1. THE CRITICAL INCIDENT DEBRIEFING PROCESS
Adapted from Jeffery T. Mitchell,
"When Disaster Strikes".

TIME FRAME
Within 48 hours optimal
Effectiveness diminishes with passage of time between incident and debriefing.
Minimal effectiveness after six weeks.

GROUND RULES
Absolute confidentiality
No criticism of others' feelings or reactions
Positive, supportive, understanding atmosphere, based on concern.
Active listening.

FORMAT
Reminder of ground rules

FACILITATOR
Someone with good group process skills and a knowledge of stress responses can be helpful in keeping the meeting going.
A professional facilitator may be helpful if you are concerned that feelings and reactions to the incident are particularly intense.

FACTS ABOUT THE INCIDENT
Each person describes the facts about themselves and the incident:
Where they were
What they saw, heard, smelled
What they did in and around incident
Group contributes all facts necessary to make incident become real again in the room.

FEELINGS ABOUT THE INCIDENT
"How are you feeling now?"
"How did you feel when that happened?"
"Have you ever felt anything like that before?"
(Be sure no one dominates, no one is left out.)

RESULTS OF THE INCIDENT
"Had you experienced any unusual things at the time of the incident?"
"What unusual things are you experiencing now?"
"Has your life changed in any way since the incident? (home, job, other)
At this phase, people frequently describe normal "stress response" symptoms.

TEACHING AND REASSURANCE
Review of normal stress responses
Support, understanding, reassurance about normal responses
Reminders and suggestions of things that can be helpful, ways to take care of yourselves.

WRAP-UP
Identify and specific concerns which warrant follow-up
Develop plan of action
Discuss any concerns about how incident may affect the transition back into the job or family; problem-solve

FOLLOW-UP
Any incident has the potential to evoke feelings that may take more than one session to relieve.
Follow-up sessions can be conducted as needed for the whole group or for part of the group or specific individuals.
Individuals may find it helpful to talk to a professional helper or counselor if feelings or symptoms seem to go on too long, seem to be "out of control," seem particularly intense, or if they are interfering with work or family life.

2. CRISIS INTERVIEWING

The first response to any emergency necessarily includes to vital activities. The first of these is to attempt to alleviate the condition creating the crisis. The second is to gather essential information on which to base our decision. The sequence in which these tasks will be addressed will depend on presenting conditions and our own response needs. An example of this process might: Police respond to a call that a robbery has occurred. Upon arriving and observing that no suspects are present, they must gather

information through observation and interview before taking any action to alleviate the situation, i.e., capture the criminals. Paramedics responding to call of a person not breathing will probably begin resuscitation of the victim if appropriate and then begin to gather information about possible causes of the condition. This information gathering will provide data on which they will base further treatment decisions. A Chaplain arrives at a crime scene and finds an emotionally distraught family. They will begin by ascertaining what has occurred. This will usually be done by contacting the primary officer on scene.

In some crisis situations, the incident causing the crisis may not be one which the first responder can successfully deal with. A case of Sudden Infant Death Syndrome in which resuscitation is not apparently possible, is a typical case of this type. It is still, however, the responsibility of the first responder to gather a considerable amount of information from people who are involved in a serious emotional crisis. This crisis may be characterized by a loss or disruption of normal thought processes and a marked inability to respond to us in a reasonable or rational manner.

Other sections of this manual describe some of the reactions we might observe in people who are involved in a personal crisis. In describing those we certainly cannot predict certain behaviors but rather point out those most commonly seen in individuals under severe stress. What is predictable, however, is that victims of crisis who are skillfully interviewed by a figure viewed as having authority and power tend to become calmer somewhat faster and to experience fewer disabling effects of the immediate crisis. The purpose of this section is not to teach a new skill but rather to review crisis interviewing techniques and to provide a framework for self evaluation of your skill and an opportunity to refine them.

INITIATING THE INTERVIEW

A very important decision faces the first responder as he or she enters any crisis situation. The decision is this:
Must I immediately take action based on what I see? Or, must I conduct an interview of those present in order to adequately assess the situation and make the proper action decisions.?

Clearly, if immediate life saving steps can be taken, the decision is obvious. If action can be taken to prevent or minimize the crisis causing event this is our first priority. In any case, at some point in our contact with these people, some form of interview must be conducted.

In a S.I.D.S. case those interviewed will usually be one or both of the parents. Many first responders to S.I.D.S. cases have reported though, that baby sitters, brothers and sisters, and grandparents may be the only people present.
As we begin the interview it must be made clear that you wish them to tell you about what has happened in their own words. Despite the chaotic conditions which may exist, the interviewer must establish a relatively structured and not-accusatory atmosphere before a successful crisis interview can occur.

PROVIDING STRUCTURE

The task of providing structure in a crisis interview is probably best handled by setting some guidelines for all involved parties to follow.

Minimally these include:
1. Clarify the reason for the interview. (Assuming that your role and authority has been established.)

2. Generally outline the time period form which you wish information. Do not ask the question in the form of "What were you doing between this hour and that hour?" Rather ask: "Could you tell what happened today?" They should be asked to describe the situation not to explain their actions.

3. If more than one person is present, assure each involved party that they will have an opportunity to tell their story. Make it clear that each person is important and has something helpful to contribute. If done properly this approach will not allow one person to speak for another. It is important for people in crisis to talk about it.

4. Choose a suitable location for ;the interview. People in crisis may not seem to notice their surroundings but in reality they do. If it is possible conduct the interview in a location which offers both privacy and comfort. If you are in the people's home, a place where guests might usually be entertained is probably most appropriate. Hallways, bedrooms, etc. are not usually good places to conduct an interview. Emergency room waiting areas and other places in the presence of other people who are not involved are locations to be avoided when possible. Most E.R.'s will have a private area which offer privacy and comfort. (But not isolation) Outdoor areas are usually not appropriate. Use car, ambulance, etc. if available.

5. The first responder's approach to dealing with the incident should be systematic but not rigid. Although you will have certain duties which must be followed, the appearance of structure will not be lost if you occasionally stop and recognize the emotional content of the crisis. A sort of on-going listening and observation process will facilitate this. Also, including the victims in the activities in which you are involved while dealing with the incident is helpful to them and may reveal additional helpful insight into the problem.

The introduction of structure by an authority figure in a crisis situation is viewed as an important first step toward resolution of the emotional chaos which exists. There is, however, a danger to be considered as we introduce this structure.
Early, strong attempts to add structure to the crisis situation may cause the victims to submit almost completely to our perceptions of the situation and inhibit the free expression of their own feelings and limit their interpretations of hat has happened. Consequently, information gathered during an interview may actually reflect what they think we want to hear rather than a true statement of their perception of the incident and the crisis. When this occurs, the victim's very real need to talk about their feelings may be frustrated temporarily or even permanently. The simplest way to avoid this is described in the discussion of opening questions. Basically though, consistently avoiding the imposition of our own perceptions of the situation during any phase of the interview seems effective. The interview than, is not a time to present our view of the situation but rather a time for the victims to tell their story in their words.

