Chapter 3
Critical Incident Stress Management

3.1 INTRODUCTION

Critical incident stress debriefing (CISD) is a unique intervention process developed by Jeffrey T. Mitchell to mitigate post-traumatic stress, thus preventing PTSD. Initially it was used to lessen or prevent post-traumatic stress in emergency services such as police, fireman and emergency medical personnel to reduce the risk of post-traumatic stress associated with these professions. Owing to the success of CISD as an intervention, it was later used in disasters to intervene with both primary and secondary victims. Traumatic events where CISD has been effectively used are natural disasters such as earthquakes, tornados and hurricanes as well as "man-made" disasters such as the New York city fire bombing in 1990, the Los Angeles riots in 1992 and crime (Everly, 1995:279).

3.2 DEFINITION OF CRITICAL INCIDENT STRESS DEBRIEFING (CISD)

Feuer (1999:497) describes debriefing as the "cornerstone" of the trauma response, "a psycho-educational group meeting that although not group therapy is by its very nature naturally therapeutic". She states that it gives the victims the opportunity to share their experiences without being judged. CISD gives them a choice of beginning the road to recovery from what had happened by using a safe secure environment and involving all victims in this helping process.

Harbert (2000:400)defines CISD as "a group process, employing both crisis intervention and an educational process, focussing on mitigating or resolving psychological distress associated with a critical incident or traumatic event". Debriefing is an established multi-phase crisis intervention process that helps individuals to work through their thoughts, reactions and symptoms, followed by training in coping techniques. It involves a structured, time-limited discussion and explanation of the incident and its effects on individuals (Spiers, 2001:8). Debriefing gives the traumatised person the opportunity to ventilate and verbalise his or her feelings within a controlled environment. The National Trauma Committee of the South

African Police Services defines debriefing as an "emotional ventilation of feelings in a controlled and safe environment. The symptoms and feelings the person experiences are normal reactions to an abnormal situation" (1998:2). Trauma debriefing can be conducted with individuals as well as in groups. Spiers (2001:27) indicates that debriefing can include one or more persons with the purpose to review the impressions and reactions of survivors to learn about common reactions and to explore existing coping strategies. Everly and Mitchell (in Harbert, 2000:396) as well as Feuer (1999:497) are of the opinion that CISD is part of the crisis intervention model and not the model itself.

According to the researcher, debriefing is a group process (including one or more individuals) where victims have the opportunity to re-experience the traumatic event through expressing their own feelings, thoughts and reactions to fellow victims, and to get a better understanding of the whole incident by listening to others, thus finding peace in the safety of the environment and the confirmation that their feelings are normal and that others do not judge, but want to comfort and support.

3.3 GOALS OF DEBRIEFING

The primary goal of debriefing is to mitigate the impact of a critical incident on those who have been primary, secondary or tertiary victims of the event, and to facilitate the recovery process of those experiencing stress reactions.

According to Harbert (2000:400) CISD is a technique used with a group of individuals who have suffered a critical incident and is done 24 to 72 hours after the incident or after they have left the scene. This time frame is essential for decreasing psychological impact on the victim. The reality of a critical incident that has happened normally starts to dawn on the victim within 24 to 36 hours of the incident (McWhirter & Linzer, 1994:404).

Feuer (1999:497) and Schulz et al. (2000:147)point out at the following goals for CISD:

- Creation of a safe harbour – to create a safe environment in which the individual or group can be supported and guided by trained debriefers and feel free to ventilate their feelings.
- To establish the principle of normality – to create a setting in which the traumatised person can realise that he/she is still "normal". The abnormality of a critical incident is often confused with the feeling of abnormality within the victim.

- Regaining control – critical incidents often makes one feel powerless and helpless and disturb a person's functioning. Debriefing provides opportunities for the traumatised person to gain control over certain aspects of his/her life and give a feeling of hope.
- Cognitive redefinition – debriefing gives the experience a cognitive structure and emotional release when reviewing it, enabling the person to distance him-/herself from the incident and redefining what has happened.
- Prevention of PTSD–debriefing is pro-active and helps to counter the development of PTSD.
- To prepare participants for possible emotional after-effects.
- To begin the process of moving those involved from victim to survivor status.

