained in debriefing; however, due to scheduling conflicts, they were replaced after only ten interventions with minimally trained research assistants who proceeded to perform the majority of debriefings.[323] The study mentioned that the interventions used were "relatively short and had limited internal structure," in stark contrast to the CISD component, which is an extremely structured seven-phase process.[324] In Mayou, Ehlers, and Hobbs's concluding comments, they stated that they believed their study supported the 1998 Cochrane debriefing findings.

Third Cochrane Review Collaboration, 2006

A third Cochrane review on individual psychological debriefing research was done by S. C. Rose, J. Bisson, R. Churchill, and S. Wellesley in 2006, published in 2009 with a database search of February 2005. All eleven studies from the 2002 review and four new studies were included in the 2006 meta-analysis, for a total of fourteen randomized studies and one quasi-randomized study.[325] In their study of women who had experienced early miscarriages, Lee, Slade, and Lygo used alternate numbers from those allocated by the nurse recruiting subject, so the study was categorized as quasi-randomized.[326] The four new studies reviewed focused on trauma victims, women following childbirth, victims of workplace robberies, and U.S. soldiers on a peacekeeping mission. It is difficult to understand why normal, healthy childbirth RCTs were included in any of the meta-analyses because the precursors for developing postpartum depression and posttraumatic stress disorder are very different. A more detailed analyses of the four RCTs added in the 2006 meta-analysis may provide some helpful insight into research design and the efficacy of various acute crisis intervention elements.

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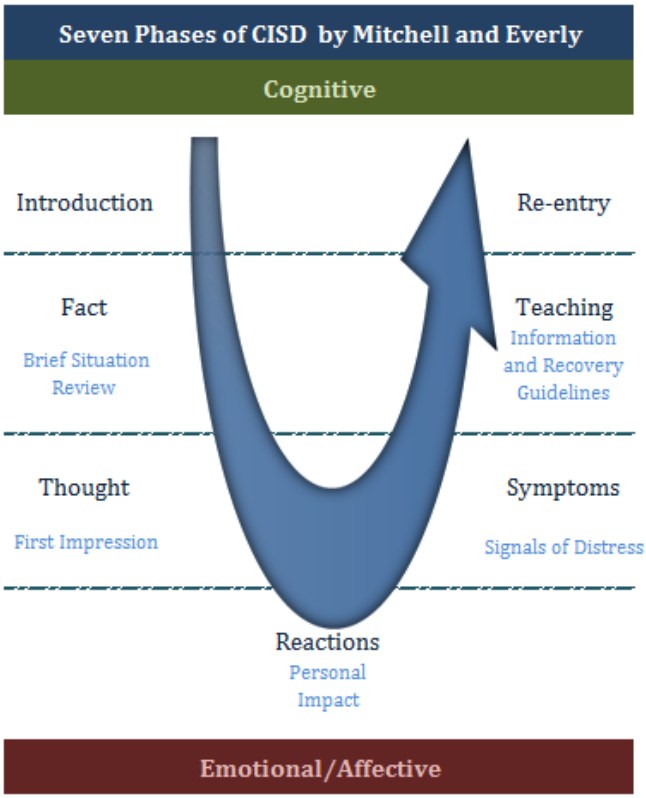
[322] R. A. Mayou, A. Ehlers, M. Hobbs, "Psychological debriefing for road traffic accident victims: A three-year follow-up of a randomized controlled trial," *Br J Psychiatry* 176, No. 6 (2000): 589– 593.
[323] M. Hobbs and G. Adshead, "*Preventive psychological intervention for road crash survivors" The Aftermath of Road Accidents* (London, England: Routledge, 1996), 159-171.
[324] R. A. Mayou, A. Ehlers, M. Hobbs, "Psychological debriefing for road traffic accident victims: A three-year follow-up of a randomized controlled trial, 589–593.
[325] S. Rose, J. Bisson, R. Churchill, S. Wessely, "Psychological Debriefing for Preventing Post-traumatic Stress Disorder (PTSD) (Review)," 1-42.
[326] Ibid., 5.



*Note light blue denotes UN PEGS Terminology for CISD

The 2002 study by M. Sijbrandij and colleagues took place in the Netherlands two weeks post-incident and included trauma victims referred by an emergency department and trauma unit in the Netherlands. The type of traumatic events is not noted.[327] The participants were divided into three groups. Two of the groups received either emotional debriefing or educational debriefing. A control group received no debriefing. Both kinds of debriefing lasted forty-five minutes to one hour. [328] Sijbrandij and colleagues noted that the emotional debriefing and educational debriefing were partially based on the seven-phase Mitchell and Everly CISD component. However, the emotional debriefing excluded two of the seven phases, and the educational debriefing excluded one of the seven phases.[329]

The emotional debriefing in the study by Sijbrandij and colleagues excluded the symptoms and teaching phases of the seven-phase CISD component.[330] The symptoms phase of CISD marks a transition where subjects move from the "emotionally-laden" content of the reaction phase toward a more "cognitively oriented" teaching phase.[331] George Everly and Jeffrey Mitchell warned that stopping prior to this phase, "would leave people in a charged emotional state which could possibly be detrimental."[332] This may be why the researchers found that "Participants in the emotional debriefing group with high baseline hyper arousal score had significantly more PTSD symptoms at six weeks than

[327] Ibid., 6.
[328] M. Sijbrandij, M. Olff, J. B. Reitsma, I. V. E. Carlier, and B. P. R. Gersons, "Emotional or educational debriefing after psychological trauma," *The British Journal of Psychiatry* 189, No. 2, (2006): 151.
[329] Ibid.
[330] Ibid.
[331] Jeffrey T. Mitchell and George S. Everly, *Critical Incident Stress Debriefing: An Operations Manual for CISD, Defusing and Other Group Crisis Intervention Services*, 176-177.
[332] Ibid., 176.

control participants." [333] Also excluded from the debriefing in this study was the teaching phase of the CISD. The teaching phase is designed to address any symptoms the participants mentioned in the earlier phases.[334] Facilitators often help normalize participants' symptoms and reactions in the teaching phase.

The educational debriefing in the study by Sijbrandij and colleagues excluded the reaction phase of the seven-phase CISD component.[335] The reaction phase allows the participants to express their emotions regarding the event.[336] The elimination of the reaction phase from a CISD takes away the participants' ability to vent in a safe, controlled environment. Atle Dyregrov asserts that allowing participants to vent emotions helps them regain a sense of perspective, balance, and equanimity over time.[337]

Sijbrandij and colleagues found that symptoms decreased significantly in all groups within the six-month period studied. However, they do cite the adverse reaction of early hyperarousal symptoms in the emotional debriefing group as a reason to discontinue the practice, and they report that they found "no evidence for the usefulness of individual single session emotional or educational debriefings."[338] Each phase of the seven-phase CISD component is essential, and any interventions or debriefings that exclude one or more of the seven steps can be expected to have a greatly diminished probability of success. Given that Mitchell and Everly warn against partial applications of the seven-phase CISD component, it does not seem reasonable for researchers to use analyses of five- or six-phase debriefings to make recommendations affecting the future use of the full seven-phase CISD component.