TYPES OF CRISIS INTERVIEWS
Interviewing in a crisis situation will normally take two forms. The first is the directed interview in which we focus on gathering that information required for our reporting of the incident. This information, frequently referred to as "names and numbers," is always required. The content of this interview depends on the legal and procedural requirements of our agency.

The other type of interview is the non-directed or open-ended type in which the subject is encouraged to tell the story in his or her own words at a pace which seems reasonable based on their emotional state or physical condition.

Although different purposes are served by each type of interview the techniques which will be described are useful for each. It is neither essential or advisable to separate the two types of interview. The ideal system is to conduct both types simultaneously. If we find when we summarize the interview that we require more information for our report we will probably be able to ask these questions of a somewhat calmer victim who is more at ease with you.

As we begin to talk about specific techniques of interviewing a few simple rules should be outlined:

1. The interview is a procedure during which you provide no information. All information should come from the victim. You will provide information at some other point in the intervention.
2. If two or more people are to be interviewed be sure to establish your impartiality and interview each separately.
3. During the interview make no judgments on what the victims might say even if you feel they are clearly wrong.
4. Make no suggestions during the interview.
5. Try not to let one person speak for another. Get the story form each person in that person's words.
6. Always summarize each interview. A good summary is an essential part of the interview. It serves as a control device which assures people that you have listened. It serves also to focus the interview and to clarify points which require it. It also gives your interviewees an opportunity to add any information you may have missed.

OPENING QUESTIONS
The opening questions in any interview should be extremely simple and should be asked without imposing the interviewers perception of the situation. Although certain facts may be obvious, avoid the temptation to ask questions that may be answered with yes and no. The first and subsequent questions should be open ended. Several questioning words can be easily used. They are:

What, When, Where, Who, How

The question WHY should normally be avoided since it implies a judgment of some action or statement. Some examples of questions are:

"Can you tell me what happened?"
"When did you realize...?"
"What did you do then?"
"Where was the baby?"
"How do you feel now?"
"What were you feelings?"
NOTE: You will see that the questions are in a form that requests information about factual content and feeling content. It is important to balance your questions in this way since many of the factual questions will evoke a strong emotional response. This response may require verbalization by the victim. For example: "What did you do then?"; "How do you feel about that?" Certainly these words can be used in an almost infinite variety of questions. Some features should always be present in the questions.

These are:
1. The question provides no information.
2. It makes no suggestions or judgments.
3. It requires more than a yes or no.
4. It relates to the current situation.

This type of question encourages a calming trend in the victim since it places him in a problem solving state which gradually adds structure to the situation.

ENCOURAGING VICTIM RESPONSE

An open ended interview conducted under stressful conditions may frequently require that we use some techniques to encourage our subjects to continue talking in response to our questions. The difficult nature of the situation may cause the person to wish to withdraw and to provide only minimal information. As we sense that the person is hesitant and when we allow a pattern of withdrawal to emerge, we will not only fail to gain adequate information, but the victim may not be able to effectively ventilate some of his difficult feelings. The following techniques might be called Neutral encouragements to talk.

Generally these are simply adaptation of normal responses for any situation in which we interact verbally with others. These encouragements are neutral phrases or gestures which encourage people to go on talking. Typical of these are phrases like, "I see.", or "Go on.", or "Please tell me more." Gestures such as selective eye contact, nodding approval or understanding, hand gesture toward your chest, etc. Observing people in normal conversation will provide us an even longer list of neutral techniques which encourage others to talk.

An important point of any method used is that it be responsive not only to the verbal information given but also to non-verbal communication which frequently reflects feelings. Since these methods are simply conscious applications of automatic responses in less stressful situations their uses tends to add reality and move toward more normal structure and activity for the victim. Use of these encouragements will make it very clear to the person you are interviewing that you are listening and it will be evident whether you do or do not understand what they are telling you. If you do miss a point or the meaning of a word or statement is not clear, an additional type of technique is necessary: clarification.

CLARIFICATION

As first responders to crisis situations we may be called into the homes of people with a wide variety of ethnic and cultural backgrounds. As a result, the use of the language may vary somewhat from ours. Another factor in crisis is the emotional response of the victims which may cause a change from normal speech patterns. The point here is that if for any reason you are not sure of meanings, ask for clarification.

If the meaning of a statement made by the people we are interviewing is not readily apparent we should immediately seek clarification rather than assuming our own interpretation. It is important that we do it quickly since if we wait until some more convenient time we will frequently provide our own clarification based on our perceptions rather than the actual meaning intended by the interviewee. Also, if we ask for clarification immediately after the unclear statement is made, the fact that we are listening carefully and that we are truly interested is reinforced for the victim.

Several specific methods for asking for clarification should be used. You will find them simple but effective. Remember, each of us wants to be understood. A crisis victim, even though he is under severe stress, feels this need and will usually respond positively to your request for clarification.

TECHNIQUES

1. Simple request for clarification.

A simple statement like "I don't understand," or "Could you explain that, I'm not sure I understand," will work. Whatever approach you use it should not appear that you are questioning the speaker's method of presenting the information, but rather that your understanding was incomplete. The request should be non-judgmental, it should not demean the speaker in any way, and it should be followed with a positive remark such as "thanks," or "Now I understand."

2. Repetition of key words.

This is a useful technique when the interviewee uses slang terms or words with multiple meanings. An example of this might be: Interviewee says: "...and then everything went crazy." Interviewer repeats: "Went crazy?" in an inquisitive tone. Usually the victim will quickly clarify the meaning with an explanation of the incident or feeling. If your approach is questioned, simply state that you are not sure what the word means in regard to the situation.

3. Paraphrasing.

This technique has the interviewer relating back to the person interviewed the essence of his or her (the interviewer's) perception of the meaning of a previous statement. The purpose of this technique is threefold:
(1) It helps you add some structure to your perception of a statement by feeding the key points of it back on your own words. Also it allows you to determine if you are, in fact, picking up the key points.
(2) It gives a clear message that you are listening and truly which to understand what is being said.
(3) It helps the interviewer focus the interview and set a pace which is effective for a good information flow.
An example of a paraphrase might be: Interviewee says: "All of these people tell me they are here to help but all they do is tell me how to feel." Interviewer says: "You don't think these people are aware of your real feelings?" Although this may seem obvious as you read it, in a crisis situation this technique will help the victim crystallize his thoughts. Here again, by seeking clarification you will avoid imposing your own perceptions on statements made by the victim.
The techniques we have discussed to this point have focused primarily on encouraging the victim to talk and to clarify his statements regarding factual material.