In addition to this, McWhirter and Linzer (1994:390) and Wilson *et al.* (2004:21) mention that debriefing provides the following:

- Education about stress reactions
- Emotional ventilation
- Promotion of cognitive organisation through clear understanding of both events and reactions
- Reassurance that the stress response is controllable and that recovery is likely
- Intervention to assist in recovery from traumatic stress
- Decrease in individual and group tension
- Mobilisation of resources within and outside the individual or group
- Preparation for experiences such as symptoms or reactions which may arise
- Screening for people who may need additional support.

3.4 EFFECTIVENESS OF DEBRIEFING

Everly (1995:282)and Parkinson (1993:202) discuss some reasons why CISD is effective and beneficial to the traumatised client:

- It gives opportunity for early intervention and assessment of post-traumatic stress.
- It reduces any short-term or long-term distressing after-effects.
- It gives opportunity to victims to express and ventilate their emotions without fear, which is very important for the recovery from psychological trauma.

- It gives the opportunity to verbalise the trauma. It is not just ventilating emotions, but also gives the opportunity to verbally reconstruct and describe the event, thus having therapeutic value.
- It gives the victim a behavioural structure in which he/she can fit all the bits and pieces into the structure, thus helping him/her to regain equilibrium and reducing stress and despair.
- The cognitive-affective structure has a tremendous advantage to the victim, because he/she moves from the less-emotional thoughts to the emotional and then back to the less emotional. This helps the victim to relax and feel safe again after the strain of showing emotions.
- It is a group intervention and so the CISD therapist can take advantage of all the group support and the group process in helping him/her to assist in the healing process of individuals.
- Peer groups can be of tremendous help in supporting each other and is also more cost effective than seeing individuals and, therefore, beneficial to the employer.
- It gives opportunity regaining feelings of hope and control.
- It reduces the incidence of sickness and absenteeism.
- It reduces personal marital and relationship problems.
- It reduces work-related problems.
- It reduces anxieties for anyone who may feel threatened or embarrassed if he/she had to ask for help.
- It reduces anxieties about stress and traumatic reactions being thought of as a sign of weakness.

The CISD therapist has to acknowledge the needs of the trauma victim. Harbert (2000:390) stresses that trauma victims have the need to talk about what happened, how they reacted and how they left. They need to "express their fear, panic and loss within a safe environment" (Harbert 2000:400). They need to realise what has happened to them and come to terms with that. They also need to pick up where they left off and restart their lives with the social, physical and emotional resources available. Most off all, they need to be listened to with empathy. Sometimes they need an individual ear and sometimes they feel safe in their peer group and want to talk to others about the incident. According to Harbert (2000:400), emotional recovery requires that traumatised individuals be able to incorporate events into their lives and to maintain at least some perception of control.

3.5 PRINCIPLES OF TRAUMA DEBRIEFING

To maximise the effectiveness of debriefing, it is necessary that implementation of the debriefing process is structured according certain principles. The principles can be explained according to the SPIE and IMPRESS A RAVEN models, as discussed by Schulz et al. (2000:148–149).

3.5.1 SPIE

The abbreviation SPIE refers to the following principles that are important in the debriefing process:

S:Simplicity– treatment should be practical and simple.
P:Proximity – traumatised individuals should be treated in the proximity of the place where the critical incident occurred, for example if the incident occurred in the workplace, the debriefing should also take place at the workplace.
I:Immediacy– treatment takes place as soon after the critical incident as possible, preferably between 24 and 72 hours after the incident.
E: Expectancy – debriefing should encourage the expectation of resuming normal duties as soon as possible.

3.5.2 IMPRESS A RAVEN

The principles of trauma management below are especially used by emergency services. The principles are abbreviated as "impress a raven".

IMPRESS

I:Immediacy– physical and psychological needs should be identified and dealt with as soon as possible after the incident in order to prevent the traumatic incident to get worse.
M:Maintain milieu – people involved in the critical incident should remain in their normal environment and not be handled as patients. The defusing process should take place as close as possible to the traumatic scene. The person must continue with his/her normal activities as soon as possible.
P: **Proximity** – the traumatised person should be given support as close as possible to the scene and within the reach of his/her support system.