S. R. Priest, J. Henderson, S. F. Evans, and R. Hagan studied women in two Australian hospital maternity wards who received CISD administered by midwives, twenty-four to seventy-two hours following childbirth. The interventions lasted between fifteen minutes

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[333] M. Sijbrandij, M. Olff, J. B. Reitsma, I. V. E. Carlier, and B. P. R. Gersons, "Emotional or educational debriefing after psychological trauma, 150.
[334] Jeffrey T. Mitchell and George S. Everly, *Critical Incident Stress Debriefing: An Operations Manual for CISD, Defusing and Other Group Crisis Intervention Services*, 178-179.
[335] M. Sijbrandij, M. Olff, J. B. Reitsma, I. V. E. Carlier, and B. P. R. Gersons, "Emotional or educational debriefing after psychological trauma, 151.
[336] Jeffrey T. Mitchell and George S. Everly, *Critical Incident Stress Debriefing: An Operations Manual for CISD, Defusing and Other Group Crisis Intervention Services*, 175.
[337] Atle Dyregrov, *Psychological Debriefing: A Leaders Guide for Small Group Crisis Intervention,* 57.
[338] M. Sijbrandij, M. Olff, J. B. Reitsma, I. V. E. Carlier, and B. P. R. Gersons, "Emotional or educational debriefing after psychological trauma, 154.

and one hour, lower than the prescribed CISD duration of one to three hours.[339] It is difficult to determine whether one could progress adequately through all seven CISD phase in less than an hour or whether the women felt rushed. The research found that CISD did not prevent or reduce postnatal psychological morbidity in either group, but that the over two-thirds of the CISD participants rated the intervention as moderately helpful or greatly helpful.[340] Priest and colleagues report that the interventions had no adverse effects on participants.[341]

K. M. Campfield and A. M. Hills used the CISD component protocol to study the optimum timing for acute crisis intervention for individuals who were robbed at their workplaces. Excluded from the study were cases involving guns or in which the individual was injured. All groups received a CISD intervention. One group received the intervention less than ten hours after the incident, more akin to the defusing component of CISM, and the second group received the intervention after forty-eight hours, with 48 percent of the second group receiving intervention between 72 and 168 hours post-incident.[342] Campfield and Hills found that the early crisis intervention group did better than the delayed intervention group on follow-up evaluations: 86 percent of the immediate debriefing group rated zero or mild on the Posttraumatic Stress Diagnostic Scale, indicating a decline in symptom severity, as opposed to just over 9 percent in the delayed debriefing group.[343] Campfield and Hills's conclusion indicated support of "immediate crisis intervention with this type of incident and victim."[344]

A. B. Adler and colleagues conducted a group-randomized trial of critical incident stress debriefings provided to U.S. peacekeepers deployed to Kosovo who had shared occupational stressors. The peacekeepers were divided into three intervention groups, receiving either CISD, stress management education, or a survey-only approach. Overall exposure to a significant stressor was low among the peacekeepers studied,[345] in contrast

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[339] S. R. Priest, J. Henderson, S. F. Evans, and R. Hagan, "Stress debriefing after childbirth: A randomised controlled trial," *The Medical Journal of Australia* 178, No. 11 (2003): 544-545.
[340] Ibid., 543.
[341] Ibid., 545.
[342] K. M. Campfield and A. M. Hills, "Effect of timing of critical incident stress debriefing (CISD) on posttraumatic symptoms," *Journal of Traumatic* Stress 14, No. 2, (2001): 330-332.
[343] Ibid., 334-338.
[344] Ibid., 327.
[345] A. B. Adler, B. T. Litz, C. A. Castro, M. Suvak, J. L. Thomas, L. Burrell, D. McGurk, K. M. Wright, and P. D. Bliese, "A group randomized trial of critical incident stress debriefing provided to US peacekeepers," *Journal of Traumatic Stress* 21, No. 3, (2008): 253-263.

to exposure in most other Cochrane RCTs. CISD participants who reported a higher degree of mission stressors showed slightly lower amounts of posttraumatic stress or aggression when compared to other intervention groups.[346] Adler and colleagues assert there was no clear positive or negative effect relative to the overall intervention.[347] Additionally, CISD has been well received and found to have positive effects on "outcomes relative to military organizations."[348] Adler and colleagues recommend that trials be conducted upon occupational groups facing extreme stressors—that is, critical incidents—to determine the validity of CISD because it was intended to be applied subsequent to a traumatic event.[349]

Criticism of the Cochrane Review Findings

In the third Cochrane review, Rose, Bisson, Churchill, and Wessely continue to assert that "there is no benefit to individual psychological debriefing" and that "compulsory debriefing of trauma victims should cease." Furthermore, they do not recommend individual debriefings for either military or civilian personnel.[350] Rose, Bisson, Churchill, and Wessely briefly mention the possibility that psychological first aid (PFA) may offer an alternative approach to debriefing, but they also remark that research and evaluation of PFA must be conducted to ascertain the validity of that approach.[351]

Opponents of the Cochrane review findings cited several criticisms of the studies used in the meta-analyses. For example, many of the studies addressed in the Cochrane review were completed with poor methodologies, a fact noted by the authors of the review.[352] Bisson, Rose, and Wessely stated, "The methodological quality of studies varied widely, but was generally poor."[353] Additionally, in 2001, the United Kingdom Department of Health evidence-based practice guidelines "acknowledged concerns over the quality of the

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[346] Ibid., 262.
[347] A. B. Adler, B. T. Litz, C. A. Castro, M. Suvak, J. L. Thomas, L. Burrell, D. McGurk, K. M. Wright, and P. D. Bliese, "A group randomized trial of critical incident stress debriefing provided to US peacekeepers, 262;
-Daniel S. Weiss, "Group Treatment of PTSD Resulting from Political Trauma," *International Journal of Group Psychotherapy*, 60, No. 3 (2010): 440.
[348] A. B. Adler, B. T. Litz, C. A. Castro, M. Suvak, J. L. Thomas, L. Burrell, D. McGurk, K. M. Wright, and P. D. Bliese, "A group randomized trial of critical incident stress debriefing provided to US peacekeepers, 257, 262.
[349] Ibid.
[350] S. Rose, J. Bisson, R. Churchill, S. Wessely, "Psychological Debriefing for Preventing Post-traumatic Stress Disorder (PTSD) (Review)," 12.
[351] Ibid.
[352] S. Rose, J. Bisson, and S. Wessely, "A Systematic Review of Single-Session Psychological Interventions ('debriefing') Following Trauma, 176; Department of Health, *Treatment choice in psychological therapies and counseling*. (London, England: Crown 2001) 24. www.doh.gov.uk/mentalhealth/treatmentguideline (accessed January 1, 2012).
[353] Ibid.

studies in the Cochrane and NICE reviews. They state that many of the published studies showing negative results for critical incident debriefing do not assure the quality of the intervention."[354] Furthermore, it is not appropriate to use individual or couples crisis intervention cases to evaluate the efficacy of the CISD group crisis intervention component.[355] One would not try to conduct group psychotherapy on an individual because it would lose the synergetic contributions of group dynamics; the same principle applies to crisis intervention models.