ACKNOWLEDGMENT OF FEELINGS
Although factual information may be obtained rather efficiently during an interview, adequate recognition of the victims feelings may not take place. For some interviewers "just the facts" are necessary. The study of crisis has shown that when both types of content, factual and feeling are recognized and acknowledged, a greater benefit is realized by the victim and is reflected during the recovery period. If a the interviewer gives permission to reveal feelings as well as facts, he will likely be viewed as a greater source of help and usually get better information.

During an interview two opportunities frequently arise when we can acknowledge feelings. The first is when the speaker makes a statement of feeling, he or she might say something like: "I felt really strange then." The interviewer might respond with: "Tell me about that feeling." The response then is designed to clearly indicate that you wish to know about that feeling since it seems important to them. This approach will allow the victim to describe the feeling and the conditions surrounding it. Usually, helpful factual information emerges as well at this time.

The second opportunity we will have to respond to feelings is when we observe non-verbal signals. Here, we respond to physical changes which indicate to us that some feeling has emerged which causes some physical response in the speaker. Occasionally, he/she will become uneasy and respond in this way. If this occurs it may also reflect a feeling that must be acknowledged. Such actions such as breaking eye contact, mumbling during some aspect of the interview, wringing hands, crying, tightening of the facial muscles, and increasing restlessness may be changes we should respond to. The technique for this response is simple and should follow the same pattern each time: a statement like, "It seems to me that you are upset about that. Am I right?"

1. Identify the type of feeling: Anger, relief, fear, etc.
2. State that you have observed the change and what your perception of the cause is.
3. Ask if your perception is accurate.
4. Ask the person to tell you about the change.

This type of acknowledgment of feeling will give the victim the clear understanding that you are more than a gatherer of information. You are a participant, a helpful and observant one, in the attempts to resolve the crisis.
So far we have talked about a number of important issues in the development of interview skills. Experience will allow us to refine these and build them into our personal style. We have specifically dealt with:

1. The need for development of better skills.
2. The fact that skillful interviewing is an important part of crisis management.
3. We discussed methods of adding structure with a skillful interview and the danger of imposing too much structure.
4. Directed and non-directed interviews were examined.
5. A set of rules for initiating the interview was established.
6. We discussed a series of techniques which facilitate a good flow of information and which acknowledges factual and feeling content.

The final technique we will deal with is the summary of the interview. As you can see in the numbered sections above, it is possible to re-cap important points rather quickly. This activity is vital since it pulls together the facts and feelings in a recordable form and serves as an opportunity to add facts that may have been omitted.

When you summarize you will deal with the story of each person you have interviewed as they finish their story. Even if each person has told a similar story summarize it for him or her.

A summary will always occur at the end of the interview. There will be occasions though, when you will wish to use a summary at some other point. If a person is having some difficulty remembering information, it is often helpful to summarize what has been said to that point. This will refresh the memory and usually allow the person to continue. Lapses of memory are frequently the result of anxiety. A good summary will show that you are listening and will normally reassure him. When do we summarize?

A. When the interview is complete.
B. When the person rambles too far into inappropriate areas.
C. When the interviewer finds himself talking too much or providing information.
D. When the summary will serve as a clarification technique.

ENDING THE INTERVIEW
As has been stated each interview will end with a summary. At that time, make it clear to the victim that he has been very helpful. It is important that the victim feels included in the efforts to resolve the problem. Information gathering does not stop with the interview and summary. As you know, you are constantly in need of additional information. Let the victim know this and ask permission to seek more information from them when necessary. For example: "I may need some more information later. Would it be all right for us to talk again?" Be sure the person acknowledged this request. This tactic not only keeps the door open to more information it also reinforces the victim's active role in assisting with the resolution of the situation.

Interviewing is skill which can be practiced almost constantly. Each time we find ourselves in need of information we have an

opportunity to sharpen our skills. The more proficient we become in interviewing the more successful our crisis intervention techniques will become.

The training plan for interviewing is to include specific lessons on each interviewing technique. Role play simulations with video-taped feedback will be used to perfect these skills.

3. DEVELOPMENT AND FUNCTIONS OF A CRITICAL INCIDENT STRESS DEBRIEFING TEAM

During the past two decades, mental-health professionals have gradually become aware of the stresses that negatively affect emergency personnel. As a result of this increased awareness, several general classifications of mental-health professionals have developed interests in emergency workers. For example:

The "entrepreneurs" who see emergency personnel as just another business deal. They generally have little understanding of the population they serve and make no special provisions for the emergency worker. A main concern is to cultivate a positive impression with administrators so they have the best potential to develop a lucrative contract.

The "glory seekers" who are nowhere to be found unless an event that attracts the media occurs. They suddenly appear as "experts" and lap up as much exposure as possible during the incident, then quickly fade away when the excitement dies down. The "number crunchers" who do not see genuine research as a tool to help emergency service workers, but instead as a way to complete a degree, get published or draw attention to themselves. They usually appear suddenly, demand a lot of survey data from emergency workers, and disappear without a trace of feedback to those who have spent ;their time working on the surveys. The "well-meaning but unknowing" who have not taken time to learn that emergency personnel are normal people reacting to abnormal events. They use non-directive or "psychiatric" interventions on emergency people which will not work. They are generally clumsy in their approach to emergency response personnel and unable to establish a connection because they failed to learn about their special personalities and needs.

The "dedicated and trained" professional who understands the unique personalities of emergency personnel and the special jobs they perform. They take the time to go through special training, read about emergency personnel and ride along with them on calls. They keep a low profile, are not primarily motivated by money and perform careful research that aims at bettering emergency workers. Most emergency personnel have encountered these types of mental-health professionals in the course of their career. They will agree that the dedicated and trained type is the very best for service on a critical incident stress debriefing (CISD) team and that the wrong type of mental-health professional is usually worse than no help at all!

4. CISD TEAMS

CISD teams are made up of dedicated and trained mental-health professionals who combine their expert knowledge and talents with specially trained peer support personnel drawn from the emergency service's ranks. The CISD team is essentially a partnership between the two groups with a common goal - the reduction of critical incident stress in emergency personnel. CISD teams serve any emergency personnel regardless of the organization. They provide services to hospital-based emergency and critical-care personnel as well as fire fighters, police officers and pre-hospital EMS providers. Individuals are not charged for these debriefing services.