The studies included in the Cochrane review that assert that they used CISM or CISD did not fully adhere to the prescribed structure, timelines, and phases of the CISD component; thus they did not adhere to the components' fidelity.[356] The Cochrane review affirms that the randomized group studies contained "key components of psychological debriefings (PD) as described by Mitchell although not necessarily adhering totally to this method."[357] Debriefing time in many of the RCTs was lower than the prescribed CISD component time of one to three hours, which is necessary for the facilitators to adequately progress through all seven phases of the CISD component. As Debbie M. Lovell-Hawker and colleagues observed, the mean debriefing time of the nine RCTs in the 1998 Cochrane review was forty-four minutes. Lovell-Hawker stated that "rushed debriefing can make matters worse possibly because it risks exposure to anxiety without sufficient time for habituation."[358] Robyn Robinson suggests it is not possible to draw conclusions about interventions if the "theoretical model" does not match the delivery.[359]

Some cases included interventions on individuals dealing with active physical injuries in addition to the psychological impact of the critical incident. This goes against the

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[354] Debbie M. Lovell-Hawker, *Debriefing Aid Workers and Missionaries: A Comprehensive Manual, 8th Edition,* 7.
- Department of Health, *Treatment choice in psychological therapies and counseling*. (London, England: Crown 2001) 24. www.doh.gov.uk/mentalhealth/treatmentguideline (accessed January 1, 2012).
[355] Robyn Robinson, Commentary on Issues in the Debriefing Debate for the Emergency Services: Moving Research Outcomes Forward, *Clinical Psychology: Science and Practice*, Vol. 14 No. 2, (June 2007).
[356] S. R. Priest, J. Henderson, S. F. Evans, and R. Hagan, "Stress debriefing after childbirth: A randomised controlled trial, 544-545; M. Sijbrandij, M. Olff, J. B. Reitsma, I. V. E. Carlier, and B. P. R. Gersons, "Emotional or educational debriefing after psychological trauma, 151; R. A. Mayou, A. Ehlers, M. Hobbs, "Psychological debriefing for road traffic accident victims: A three-year follow-up of a randomized controlled trial, 589– 593.
[357] S. Rose, J. Bisson, and S. Wessely, "A Systematic Review of Single-Session Psychological Interventions ('debriefing') Following Trauma, 178.
[358] S. Rose, J. Bisson, and S. Wessely, "A Systematic Review of Single-Session Psychological Interventions ('debriefing') Following Trauma, 178; D. Lovell-Hawker, *Debriefing aid workers and missionaries: A comprehensive manual,* 6th Edition *(London, England:* People In Aid, 2010).
[359] Robyn Robinson, Commentary on Issues in the Debriefing Debate for the Emergency Services: Moving Research Outcomes Forward.

protocol of most acute crisis intervention models.[360] Mitchell opposes interventions while people are experiencing severe physical pain.[361] Debbie Hawker asserts that rest and medication go farther to alleviate physical pain than discussing the incident.[362]

The two RCT studies, which concluded that debriefing may be harmful, failed to achieve equivalent group membership at pretest. [363] Furthermore, the Cochrane review included many studies with small sample sizes or low response rates, which rendered the conclusions that flowed from them less reliable.[364] Many of the cited studies used CISD as a solitary intervention mechanism. CISD was never intended to be used as a solitary intervention; rather it is to be one component in CISM's multicomponent, comprehensive, systematic, and integrated range of crisis support services. Multicomponent crisis intervention is the standard in the majority of acute crisis intervention models. Many of the cited cases employed minimally trained facilitators.[365]

The reviews were also problematic because some of the cited studies assessed people who had not experienced a critical incident or significant trauma. Hawker and colleagues summarized their concern over the adapted and truncated CISM components used in many of the RCTs, saying that they were "offered to the wrong people, too soon, in the wrong setting, too briefly, too intrusively, and without follow-up."[366]

Finally, critics of the Cochrane review findings have noted the overgeneralization of the term debriefing and disagree with the call for a moratorium on all compulsory, psychological debriefings of groups of trauma victims. The Cochrane review used the generic term psychological debriefing to describe several different intervention models. George Engel describes the challenge with using overarching or generic terminology in conducting research:

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[360] J. I. Bisson, P. L. Jenkins, J. Alexander, and C. Bannister, "Randomized Controlled Trial of Psychological Debriefing for Victims of Acute Burn Trauma," 78; M. Hobbs and G. Adshead, "*Preventive psychological intervention for road crash survivors" The Aftermath of Road Accidents,* 159-171.
[361] J. T. Mitchell, "When disaster strikes . . . the critical incident debriefing process," *Journal of the Emergency Medical Services* 8, (1983): 36–39; Debbie M. Hawker, John Durkin and David S. J. Hawker, "To Debrief or Not to Debrief Our Heroes: That is the Question*,"* 455.
[362] Debbie M. Lovell-Hawker, *Debriefing Aid Workers and Missionaries: A Comprehensive Manual, 8th Edition,* 7.
[363] J. I. Bisson, P. L. Jenkins, J. Alexander, and C. Bannister, "Randomized Controlled Trial of Psychological Debriefing for Victims of Acute Burn Trauma," 78.
[364] Ibid., 80.
[365] M. Hobbs and G. Adshead, "*Preventive psychological intervention for road crash survivors" The Aftermath of Road Accidents,* 159-171.
[366] Debbie M. Hawker, John Durkin and David S. J. Hawker, "To Debrief or Not to Debrief Our Heroes: That is the Question*,"* 458.

> A substantive issue in rational discourse is the need to use terms consistently. . . . No discussion of issues, no debate about theory or research, nor any conduct associated with inquiry regarding effective practice can be meaningful, nor be considered anything but pseudo-science, without a definition of, and agreement upon, fundamental terms and concepts.[367]

Until 2009, some of the initial summaries on the Cochrane reviews read, "There is no current evidence that psychological debriefing is a useful treatment," with no distinctions made about whether the debriefing occurred with individuals or groups and whether the debriefings were conducted in single or multiple sessions. The omission regarding single sessions was later rectified by the Cochrane review authors following input from clinical psychologist Colin Elliott in a 2000 feedback letter called "Misleading Reviewers' Conclusions."[368] However, the consistent use of the term psychological debriefing can leave the reader with the impression that the same intervention model was used each time the term was used or that all acute crisis intervention models that contain a debriefing portion are ineffective or potentially harmful. This lexicological challenge continues throughout current literature.[369] Perhaps the most important lesson learned from the Cochrane review is the need to replace the term psychological debriefing with the actual names of the models used.