The makeup of a team is roughly one-third mental-health professionals and two-thirds peer-support personnel. Most teams have 20 to 30 specially trained people chosen for service after they have applied and been interviewed by the team leadership.

The average team serves a community of about 100,000 people and is activated for major stressful events six to eight times a year. There may also be a number of smaller events that require the services of one to two peers and, occasionally, a mental-health professional. Caution should be exerted, therefore, not to establish too large or too small a team since team members won't want to be over or under utilized.

Another point to keep in mind when establishing a team is the size of the area served. Since mental-health resources are limited, it is recommended that a team serve a region encompassing several jurisdictions. The majority of current CISD teams encompass several jurisdictions and all emergency agencies within them.

Serving a large area is important for several reasons. First, it is not a good idea to formally debrief your friends and fellow workers because it is too emotionally draining. Second, supervisory staff members may join the team and are always more helpful to people outside their own organizations because of management issues that may arise. Third, the debriefing attendees feel more comfortable when receiving services from people they do not see or work with on a regular basis.

GENERAL FUNCTIONS OF A CISD TEAM
CISD teams function in three areas: pre-incident, incident and post-incident.

PRE-INCIDENT CISD FUNCTIONS:
The pre-incident functions have always been an essential part of CISD team activity and include:
Educating line personnel about stress, stress recognition and stress reduction. Education should include material on critical incident stress, how it differs from non-emergency stress, a description of the CISD team and how to utilize it if the need arises. Education the command staff about stress and its effects on themselves and their personnel. This segment should include specific information on field strategies for stress control during a crisis. Commanders should also know the capabilities and limitations of the CISD team and how to initiate services during and after a critical incident.

Developing stress management protocols for field use. It is well-established that if guidelines for commanders on items such as the optimal length of work time, frequency of rest periods, maximal time at the scene, food, shelter, replacement of gloves and use of the CISD team members during major events.

Providing significant other or spouse and family education programs to enhance the quality of life for emergency personnel and the people important to them.

Organizing individual counseling programs, employees assistance programs, chaplain services and disaster intervention plans as well as any other programs helpful to emergency responders.

CISD FUNCTIONS DURING AN INCIDENT:
On-scene support servicesOn-scene support servicesOn-scene support services:

During the incident, a debriefing team is involved with providing on-scene support services that assist obviously distressed personnel. It advised and counsels responders and gives dire and indirect support to the victims and other appropriate agencies that can mobilize to provide services.

These are shorter, unstructured debriefings that encourage a brief discussion of the events and significant reduce acute stress. Defusing can be done anywhere from one to three hours following the incident, often at the station, and generally last from 30 minutes to an hour. Only those crews most affected are involved; not all workers from the scene attend, as would be the case in debriefings.

If the defusing is not accomplished within 12 hours, a full formal debriefing is the next alternative approximate three days after the incident. A well-run defusing often eliminates the need for full formal debriefing. Even if both are still necessary, a debriefing held three days to a week after a defusing usually is more beneficial. People are more willing to talk during a debriefing when finally presented with a supportive defusing shortly after the incident.

DEMOBILIZATIONS:
These are reserved for large-scale incidents only and take the place of defusing. Immediately after emergency units cease and disengage from operations at a major incident, units are sent to a large meeting facility where they are met by a mental-health professional. Unlike the defusing or debriefing, personnel are not requested to discuss the incident. Instead, the mental-health professional assigned to their unit gives a 10-minute presentation on the typical effects of critical incident stress and the signs and symptoms that may appear. The personnel are given as many practical suggestions for stress management as possible along with an opportunity to ask questions or make comments. The mental-health person assigned to the group remains available to privately discuss the situation or their reactions. Talking to the other mental-health professionals at the debriefing center is an option. Chaplains may be present at the debriefing center and are available if an emergency person would prefer to discuss something with them. No one is required to talk unless they choose.

All of the personnel being demobilized are given an opportunity to get something to eat and relax before returning to duty or home. They are encouraged to rest during the transition from a main event back to routine duties. The entire demobilization process should be completed within 30 minutes, and two-thirds of that time should be allotted to rest and eating.

POST-INCIDENT CISD TEAM FUNCTIONS:
Once an incident is over and defusing and demobilizations complete, emergency personnel enter a phase lasting about 24 hours where they generally prefer not to discuss the situation with outsiders. Many private thoughts emerge as crew members attempt to sift through all the details of the incident. Many times they are concerned with whether protocols and procedures were followed exactly. It may be required that they write reports or go through the preliminary investigations. They are usually not ready to deal with whatever feelings may have been generated during the incident.

Emergency responders usually do not benefit from CISDs during the 24-hour period because their reactions are too intense to absorb the important messages presented in a debriefing. What is usually more important is to provide individual support to those people showing the greatest need and to provide advice to command staff trying to plan for the support services required. Following a crisis, emergency workers are likely to close ranks, preferring to talk with individuals in the unit or participate in small

group conversations related to the event. This conversations is called the "initial discussion" and CISD teams usually have little involvement in it. However, peer support personnel, including those involved in the incident, are trained to watch for telltale signs of distress in their fellow workers: irritability, excessive humor, increased derogatory remarks against one another, significant changes in behavior and withdrawal from others. When these signs of distress become apparent in their coworkers, peer support personnel contact the CISD team coordinator who may initiate the setup of a formal CISD.

FORMAL CRITICAL INCIDENT STRESS DEBRIEFING

The formal CISD is a psychological and educational support group discussion that utilizes a specially trained team of mental-health professionals combined with peer support personnel. The main objectives of CISD are to mitigate the impact of a critical incident and accelerate the return of personnel to routine functions after the incident.

Events that require a CISD include the following:

Any event that has significant emotional power to overwhelm usual coping mechanisms.
Line-of-duty deaths
Serious line-of-duty injuries
Emergency-workers suicide
Disasters
Unusually tragic deaths to children
Significant events where the victims are relatives or friends of emergency personnel
Events that attract excessive media attention
Events that seriously threaten the lives of the responders

Because overuse of CISDs dilutes their effectiveness, they are reserved for only those events that overwhelm the usual coping methods of emergency personnel.

Before a debriefing is held, all of the coordination associated with the debriefing is done, including the announcement to those involved and the setup of the room. Also, the CISD team reviews the incident by reading the reports and newspaper clippings and by viewing photographs or video tapes of the incident. Many CISD teams visit the scene before conducting a debriefing.

Once the debriefing begins, it follows a carefully designed structure that progresses through seven phases and provides important stress-reduction information. While participants are not required to speak, they are encouraged to discuss various aspects of the incident that distressed them. The whole process usually takes two to three hours to complete.

During the debriefing, personnel should not be required to respond to calls; others in the system need to fill in for them. Also, only those involved in the incident should attend, including command officers. If the critical incident affected various types of emergency personnel at the scene, a joint multi-agency debriefing is often held. It is important then to pick peer-support personnel from each of the services for the CISD team. If an incident involves only EMS personnel, it is important to choose EMS peers since EMS people are more likely to trust fellow workers. The same concept holds true for police and fire personnel.

The CISD begins with an introduction from the CISD team members at which point they state that the material to be discussed is strictly confidential. It should also be emphasized that the CISD is not an operation critique. Attendees are than told what to expect during the debriefing and assured that the major concern of the CISD team is to restore people to their routine lives as soon as possible with minimal personal damage to the emergency service's worker. The basic rules of the debriefing are explained before the team members move into the next phase.

The second phase of the CISD is the fact phase in which people are asked to describe what happened at the scene. This is a relatively easy phase for emergency personnel used to talking about the operational aspects of an incident.

Once the incident is described, the debriefing team leader will lead the discussion into the thought phase of the process. The usual question asked in this phase is, "Can you recall your first thought once you stopped functioning in an automatic made at the scene?" This helps people to "personalize" their experiences. The events are no longer a collection of facts but an individual, meaningful recollection of how they personally experienced the incident.

The fourth phase of a debriefing is the reaction phase, the point at which people can describe the worst part of the event for them and why it bothered them. If a critical incident has any significant emotional content attached to it, it will usually be discussed during this phase. It can occasionally become a heavy emotional phase of the debriefing but is not necessarily intense.

It is not the objective of a CISD team to promote emotional behavior but, instead, to foster discussion so that recovery is as rapid as possible. This phase allows people to discuss the worst parts of an incident in a controlled environment that enhances venting thoughts and feelings associated with the event and prepares them for useful stress reduction information.

The fifth phase of the CISD process is the symptom phase. The group is asked to describe stress symptoms felt at three different times: The first being those symptoms experienced during the incident; the second are those that appeared three to five days after

the incident; and the last being symptoms that might still remain at the time of the debriefing. Changes, increases and decreases of symptoms are good indicators for the mental-health person of the need for additional help for some attendees.

The next phase of the CISD process is the teaching phase. The CISD team members furnish a great deal of useful stress-reduction information to the group. They also incorporate other information, such as the grief process, promoting communication with spouses and suggesting how to help one another through the stress.

The seventh phase of the debriefing process is called the re-entry phase, when personnel may ask whatever questions they have. A summary is given by the team and the CISD is concluded.

After debriefing, the team remains at the debriefing center to talk with those needing additional individual assistance. Referrals are made for counseling if necessary.

Finally, the CISD team holds a post debriefing meeting to quickly review the debriefing and discuss ways to improve their functions for future debriefings. However, the main reason for meeting is to make sure that everyone on the team is OK before going home-hearing the pain that others experience my bring about some pain for the debriefers.

FOLLOW-UP SERVICE
All defusing, demobilizations and debriefings must receive follow-up services. Follow-ups usually begin 24 hours after the debriefing. The many ways that follow-up can be achieved include:

Telephone calls to individuals
Discussions with commanders
Visits to the stations
Sending peers to see that personnel are doing all right
Educational programs
Individual counseling sessions
Spousal support services
Other activities as the needs arise.

OTHER CISD TEAM CONSIDERATIONS
Simply reading this article in no way gives anyone the ability to perform a CISD. Minimum training time for a CISD team is two days with continuing education on a timely and regular basis. A CISD is ineffective without trained peer-support personnel.

Likewise, a CISD team without mental-health professionals is not only ineffective, but dangerous because mental-health professionals are necessary to provide leadership and supervision. They also possess diagnostic skills to recognize those issues more serious than stress alone. Missed symptoms may cause an emergency worker to commit suicide.

It takes a special task force at least six months to one year to properly organize a CISD team in most communities. CISD teams should have the same training and operating protocols, and these should be developed in writing, so that they are interchangeable.

People should be accepted onto CISD teams because of their competency, not because of politics.

CISD teams survive and are successful in they meet regularly, cross-train by having mental-health personnel ride on emergency units for field exposure and provide continuing stress education to field personnel.

Much has already been written on CISD teams and their development. Review the protocols and the accomplishments of other teams before developing a team in your region.

CONCLUSION
Critical Incident Stress Debriefing teams have experienced a phenomenal growth in five years, overcoming many problems and achieving many successes. They have assumed as important place within emergency services organizations and are likely to continue their support within these organizations.

Teams need to be carefully developed, protocols need to be expanded and improved and team members must be given the very best training. There are many challenges associated with the development and operation of a CISD team. It will take many dedicated people to ensure the stability and success of the teams as they provide the valuable service of healing the helpers. Additional information on CISD teams can be obtained from: Jeffrey T. Mitchell, PhD, Emergency Health Services Department, University of Maryland, Catonsville, MD. 21228, 301/455-3223

5. WHEN DISASTER STRIKES: THE CRITICAL INCIDENT STRESS DEBRIEFING PROCESS

Major disasters over the past five years have brought attention to the fact that rescue workers themselves can become psychological casualties from the overwhelming carnage and suffering they witness. The Critical Incident Stress Debriefing is a

simple, but effective tool to help the emergency worker cope with what he has seen, and continue a productive career with minimal long-term effects.

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The broken bodies and the overwhelming wreckage of such tragedies as the 1978 pacific Southwest Airlines crash in San Diego, the Kansas City Hyatt Regency Hotel disaster in 1981 and the past summer's loss of the Pan American 727 in Kenner, Louisiana have dramatically accelerated a growing national trend to recognize and meet the special needs of emergency service personnel. The disasters of these past five years have pointed out clearly that the "stiff upper lip," or "John Wayne Syndrome" (you're not hurt unless a bone is showing), is a fallacy--those who work under the assumption that rescuers are never affected by what they experience are living in serious danger. Among the lessons learned from these tragedies is the fact that rescuers are vulnerable human beings who have all the normal physical and psychological responses to the horror of human suffering.

In an effort to reduce the number of psychological casualties among emergency service personnel, a relatively new form of crisis intervention that is specifically designed to assist them is now under development at the Emergency Health Services Program of the University of Maryland Baltimore County. it is called "Critical Incident Stress Debriefing" and its main goal is to support those who are involved in emergency operations under conditions of extreme stress. A critical incident stress debriefing will generally alleviate the acute stress responses which appear at the scene and immediately afterwards and will eliminate, or at least inhibit, delayed stress reactions. These emotional aftershocks can appear days, weeks or even months later and can seriously affect a person's performance within the emergency organization as well as his relationship within his family.