The moratorium on compulsory debriefing of trauma victims called for by Rose, Bisson, Churchill, and Wessely seems to have been issued prematurely. Only two of the fifteen studies they cited showed a negative outcome, and three showed a positive outcome. Equivalent group membership was not achieved in either of the two RCTs that found an adverse effect: the severity of injury was higher in both intervention groups. Hawker and colleagues contend,

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[367] George S. Everly and Jeffrey T. Mitchell, "The Debriefing "Controversy" and Crisis Intervention: A Review of Lexical and Substantive Issues, 211.
[368] S. Rose, J. Bisson, R. Churchill, S. Wessely, "Psychological Debriefing for Preventing Post-traumatic Stress Disorder (PTSD) (Review)," 44.
[369] George S. Everly and Jeffrey T. Mitchell, "The Debriefing "Controversy" and Crisis Intervention: A Review of Lexical and Substantive Issues, 2-4.

> When initial trauma symptoms and severity of injury were controlled for, the negative effect of debriefing on later trauma symptoms was reduced to marginal significance ($p<0.07$, Mayou et al., 2000) or disappeared, with the initial symptoms being the only variable that predicted trauma symptoms at follow-up (Bisson et al., 1997)[370]

Conversely, it appears no concern was voiced regarding the potential harm done by withdrawing crisis intervention models from the occupational groups who had been successfully using these models for over twenty years."[371]

Raymond Flannery notes that no single type of medical intervention will work for all people all of the time, and occasionally there may be unforeseen harmful side effects.[372] In treating breast cancer, doctors may suggest a course of treatment applicable to the majority of patients, but the treatment may have an adverse effect on a few. Given this circumstance, doctors do not stop treating all of their patients; instead, they try to separate the aspects of the treatment found effective and continue with those and then try new or adapted approaches to replace the harmful elements of their treatment. Atle Dyregrov of Norway stated, "In my opinion the debate on debriefing is not only a scientific but also a political debate. It entails power and positions in the therapeutic world."[373]

What Can Be Learned from the Studies Assessed in the Cochrane Review?

Many lessons can be learned from the three Cochrane review iterations. First, any type of crisis intervention should be part of a multicomponent, comprehensive, systematic, and integrated range of crisis support services and not a stand-alone intervention. Furthermore, it is imperative to strictly adhere to the stipulated protocols of any crisis intervention model and to avoid truncated or adapted elements, which could lead to undesirable results. Formal names of models and approaches rather than generic names such as debriefing should only be used. Credibility, training, and competency of facilitators are essential in any crisis intervention model or approach. As in any context, the use of

[370] Debbie M. Hawker, John Durkin and David S. J. Hawker, "To Debrief or Not to Debrief Our Heroes: That is the Question," 454.
[371] Ibid., 456.
[372] Raymond B. Flannery, *The Assaulted Staff Action Program: Coping With the Psychological Aftermath of Violence* (Ellicott City, MD: Chevron Publishing Corporation, 1998), 149.
[373] Jeffrey T. Mitchell, *Crisis Intervention and CISM: A Research Summary* (International Critical Incident Stress Foundation, February 2003), 4. http://www.cism.cap.gov/files/articles/CISM%20Research%20Summary.pdf (accessed January 1, 2012).

minimally trained or poorly skilled facilitators can have an adverse effect on even empirically proven, successful programs.

Routine or mandatory crisis intervention is not recommended. Participation in a crisis intervention component or model should be voluntary and based on the needs and receptiveness of the individual. Furthermore, crisis intervention models should rarely be used with people on medication or experiencing physical pain. Researchers who are measuring acute crisis intervention models and approaches should ensure that participants in their studies have been exposed to a traumatic event, preferable a critical incident where the role of subjective interpretation is low. Some of the RCTs cited in the Cochrane review assessed people who had not experienced a critical incident or significant trauma. This may be key for researching effects because one is not likely to have a psychological crisis and hence manifest symptoms of distress if one has not experienced a traumatic event. Furthermore, one would not be likely to need crisis intervention if one had not been through a crisis.

Finally, establishing what outcomes make a crisis intervention successful or valuable is vital. The Cochrane review at first measured both mitigated short-term distress and PTSD, but later results focused strictly on decreasing the incidence of PTSD. The Cochrane review's focus on PTSD seems unreasonable given that the models they employed were meant for crisis intervention and not intended to be psychotherapy or a psychotherapy substitute. Perhaps future research should give greater consideration to some of the other findings of the studies, such as decreased alcohol use, positive effects on "outcomes relative to military organizations," mitigated short-term distress, and overall usefulness and likeability as cited by many of the participants within the adapted CISD component intervention groups.[374]

[374] A. B. Adler, B. T. Litz, C. A. Castro, M. Suvak, J. L. Thomas, L. Burrell, D. McGurk, K. M. Wright, and P. D. Bliese, "A group randomized trial of critical incident stress debriefing provided to US peacekeepers, 257, 262; S. R. Priest, J. Henderson, S. F. Evans, and R. Hagan, "Stress debriefing after childbirth: A randomised controlled trial, 545.

Applicability with Complex Emergency Responders

With regard to robbery victims, Campfield and Hills supported "immediate crisis intervention with this type of incident and victim."[375] To what extent and for what reasons would similar conclusions be reached for responders working in complex emergencies?

An understanding of occupational cultural competence is essential for determining which crisis intervention models and approaches may have a more positive effect on responder populations as opposed to the general population. The main differences revolve around preparedness, training, resiliency, personality traits, mental health stigmas, and camaraderie.

Debbie Lovell-Hawker refer to overseas aid and emergency service workers as "generally healthy, resilient people with strong coping skills who have some expectation that they may encounter stress and trauma while overseas, and so are partially prepared to cope with this."[376] Some organizations understand the need for preparedness of their staff and provide training or books on coping with stress[377] or managing the stress of humanitarian emergencies.[378] Emergency service and overseas aid responders are different from civilian participants in the Cochrane review studies who unexpectedly experienced trauma and may not have had a foundation for coping in highly stressful situations. Responder populations are also familiar with operational debriefings following missions, deployments, or particular incidents, so psychological debriefings are not much different from operational debriefings, with the exception of addressing emotions.