THE CRITICAL INCIDENT

A critical incident is any situation faced by emergency service personnel that causes them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later. A major disaster is one type of critical incident that comes to mind, but a situation does not have to be of this magnitude to classify as a critical incident. All that is necessary is that the incident, regardless of the type, generates unusually strong feelings in the emergency workers. The following are examples of critical incidents:

The serious injury or death of an emergency team member in the line of duty.

The serious injury or death of a civilian resulting from emergency service operations. This would include a shooting by a police officer or a civilian injury or death caused by the collision of emergency units responding to a fire or EMS call.

Almost any case which is charged with profound emotion such as the sudden death of an infant under particularly tragic circumstances.

Almost any case which attracts extremely unusual attention from the news media.

Any loss of life which follows extraordinary and prolonged expenditures of physical and emotional energy in the rescue.
Any incident which can be considered a serious physical or psychological threat or a sudden loss to the rescuers.

Almost any incident in which the circumstances are so unusual or the sights and sounds so distressing as to produce a high level of immediate or delayed emotional reaction that surpass the normal coping mechanisms of emergency personnel.

STRESS RESPONSE SYNDROMES

Critical incidents produce a characteristic set of psychological and physiological reactions or symptoms (thus the term syndrome) in all people, including emergency service personnel. Since the American Civil War it has been known that soldiers and others exposed to war and disasters or critical type incidents have experienced, among other symptoms, restlessness, irritability, excessive fatigue, sleep disturbances, anxiety, startle reactions, depression, moodiness, muscle tremors, difficulties concentrating, nightmares, vomiting, diarrhea, and suspiciousness. Even Freud was impressed with the quantity and intensity of the stress response symptoms experienced by World War I veterans. He found that those who had been exposed to traumatic events repeatedly experienced mental imaged of those frightening scenes even when they tried to forget them. More recently, researchers have concluded that just viewing gory sights or hearing disturbing sounds is enough to trigger stress responses in people.

The physical and emotional symptoms which develop as part of a stress response are considered normal in every way. They develop in most people facing stress, threat or loss, and are primitive responses of the mind and body designed to help the person survive. The stress response syndromes, although normal, have the potential to become dangerous to the emergency service worker's health if symptoms become prolonged. They sap energy and leave the person vulnerable to illness. Under certain conditions, they may have the potential for life-long after effects. They are especially destructive when a person denies their

presence or misinterprets the stress responses as something going wrong with him.

CRITICAL INCIDENT STRESS DEBRIEFING

There are many methods to deal with a stress response syndrome. Among them are strenuous physical exercise and special relaxation programs within 24 hours after the critical incident. But one of the most effective methods to deal with a stress response syndrome, especially in emergency personnel, is a Critical Incident Stress Debriefing (CISD).

The CISD is an organized approach to the management of stress responses in emergency services. it entails either an individual or group meeting between the rescue worker and a caring individual (facilitator) who is able to help the person talk about his feelings and reactions to the critical incident. Basically, the CISD has three parts. The first part allows for an initial ventilation of feelings by the rescuer and an assessment by the facilitator of intensity of the stress response in the workers. Part two of the CISD entails a more detailed discussion of the signs and symptoms of the stress response and provides for support and reassurance from the facilitator. The third part of the CISD is the closure stage where resources are mobilized, information is provided, a plan of further action may be designed and referrals, if necessary, are made.

The victim of stress response syndrome responds remarkably well to this supportive crisis intervention format if the intervention takes place timely. Within 24 to 48 hours is the ideal time for intervention. As the length of time between the incident and the CISD grows, the effectiveness of the intervention decreases. After about six weeks the effectiveness is minimal and the person is then considerably more vulnerable to lifelong emotional fallout form the incident. For example, several years ago a drilling platform in the North Sea broke apart and toppled over in a storm. There was a great loss of life. Survivors were brought to port in two groups which arrived several hours apart. The first group was hospitalized and interviewed by psychiatrists as part of their treatment. The word that the first group was being seen by psychiatrists somehow reached the second group of survivors. When the second group arrived, they were also hospitalized, but had decided on the way in that being seen by psychiatrists was a weakness. They refused to be interviewed by the psychiatrists. Today, the members of the group which allowed psychiatric interviews are well adjusted and functioning normally in life. Most have returned to their former jobs at sea. Many members of the group which refused help are currently experiencing a variety of distressing emotional and physical symptoms and are unable to work in their old jobs even though some of them received a debriefing several months after the incident.

TYPES OF DEBRIEFINGS

There are essentially four types of Critical Incident Stress Debriefings. Each has its own purposes and procedures but the overall goals are basically the same: to protect and support EMS personnel and to minimize the development of abnormal stress response syndrome which may cause lost time and effectiveness at work and problems within the family.

The On-Scene or Near-Scene Debriefing. This is the briefest form of CISD. It is typically performed by a mental health professional familiar with emergency operations but may be performed by a chaplain or an officer not directly responsible for the management of the scene. In any case the facilitator functions as an observer/advisor and watches for the development of acute reactions. Checklists of symptoms are available form several sources and should be utilized, since a single symptom is not indicative of an acute stress reaction. The facilitator briefly checks on the well-being of the personnel, offers encouragement and support and suggests to command officers which individuals or groups may need a break or a change in duties. The facilitator spends some time with those who are resting and allows some ventilation of feelings and reactions. A key to helping the personnel here is a good listening ear. The Israeli army has instituted this very type of CISD and has found it very successful in cutting down the incidence of prolonged serious stress reactions in combat troops.

The Initial Defusing. The initial defusing is a form of CISD which is usually performed very shortly (within a few hours) after the critical incident. It may be led by a mental health professional but it is more often organized and led by command officers. At times there is no designated leader. The whole initial defusing may be quite spontaneous as those who had been involved, in the critical incident gather around after cleaning equipment and preparing their units for the next call. They start talking about their feelings and reactions to the incident and the defusing is underway.

It really does not matter whether the initial defusing is led by a specific person or completely spontaneous. What does matter is that the atmosphere of the initial defusing is positive, supportive and based on care and concern for the team members. No one should be criticized for how they feel. Instead, they should be allowed free expression of feelings with acceptance, support and understanding from each other and their leaders.

The best format for this initial defusing would be a mandatory team meeting as soon as possible after the conclusion of the incident. About one hour is usually enough to go through the process. During this time, the team members and leaders should check on each other's well-being and provide support and friendship to those who seem to be hardest hit by the incident. This is not the time for criticizing personnel or critiquing the incident. No responsibility for malfunctions should be distributed to any of the team members; just understanding.