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[375] K. M. Campfield and A. M. Hills, "Effect of timing of critical incident stress debriefing (CISD) on posttraumatic symptoms, 327.
[376] Debbie M. Lovell-Hawker, *Debriefing Aid Workers and Missionaries: A Comprehensive Manual, 8th Edition,* 12.
[377] United Nations Department of Peacekeeping Operations, *UN Stress Management Booklet* (New York, NY: United Nations Department of Peacekeeping Operations: Office of Planning and Support, 1995).
[378] United Nations High Commissioner for Refugees: Staff Welfare Unit Career and Staff Support Services, *Managing the Stress of Humanitarian Emergencies,* International Federation of Red Cross and Red Crescent Societies, Managing Stress in the Field (International Federation of Red Cross and Red Crescent Societies, 2009).

QUOTES FROM THE FIELD

"Humanitarian workers living in countries in crisis and conflict are subjected to a great deal of stress. They deny themselves the right to feel tired and exhausted, at times they are at the limits of their capacities without realizing it."

Health Workers on the Front Line,
by Paul E. Ares
(Danieli, 2002, 118)

Embedded within the persona of war journalists is an element of self-deception, the idea that they are people who can confront war with invulnerability.[379] Jeffrey Mitchell and Grady Bray conducted a study of general personality traits of emergency service providers [380] that may be similar to complex emergency responders' personality traits. Mitchell and Bray state that emergency service providers are risk takers and are internally motivated, highly dedicated, and action oriented. They possess a strong need to be needed, prefer instant gratification, and like being in control.[381] These personality traits are in contrast to their perceptions of seeking help. The Netherlands Centre for Social Development found that workers dealing with survivors of violence tend to refrain from seeking help due to "the dominant professional framework and the existing power structure in which survivors and care workers meet." [382]

> Victims are weak, helpless, and without resources. Care workers are strong, powerful and resourceful. In this context a care worker may feel that his or her need for consultation is a personal weakness, and will therefore be proud to bear anything in order to maintain an image of self-control and invulnerability. [383]

Those wishing to provide acute crisis intervention or longer-term psychotherapy must be aware of the distinct personality traits typical of those in the profession and work to mitigate real and perceived barriers to seeking help.

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[379] Anthony Feinstein, *Journalist under Fire: The Psychological Hazards of Covering War*, 6
[380] Alan A. Mikolaj, *Stress Management for the Emergency Care,* 26
-Adapted from J. Mitchell and G. Bray, *Emergency Services Stress: Guidelines on Preserving the Health and Careers of Emergency Services Personnel*, 19-21.
[381] Ibid.
[382] Mental Health and Psychosocial Support Network, *Prevention of Professional Burn-out with Care Workers: Self-Care and Organizational Care, 7.* http://lastradainternational.org/lsidocs/807%20admira_work_for_care_2005_module_13_prevention.pdf (accessed January 1, 2012).
[383] Ibid.

Often the only ones from whom responders will seek help are peers who understand the occupational culture and stressors and who treat them like comrades rather than patients. Lovell-Hawker states, "People who have suffered a traumatic incident often talk more readily to other people who have experienced similar incidents."[384] Notably, responders sometimes find it challenging to speak to friends and family back home about their experiences, feeling they could not possibly comprehend or would be traumatized by hearing the responder's narrative. How does one explain to loved ones the circumstances of war, mass causality triage, child soldiers, or people dying of starvation, let alone how it makes one feel! Journalists Carlos Mavroleon and Des Wright state, "When you do try to talk to people who were not there, they don't understand, they have no idea what it was like. . . . It's just not possible. . . . The key is that they cannot smell it, you can hear it, you can see it but you cannot smell it." [385]

Lovell-Hawker writes, "The nature of humanitarian work requires that staff adopt a calm, efficient, methodical approach to their work, suppressing feelings in order to respond to a crisis." This often results in their suffering in silence or keeping a stiff upper lip.[386] The possibility of feeling or being perceived as vulnerable or the chance that someone just will not understand are among the greatest trepidations responders face when seeking psychological help.

QUOTES FROM THE FIELD

"The knowledge that I am forever change, and wondering if I am capable of ever being normal again. What happened to me? Do the other guys who have seen and done what I done feel the same way?"

Voices Cambodia Diary, by Mike Daly, (US Army Military Observer, 1993, 49

"I was desperate to talk to someone who I knew would be able to handle extremely traumatic experiences. I had shared some of it with others, but most people could not cope, which left me worse off."

Debriefing Aid Workers and Missionaries, by Dr. Debbie Lovell-Hawker (People In Aid, 2011, 13)

"There appears to be a fundamental need that many, if not all, humans have, namely to share frightening and distressing experiences with others who have at least some understanding of what has been experienced and who feel some caring or concern that this has occurred."

Dealing with Emergency Services: Critical Incident Stress Management (Cambridge University Press, 2000, 104)

[384] Debbie M. Lovell-Hawker, *Debriefing Aid Workers and Missionaries: A Comprehensive Manual, 8th Edition,* 9.
[385] Kyra Thompson, Director, *Dying to Tell the Story,* Carlos Mavroleon and Des Wright Interview.
[386] Debbie M. Lovell-Hawker, *Debriefing Aid Workers and Missionaries: A Comprehensive Manual, 8th Edition,* 9.

Peacekeepers still hold to a "suck-it-up or tough-it-out mentality" and often will not seek help because of lingering shame and mental health stigmas.[387] Furthermore, they often will not report psychological problems out of fear that it will negatively affect their career.[388] Other responder populations feel that mental health professionals do not possess the cultural competencies to help. In the early 1990s, UNHCR referred some of their staff to external mental health counselors when they exhibited a combination of symptoms that included extreme fatigue, nightmares, muscle pain, and hypersensitivity to noise or odors.[389] Notwithstanding the professionalism of the psychotherapist, a disconnect appeared with the staff's experiences as well as a failure to understand why a staff member would continue working in such a stressful environment.[390] Many mental health counselors believe that horrific images of death and mayhem are the most psychologically damaging. However, some responders will argue the dead are dead. The BBC's Middle East correspondent Jeremy Bowen said, "It was not death itself but the consequences of death on those who lived that provided the most memorable and troubling recollections."[391] Often it is encounters with people who remind responders of loved ones back home that cause psychological difficulties.

QUOTES FROM THE FIELD

"After the ambush incident in Egypt, where a colleague and four police officers were killed and I was shot, the group of us who survived hardly talked about it. Stress counseling and debriefings were not yet popular. I suppose they would have been even considered a sign of weakness. We all just thought that time would make a difference and we'd get over it. After six months, the situation didn't improve as we all suffered from one symptom or another."

Risk and protection for UNICEF Field Staff, by Nils Arne Kastberg (Danieli, 2002, 72)

In a study on victims of violent crimes conducted by S. Rose and colleagues, only 11 percent of victims responded to institutional invitations to discuss their condition.[392] This phenomenon surfaced in many of the Cochrane RCT studies, as seen in the low rate of response to the invitation to participate, as well as in the low rate of return for follow-up

[387] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst,* 18 (*Peacekeepers in Peace-Builders Under Stress,* Sue Downie).
[388] Wanderson Fernandes Souza, Ivan Figueira, Mauro Mendlowicz, Eliane Volcham, Cara Marques Portella, Ana Carolina Feraz Mendonca-de-Souza and Evandro Silva Freire Coutinho, "Posttraumatic Stress Disorder in Peacekeepers A Meta-Analysis," 311.
[389] Yael Danieli, *Sharing the Front Line and the Back Hills: International Protectors and Providers: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst, 55* (*Caring for Staff in UNHCR,* Soren Jessen-Petersen).
[390] Ibid.
[391] Anthony Feinstein, *Journalist under Fire: The Psychological Hazards of Covering War*, 21.
[392] S. Rose, CR Brewin, B. Andrews and M. Kirk, "A randomized controlled trial of individual psychological debriefing for victims of violent crime," *Psychological Medicine 29, No. 4 (*1999): 793–799.

sessions. However, studies done with some form of a CISD component found a higher rate of response. One can surmise that stigmas about mental illness or showing vulnerability may inhibit individuals from seeking professional mental health services, but CISM and other models and approaches, which are seen as an intervention and are not perceived as a mental health service, may help bridge the divide in the continuum of care.[393] This may be more relevant with the complex emergency responder population and less relevant with civilians.

[393] David Richards, "A Field Study of Critical Incident Stress Debriefing versus Critical Incident Stress Management," *Journal of Mental Health*, 2001, 10 No. 3 (2001): 351-362.

Summary of the Cochrane Review

This chapter assesses the Cochrane review for four reasons. First, only a few randomized controlled studies have been accomplished targeting acute crisis intervention models, and hardly any exist on complex emergency responders. Therefore, it is imperative to try to learn which elements make up effective early interventions from RCTs conducted on other populations. Cochrane studies employ some of the most highly internationally recognized standards for conducting reviews of primary evidence-based research within the human health care field.[394]

Second, the conclusions reached in the Cochrane review had widespread ramifications for acute psychological crisis intervention policy, practices, and guidelines. These ramifications go beyond the models and the populations in the RCTs that were included in the Cochrane review. CISD group crisis intervention among complex emergency responders was one area influenced by the conclusions of the Cochrane meta-analyses even though group crisis intervention was not part of the Cochrane reviews.

Third, over half the studies in the Cochrane review meta-analyses indicate use of at least one of the components within the CISM model recommended for complex emergency responders in Chapter 6 and used with NGO staffs and peacekeepers following critical incidents. An adaptation of the CISD component is cited within half the studies.

Finally, although the studies in the Cochrane review focus predominantly on acute individual crisis intervention with civilians experiencing traumatic events, insight can be gleaned from individual intervention methodology in order to appropriately design future adapted forms of RCTs on crisis intervention practices with the complex emergency responder population.

The Cochrane Collaborative meta-analyses conducted on acute individual psychological debriefing and the underlying RCT studies with predominately civilian populations experiencing trauma events, may not provide a perfect comparison to predict the efficacy of crisis intervention techniques applied to the complex emergency responder population. Nonetheless, they provide us with helpful information regarding certain elements of crisis intervention, such as timing, model fidelity, and credible facilitators.

[394] The Cochrane Collaboration. http://www.cochrane.org/cochrane-reviews (accessed December 12, 2011).

Furthermore, they offer important insight into the challenges of designing an RCT to measure crisis intervention effectiveness with multiple dynamic variables. Finally, they help assess some of the main differences between the complex emergency responder population and the general public—differences such as preparedness, personality traits, and mental health stigma that may affect the efficacy of acute crisis intervention tools.

Following the initial Cochrane review finding that debriefings can be harmful, many organizations disbanded their CISM teams, motivated by an ethical or legal obligation to do no harm to people who were already suffering. The North American Treaty Organization (NATO) stated regarding Critical Incident Stress Debriefings, "There is still no consensus on the role, if any, of acute interventions. Classic CISD debriefings can no longer be recommended."[395] The surgeon general of the United Kingdom sent out a policy letter in January 2006 to military personnel asserting, "the medical evidence demonstrates no value and therefore [CISD] is not recommended by DMSD"—the Defense Medical Services Department.[396] Debbie Hawker and colleagues report that the United Kingdom's largest travel health clinic, used by 300 aid and mission organizations, cited the Cochrane and National Institute for Clinical Excellence (NICE) guidelines as reasons to cease using interventions with debriefing components.[397] It is likely that few read beyond the headlines and summary conclusions of the Cochrane review and critically analyzed the individual studies. Compounding the problem were subsequent meta-analyses conducted using many of the substandard studies cited in the Cochrane review.

The Van Emmerik Meta-Analysis

In 2002 the leading medical journal, the Lancet, published the meta-analysis on crisis interventions conducted by Arnold van Emmerik and colleagues. The authors concluded that "CISD and non-CISD interventions do not improve natural recovery from psychological trauma."[398] All of the interventions van Emmerick and his colleagues studied were undertaken with individuals or couples, rather than with groups as was intended for the CISD component.[399] Four out of the five cases they assessed were from the Cochrane review, including Bisson, Jenkins, Alexander, and Bannister on acute burn patients; Mayou,

[395] Grant Devilly, Richard Gist and Peter Cotton, "Ready! Fire! Aim! The Status of Psychological Debriefing and Therapeutic Interventions: In the Work Place and After Disasters," *Review of General Psychology,* Vol. 10, No. 4 (2003) in references to (NATO, 2002) NATO-Russia advanced research workshops on social and psychological consequences of chemical, biological and radiological terrorism.
[396] Debbie M. Hawker, John Durkin and David S. J. Hawker, "To Debrief or Not to Debrief Our Heroes: That is the Question,*";* Ministry of Defense. Surgeon General's Policy Letter (SGPL) 03/06. *The prevention and management of traumatic stress related disorders in armed forces personnel deployed on operations* (London: Ministry of Defense, 2006).
[397] Debbie M. Hawker, John Durkin and David S. J. Hawker, "To Debrief or Not to Debrief Our Heroes: That is the Question,*"* 457; A. Hargrave, "Interhealth and trauma management," *Developing Mental Health* Vol. 4, No. 4 (2006): 1-4.
[398]Arnold AP van Emmerik, Jan H Kamphuis, Alexander M Hulsbosch, Paul M G Emmelkamp, "Single session debriefing after psychological trauma: a meta-analysis," *The Lancet,* Vol. 360, No. 9335 (September 7, 2002): 766.
[399] Ibid.