The Formal CISD. The formal CISD is typically led by a qualified mental health practitioner 24 to 48 hours after the conclusion of the incident. A skilled professional is usually necessary in this debriefing because the emotional content released during the session may overwhelm an untrained facilitator. The facilitator should be skilled in human communications and should have a fairly good background in group dynamics or group interactions. A good working knowledge of stress response syndromes and the operational procedures of the emergency service group are essential for the success of the debriefing.

In the majority of cases, a formal CISD is generally not organized for the first 24 hours because the EMS personnel are still too worked up to be able to deal appropriately with an in-depth group discussion of the incident, especially as it relates to their inner feelings. They are trained to suppress emotional reactions during and for a brief time after an incident. Natural feelings of denial and avoidance predominate during the first 24 hours. Often emergency service workers attempt to intellectualize about the incident, and they run it through their minds over and over as they try to make sure that they handled their part correctly. Several hours after the incident their cognitive activities decrease and fairly intense feelings may then come to the surface. This is the time for a CISD (In some situations they may occur earlier than 24 hours. The one-day time limit is only a guide.)

The formal CISD should be mandatory for all personnel involved in the scene. At times a joint debriefing between police, fire and EMS personnel is extremely beneficial. Again, this is not an incident critique. The tone must be positive and understanding. Everyone has feelings which need to be shared and accepted. The main rule is - no one criticizes another; all listen to what was, or is, going on inside each other.

The formal CISD follows this general format:
A. Introductory Phase. The facilitator begins by introducing himself or herself. The rules of the process are then described. The need for absolute confidentiality is carefully explained. Members are encouraged to make a pact with each other to be silent forever regarding details of the debriefing, especially any details which could be associated with any particular individual. Participants in a debriefing need to be assured that the open discussion of their feelings will in no way be utilized against them under any circumstances.

B. The Fact Phase. Most facilitators begin this phase by asking the participants to describe some facts about themselves, the incident and their activities during the critical incident. They are asked to state who they are, their rank, where they were, what they heard, saw, smelled and did as they worked in and around the incident. Each person takes a turn adding in the details to make the whole incident come to life again in the CISD room.

C. The Feeling Phase. Once all participants have shared sufficient factual information to bring the incident into vivid memory, the facilitator begins to ask feeling-oriented questions. "How did you feel when that happened?" "How are you feeling now?" "Have you ever felt anything like that in your life before?" Again each person in the room gets a chance to answer these and a variety of other questions regarding their feelings. At times, a facilitator has to do very little. People start talking and the whole process goes along with only limited guidance from the facilitator. What is important under these circumstances is that the facilitator makes sure that no one gets left out of the discussion and that no one dominates the discussion at the expense of others. People will most often discuss their fears, anxieties, concerns, feelings of guilt, frustration, anger and ambivalence. All of their feelings, positive or negative, big or small, are important, and need to be expressed and listened to.

D. The Symptom Phase. This phase of the debriefing concerns itself most with answering the questions, "What unusual things did you experience at the time of the incident?" "What unusual things are you experiencing now?" and "Has your life changed in any way since the incident?" The participants are urged to discuss what is going on now in their homes and in their jobs as a result of their experiences. In other words, they are describing their own versions of stress response syndromes.

E. The Teaching Phase. The facilitator takes this opportunity to teach the group something about the stress response syndromes. The emphasis is on describing how normal and natural it is for emergency service people to experience a variety of signs, symptoms, and emotional reactions to the critical incident they lived through.

F. The Re-Entry Phase. This final phase seeks to wrap up loose ends, answer outstanding questions, provide final reassurances and make a plan of action. Groups often need a direction or specific activity after a debriefing and this is an opportune time to work out a plan for such an activity. For example, in one case where a drunk driver killed several people, EMS personnel made a plan to appear in court at the trial in full uniform as a form of protest against light sentences for drunk driving. It gave them a sense of purpose and unity. Summary comments are then offered and the personnel are advised about getting additional help should they need it.

All six segments of the CISD usually take three to five hours to complete.

The Follow-up CISD is performed several weeks or months after a critical incident. it is not always necessary, but when it is, its main purpose is to resolve some issue or problem that came up as a result of the critical incident and is still present. The follow-up CISD may be performed with the entire group, a portion of it, or with an individual. it is by far the most difficult CISD for the facilitator to perform and is closely identified with a therapy process. More than one session may be necessary to achieve the goals of relieving emergency personnel from a set of painful psychological and physical reactions, but the end result is well worth the extra effort. Once freed from frustration, anxiety and guilt, emergency personnel are able to function happily again in their jobs and in their homes.

CONCLUSION

The simplicity of the critical incident stress debriefing should not cause one to underestimate its value. Well-executed CISDs have an enormous potential to alleviate overwhelming emotional feelings and potentially dangerous physical symptoms. When used properly, they can extend the careers of personnel, thus saving great outlays of resources to replace perfectly good men and women who have seen too many broken bodies and too much human misery.

6. POST TRAUMATIC STRESS DISORDER: RECOGNIZING IT, TREATING IT

Post traumatic stress disorder (PTSD) is the usual diagnosis that mental health people apply to persons who have suffered severe trauma in their lives and develop certain symptoms as a result.

Such trauma is defined in the diagnostic and statistical manual, third edition as an event outside the range of usual human experience, and event which would prove remarkably distressing to almost anyone. The stressor could be a serious threat to one's life or physical integrity, serious threat or harm to one's family, sudden destruction of one's home or community, or the witnessing of anothers serious injury or death. Crime could cause each of these situations.

PTSD is characterized by psychologically re-experiencing the event through nightmares, daydreams, flashbacks and/or intense distress when reminded of the original event. There may be symptoms of avoiding things that remind one of the trauma, social isolation, a feeling of being different from other people and a general lack of interest in the world. Other symptoms include tension and anxiety, such as difficulty falling asleep, irritability, outbursts of anger, trouble concentrating or being exceptionally jumpy.

Any individual who has experienced trauma may suffer from these symptoms. Being in crisis, however, doesn't mean the individual will develop PTSD. PTSD may occur if the victim hasn't had the opportunity to work through their crisis.

To recognize PTSD in individuals, counselors should first understand the theory of why people develop psychological distress following a major shock. We developed this acute trauma model after years of experience in counseling survivors of traumatic events. The model has three distinct phases of acute post-trauma reactions: the shock phase, the impact phase and the recovery phase.
The first phase, shock, generally begins during the actual traumatic event and can last a few days or even a few weeks. Two emotional responses normally characterize the shock phase: Immobilization and denial.

During immobilization, the typical response is one of confusion, disorganization and an inability to perform simple, routine tasks. For instance, during a robbery a store clerk may be unable to open the cash register. At the same time, the victim may also experience denial, refusing to believe that the trauma is actually happening.

Shock may manifest itself through perceptual changes in which time is altered and events seem to be happening in slow motion. Visual perceptions are modified; people sometimes have a derealized "out-of-body" experience or may feel they are simply observing rather than participating in the event. Another frequent alteration is a tunnel vision that causes the victim to focus on one aspect of the trauma to the exclusion of everything else.

That same store clerk who couldn't open the cash register visually focused solely on the robber's gun throughout the hold-up; in fact, form what he was he and the gun were the only things in the store. Later, when talking to police, he couldn't remember what the perpetrator looked like or whether anyone else was present during the crime.

Not all trauma victims experience the shock phase. People trained to deal with trauma regularly, such as military, police, or medical emergency workers, may initially bypass these reactions, though residual elements are often evident.

Once the shock and disbelief subside, the impact phase begins. This phase takes hold with a period of anger and/or extreme

anxiety that manifests itself through trembling, crying, or subjective feelings of tension, anxiety, or outrage. This anger is commonly displaced: in the robbery's aftermath, the aforementioned store clerk becomes extremely angry with the store's owner and the police. He is not angry with the perpetrator.

As the impact phase continues, the victim moves to the "what-if-and-maybe" stage, the process of self-doubt. Victims will go to great lengths to invent different scenarios, ignoring the actual fact and outcome of the trauma. "If only i'd been five minutes earlier..." "If only I had reacted more quickly..."
We often see self-blame in ambulance crews or police officers who have been involved in critical incidents. This guilt may last indefinitely, if not dealt with, as the victim embroiders more and more elaborate "if only" stories. The "if only" stories are encouraged by intrusive thoughts of the trauma, such as flashbacks. The more involuntary thoughts the victim has of the trauma, the more "if only" versions they'll create.

This self-doubt eventually will bring about the final part of the impact phase, depression. The trauma victim becomes irritable and feels isolated, misunderstood, helpless and bereft of hope for the future. "Leave me alone, there's nothing wrong with me" is the prevailing attitude.
If the victim fails to face the trauma at this point, they will continue to oscillate between anger/anxiety and depression and will be unable to progress to the recovery phase, to try to reclaim a normal life. The ptsd becomes chronic.

If the trauma is dealt with right away, the chances of getting stuck in this glitch are slim. If a victim sees a crisis counselor at the scene of the crime or soon afterward, it is likely they will return to normal functioning sooner than they would otherwise. The counselor explains to them what they're experiencing, why they are experiencing it and what to expect next. Victims need the assurance that what they're feeling is normal.

Once a person resolves the guilt and returns to a relatively symptom-free mode of functioning, they may remain there for sometime. A new disturbance, though, or a reminder of the original trauma, can cause symptoms to recur. Similarly, an accumulation of the stresses of daily life, such as financial problems, employment difficulties, or ill health, may also cause the trauma survivor to regress. But with effective treatment, survivors can learn to control many of the symptoms of anxiety and depression, and so function more productively.

Those subject to constant high levels of stress, such as emergency response workers or police, seem unable to remain in a symptom-free mode because of constant immersion in trauma. Victims who haven't worked through their trauma, who don't understand what they are experiencing, may become trapped in the anxiety/depression cycle.

Without support, individual reactions to such ongoing stress may be unhealthy. People experiencing incessant intrusion and anxiety tend to self-medicate in an attempt to alleviate their symptoms; alcohol and drugs can become a severe problem.

A less obvious form of self-medication is sensation seeking to get symptom relief through an adrenaline rush. Some people suffering chronic post traumatic stress disorder have interests in high risk activities like parachuting, driving motorcycles, or rock climbing. Another way some victims of ptsd relieve stress is the constant seeking of excitement through numerous sexual encounters.
When a victim suffering ptsd becomes trapped in the anxiety/depression cycle, their guilt overwhelms them. They feel guilty for surviving and responsible for the fate of others or for the event having happened in the first place.

Termed "existential guilt," this guilt is characterized by the survivor's confusion over having lived and the meaning of this survival. For instance, if the trauma includes death of other individuals we sometimes see variations on this theme: the survivor wishes to change places with the person who died, and the guilt is expressed as "I should have died, and they should have lived." Because their own lives have been so chaotic since the trauma, they feel that the person who died would have had a better life with more to live for, failing to recognize that it's likely this person would be struggling with similar emotions.

After hearing about the trauma during an interview, I frequently ask, "How come you lived through that?" Often i get the response,

"I don't know, I ask myself that question all the time," or, on a more positive note, "Perhaps there is some purpose for my life after facing the probability of my own death."

Content guilt, as opposed to existential guilt, is a result of a person's having done something to ensure their survival, such as hiding under a table during a shooting. This is a much easier from of survivor guilt to recover from because there are actual behaviors to talk about and understand.
Because survivor guilt has both emotional and intellectual components, a major goal in counseling is to separate the feeling and thinking elements. The survivor must learn that it is okay to feel sad about someone's having died or been injured in a traumatic situation, but it is neither rational nor appropriate to feel totally responsible for the person's death. The situation or perpetrator should be blamed, not the survivor.

To keep the victim accessible to counseling, however, the counselor cannot say "You have nothing to feel guilty about," because victims often cling to their guilt for comfort. The counselor should attack the guilt through the issue or responsibility. Getting survivors to share responsibility for what happened starts with pointing our other factors involved in the incident. One of the factors may be time and space; they may have been in the wrong place at the wrong time. They may have been the victim of a random act.

Survivors of trauma tend to remember the traumatic situation in an unchanged way; their initial perception of the event is the way they continue to view it, as if the traumatic event were frozen in their memories. The healing process involves thawing those memories and looking at them realistically. Because the memories have a negative focus, the goal of re-thinking is simply to look at the original trauma in a different light.

As pointed out earlier, victims, when having intrusive thought about the traumatic incident, automatically follow the original thought with a host of "what-if-and-maybe" versions of the event, reinforcing their guilt and self-blame. To help victims stop this negative behavior, tell clients to simply shake their heads "No" and say to themselves "No, here is what happened." In effect they train themselves to look only at the reality of a the situation, and to live with it.
In dissolving the "what-ifs-and-maybes" and the anxiety/depression cycle, the first step a client goes through in re-thinking is confusion. This positive sign shows they are beginning to doubt their original perception. They're realizing that the trauma has other facets that have been ignored, forgotten, or devalued. Make a point of letting the client know why this confusion is a good sign, because it is a sign of change.

Finally, victims' religious beliefs may need to be addressed. Victims with religious convictions find these beliefs either strengthened or weakened by the experience. I urge all trauma counselors to have some contact with the clergy in their community. Talking to the clergy can do much to alleviate individual guilt.