Ehlers, and Hobbs on car accident victims; Lee, Slade, and Lygo on miscarriages; and Rose, Brewin, Andrews, and Kirk on victims of violent crime.[400] The only new case in the van Emmerik meta-analysis was a study on police officers by I. V. E. Carlier, A. E. Voerman, and B. P. R. Gersons. This study is helpful for comparison to complex emergency responders.[401]

Carlier and colleagues studied the use of CISD briefings adapted for individuals with police officers in the Netherlands. Adapted CISD interventions were conducted in three subsequent sessions at approximately twenty-four hours, one month, and three months post-incident by CISM-trained peer police officers and supervised by police social workers.[402] Initial sessions lasted between five minutes and two hours, with an average of 41.4 minutes and standard deviation of 24.9, while subsequent sessions were significantly shorter, at an average of 17.4 minutes for the second session and 15.9 minutes for the third session. [403] Of the participants, 98 percent expressed great satisfaction with the CISD process.[404] Carlier and colleagues believe this is supportive of other studies that indicate "a natural tendency in people who have recently been traumatized to seek emotional support, recognition, understanding, and endorsement."[405] Nonetheless, the study found no differences in psychological morbidity between those who received the intervention and those who did not.[406]

Carlier and colleagues postulate that no difference was found because of the low rate of PTSD symptoms and because Dutch police officers are offered CISD following every critical incident, regardless of whether the incident triggered intense emotions.[407] The Dutch police forces' policy is in contrast to Everly's argument that crisis intervention tactics should be "predicated upon evidence of human distress and/or dysfunction, not merely the occurrence of an event" stressor.[408] Furthermore, Carlier and colleagues suggest, occupational training and preparedness may have mitigated the police officers' feelings of

[400] Ibid., 766-780.
[401] Ibid.
[402] I. V. E. Carlier, A. E. Voerman and B. P. R. Gersons, "The influence of occupational debriefing on post-traumatic stress symptomatology in traumatized police officers," (*British Journal of Medical Psychology,* Vol. 73, No. 1 (2000): 89-90.
[403] Ibid.
[404] Ibid., 89-90, 94.
[405] Ibid., 94.
[406] Ibid., 94-95.
[407] Ibid., 95.
[408] George S. Everly, "Five Principles of Crisis Intervention: Reducing the Risk of Premature Crisis Intervention.

"intense fear, helplessness, or horror," which often contribute to PTSD.[409] It is likely that the training and preparedness factor may replicate itself in studies conducted on responder populations. The findings of Carlier and colleagues are relevant to complex emergency responders because they show the role that preparedness, training, and other prior critical incidents can have in one's resiliency and ability to manage and mitigate intense emotions in future traumatic incidents, as well as the need to base intervention on signs of human distress and not solely on the event. Carlier and colleagues advocate for future research on the efficacy of group rather than individual debriefings.[410]

Only the Bisson, Jenkins, Alexander, and Bannister study on acute burn patients and the Mayou, Ehlers, and Hobbs study on car accident victims showed a harmful effect resulting from the intervention; the three other studies showed no differences and no adverse effects among participants. Van Emmerik and colleagues did not include the three cases that indicated positive outcomes in the Cochrane review. Inclusion of the positive cases might have changed the overall weighted findings.

National Institute of Clinical Excellence Guidelines

In 2005, upon completion of a meta-analysis, the National Institute for Clinical Excellence (NICE) published guidelines that recommended against single-session critical incident debriefing as a routine practice. Their meta-analysis was conducted using many of the same studies assessed in the Cochrane review, including Bisson, Jenkins, Alexander, and Bannister on burn patients and Mayou, Ehlers, and Hobbs on car accidents victims, each of which showed a negative outcome. The NICE publication refers to "methodological reservations,"[411] thereby noting the poor quality of the studies, before making its recommendations. Although the NICE guidelines recommend against single-session debriefings, many readers would not delineate between a stand-alone single session and a single session within an integrated, multicomponent model. Given the reservations about

[409] I. V. E. Carlier, A. E. Voerman and B. P. R. Gersons, "The influence of occupational debriefing on post-traumatic stress symptomatology in traumatized police officers," 95.
[410] Ibid., 96.
[411] National Institute for Clinical Excellence, Post-traumatic stress disorder (PTSD) The management of PTSD in adults and children in primary and secondary care, Clinical Guideline 26, March 2005, Developed by the National Collaborating Centre for Mental Health. http://www.ncbi.nlm.nih.gov/books/NBK56498/ (accessed January 1, 2012).

methodology, it is difficult to understand why NICE made the recommendation it did and why it did not include more details in its recommendation.

The 2011 Sphere Project Recommendations

The 2011 Sphere Project Humanitarian Charter and Minimum Standards in Humanitarian Response states, "Psychological debriefing is ineffective and should not be provided,"[412] but it makes no distinction between intervention models and neither offers nor cites references to support the claim.[413] As with the Cochrane review, generic use of the term psychological debriefing can leave the reader with the impression that all models containing a debriefing portion are ineffective or potentially harmful. As a result, some potentially beneficial crisis intervention models may not even be considered for use in the arena of complex emergencies, where critical incidents are prevalent. Hopefully, future Sphere publications will contain more details as to the rationale behind the recommendation against "psychological debriefing" and may consider adjusting their findings based upon further research and review of ongoing advancements in the field.

Rebuttals

S. Wessely and M. Deahl point out nineteen studies that were excluded from the Cochrane review. Among the excluded studies were randomized controlled trials (RCTs) of group debriefings in naturalistic settings.[414] Deahl raises concerns about the "nature of evidence and the status of RCTs as the imprimatur of good evidence":[415]

> Evidence of Random Control Trials have become the dominant paradigm of treatment outcomes studies to the virtual exclusion of naturalistic, observational studies or case series. In attempting to satisfy the rigorous methodological criteria demanded, . . . many RCTs lose validity and become

[412] The Sphere Project, *The Sphere Handbook 2011: Humanitarian Charter and Minimum Standards in Humanitarian Response* (United Kingdom, Practical Action Publishing, 2011), 73. http://www.sphereproject.org/resources/download-publications/?search=1&keywords=&language=English&category=22 (accessed January 1, 2012).
[413] Email Correspondence on February 5, 2012 from Mark van Ommeren, Author of the Sphere Psychosocial aspects "We were influenced by the NICE PTSD guidelines and the subsequent study Adler AB et al (2008). A group randomized trial of critical incident stress debriefing provided to U.S. peacekeepers. Journal of Traumatic Stress, 21:253-63."
[414] S. Wessely and M. Deahl, "Psychological debriefing is a waste of time," *British Journal of Psychiatry* 183, No. 1 (2003): 13-14.
[415] Ibid.

> so divorced from clinical reality that their findings are clinically meaningless.[416]

Rebuttals to the Cochrane review, the meta-analysis by van Emmerik and colleagues, and the NICE guidelines were "empirically validated through thoughtful qualitative analyses and controlled investigations."[417] However, just as a retraction buried deep in a newspaper does not counteract earlier headlines on the front page, rebuttals cannot counteract the rehashing of Cochrane review studies that cast psychological debriefing and other forms of early crisis intervention in a negative light. Hawker, Durkin, and Hawker state that it is challenging to secure funding and ethical approval for future RCTs to counter the Cochrane study's findings because most officials responsible for approval feel that the debate is closed and that debriefings have been proved to be harmful.[418]

[416] Ibid.
[417] Albert R. Roberts, *Crisis Intervention Handbook: Assessment, Treatment and Research, 3rd* Edition (New York, NY: Oxford University Press, 2005), 240.
[418] Debbie M. Hawker, John Durkin and David S. J. Hawker, "To Debrief or Not to Debrief Our Heroes: That is the Question," 461.

Chapter IX: Conclusion

Does using immediate crisis intervention tools post–critical incident mitigate short-term distress or long-term negative psychological impact on responders in complex emergencies? Anecdotal evidence suggests that the use of acute, multifaceted psychological crisis interventions as a means of mitigating short-term distress has proved valuable throughout history and across multiple professions. Evidence for the ability of crisis intervention tools to mitigate long-term psychological dysfunction is inconclusive, but through indirect data, observation, and random controlled trial (RCT) analyses, it has been determined that it may decrease the incidence of some precursors to posttraumatic stress disorder. Interventions whose use is established in other professions with similar critical incidents may be transferable to responders in complex emergencies. Given the demonstrated need to mitigate responders' psychological wounds from working within complex emergencies, these established acute crisis intervention tools should be used, monitored via observation, and adapted through expert consensus in the field when necessary.

Some argue that the Cochrane review recommendations regarding the cessation of debriefing components should be applied to the complex emergency context. However, beyond the fact that poor methodology was used within many of the studies cited by the authors of the meta-analyses, the comparison appears ill-fitted. The general population targeted in many of the Cochrane RCT studies seems incongruent with complex emergency responders, who are often highly resilient and able to work in demanding and stressful environments, and who are often prescreened medically and psychologically by their sponsoring agencies. The Cochrane meta-analyses may provide guidance on crisis intervention, but should not be regarded as the sole body of evidence regarding its efficacy with complex emergency responders following critical incidents.

Studies that measure the effectiveness of crisis intervention models in naturalistic real-world settings such as complex emergencies, rather than measuring effectiveness under ideal conditions, must be conducted, then must be considered in determining the value of an intervention model. Although RCTs are an important contributor to knowledge about the validity of a crisis intervention method, they cannot serve as the sole

"imprimatur of good evidence" in determining the validity of a crisis intervention method.[419]

George Everly advocates using acute measures that are situational, temporally relevant, and well-defined rather than trait-dependent psychometrics.[420] A first step in that direction would be to measure cumulative exposure to critical incidents for responders who have over four years of complex emergency field experience. Such measurements would be made using a combination of qualitative narratives and traditional quantitative perspectives. Critical Incident History Questionnaires or comparable instruments could be used to collect the narratives as well as measure the cumulative exposure to incidents. After the dynamics of complex emergency critical incidents are solidified, a future study would assess which incidents have the greatest impact—where the actuality of threat, rather than the perception of threat, dictates the reactions. Those critical incidents would be the ones for which the analyst would conduct an adapted form of RCTs and subsequent meta-analyses. A pure RCT would be impossible to conduct in field conditions due to multiple variables, time constraints, logistical challenges, and ethical issues.

The future study would employ and compare the effectiveness of two crisis intervention models, components, or approaches based on an incident strategic planning framework. Withholding any type of crisis intervention during the study could be unethical given the magnitude of the incident and the potential for distress. Therefore, one group may receive an integrated multicomponent crisis intervention such as CISM, and the other groups could receive the more rudimentary approach of Psychological First Aid. The researchers performing the study would need to ensure that the models or approaches employed in each of the cases were carried out with fidelity to the protocols and steps intended by the developers of the models. Furthermore, the researchers would need to confirm that the interventions included in the study were conducted by well-trained and credible facilitators.

It is essential for researchers to use uniform psychometric instruments throughout all RCTs in assessing both the impact of the critical incident as well as the effectiveness of the intervention. Given the challenges with measuring PTSD in this arena, it may be more

[419] S. Wessely and M. Deahl, "Psychological debriefing is a waste of time, 13-14.
[420] Email Correspondence with George Everly March 28, 2012 "RCTs are preferable. It is important to abandon the use of trait dependent psychometrics and use more acute measures that are situationally and temporally relevant and well-defined."

advantageous to measure its precursors, such as acute stress disorder and other forms of distress and dysfunction mentioned in chapter three. Other areas of interest for inclusion in future studies may be substance abuse, intrusive memories, decreased work performance, or anxiety. Finally, demographic information is critical, as it will allow for comparison between responder types, field experience, operations, and critical incidents. The future study should use population exposure models to determine the participants' proximity and potency exposure to the events to create equivalent group membership. With good data and research, best practices for crisis intervention within complex emergencies can be established, enhanced, and operationalized to help responders following critical incidents.

Moving forward, it is imperative for the community of responders to candidly share the lessons they have learned from successes and failures of stress management and crisis intervention. Where limited practices exist within the responder field, a great deal can be gleaned from the crisis intervention approaches used by military and emergency service personnel and others. Many of these approaches are being adapted, and more can possibly be adapted, to meet the needs of complex emergency responders.

The Centers for Disease Control and Prevention have been convening international conferences and conducting studies to analyze the stress of working in complex emergencies and the mental health effects on responders.[421] The Antares Foundation has created recommendations for a minimum standard of care for aid workers.[422] The activities recommended by the Antares Foundation, along with others from People in Aid, the Headington Institute, the Centre for Humanitarian Psychology, and the IFRC Psychosocial Centre serve as good first steps, but this momentum must continue. We have a moral imperative not to go back to the days of Henry Dunant and the Battle of Solferino, when addressing psychological casualties was an afterthought. We owe our responders more!

[421] Global Health-Global Disease Detection and Emergency Response: IERH Scientific Publications: Mental Health in Aid Workers: Fact Sheet: http://www.cdc.gov/globalhealth/gdder/ierh/Publications/mentalhealth_aidworkers_pib.htm (accessed January 1, 2012).
[422] Antares Foundation, *Managing Stress in Humanitarian Workers,* Guidelines for Good Practice. (April 2005), 2. http://www.antaresfoundation.org/download/managing_stress_in_humanitarian_aid_workers_guidelines_for_good_practice.pdf (accessed January 1, 2012).

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