R: **Rest and replenishment** – a period of rest and opportunity to replenish the internal resources (psychological and physical) must be given. The traumatised person can be offered food, something to drink; clothes (if necessary) and a place to rest.

E: **Expectancy** – the expectation that a person must resume his/her normal functioning as soon as possible should be emphasised. The fact that the traumatised person is a survivor and not a patient should also be emphasised.

S: Simplicity – treatment must be practical and simple and must be accompanied by extensive diagnostic and remedial techniques. Intervention where the traumatised person gets the opportunity to ventilate and talk about the incident and his/her actions should be available.

S: Supervision – the individual's condition and adaptation must constantly be monitored by professional health workers and management. Family and friends should also receive the necessary information on symptoms and behaviour in order to be aware of the person's adaptation.

A

A: Activity – the person should be mobilised to continue with normal functioning and activities. The person should also remain involved in therapeutic activities. The emphasis on the continuation of normal activities shows that the traumatised person is not a "sick" person.

RAVEN

The following principles should be applied during the debriefing process.

R: Reaction – the traumatised person must realise that he/she can expect certain symptoms as a reaction to the critical incident. These symptoms are normal under abnormal circumstances. The experiencing of symptoms is not a permanent mental dysfunction.

A: Awareness – the traumatised person must constantly be made aware of his/her feelings, actions and thoughts regarding the critical incident.

V: Ventilation – the traumatised person must be encouraged to talk about his/her emotions and thoughts concerning the incident to a professional person, friends and family.

E: Encouragement – the traumatised person should be encouraged to unload emotionally towards friends and family members and during the debriefing process. He/she must also be encouraged to work as soon as possible.

N: Normal behaviour – the normality concept should be emphasised. The traumatised person should be reminded that the symptoms he/she experiences are normal under abnormal circumstances.

Applying these principles before and during the debriefing process helps the debriefer to maximise the effectiveness of the debriefing process so that the individual can benefit as much as possible and return to his/her normal functioning as soon as possible.

3.6 TRAUMA DEFUSING

Defusing is a short version of the debriefing process and is usually performed within a few hours of the critical incident. The goal of defusing is to defuse the impact of the event and to assess the needs of the group. The process is brief (usually 20 to 45 minutes). According to Du Toit (in Roos, du Toit & du Toit., 2003:108), there is a vast difference between trauma debriefing and trauma defusing. Defusing refers to "dealing with traumatized people on the scene of the incident or immediately after the critical incident". The focus of trauma defusing differs from trauma debriefing, and requires different skills and techniques.

The process of defusing creates support mechanism and procedures, before, during and immediately after a critical incident with the aim of providing a positive and supportive atmosphere and to re-establish the solidarity of the meaning to be a successful and happy human being (Schulz et al., 2000:152).

3.6.1 Aims of defusing

Roos *et al.* (2003:109–111) and Schulz et al. (2000:151) discuss the aims of defusing as follows:

- **To ensure the safety of the victims of the trauma**
  The first priority is to ensure that victims are safe and to minimise the risk of further traumatisation. This may necessitate those victims to be removed from the specific scene but not the general scene. The assistance of the emergency services may be called in to help secure safety.

- **Gaining the confidence of the victims**

  The trauma diffuser only has a few moments to gain the confidence of the trauma victim. The moment the trauma diffuser arrives at the scene, he/she enters the personal lives and privacy of the victims. The way in which the trauma diffuser approaches the victim already establishes a relationship and the attitude of the trauma diffuser should reflect calmness, confidence, empathy and respect. Before the trauma diffuser approaches the victim/victims, he/she should try to get the names and as much information regarding the victims from the emergency services or other relevant people.

- **Calm the victims**

  Trauma scenes are usually characterised by extreme emotions. The trauma diffuser has to be prepared for reactions ranging from fierce and uncontrolled anger, hysteria, apathy or total denial. These reactions are normal and can be expected under the circumstances. The diffuser should feel comfortable with these emotions and should not panic. He/she should stay calm and reassuring and should not take anger or refusal to talk personally.

- **Establish what happened**

  After the trauma diffuser introduced him-/herself and calmed the victims to the extent that they can talk, the diffuser can request the victim to tell what happened. Usually at this stage the victims are eager to tell their story. This gives the trauma diffuser the opportunity to gather information in order to make a decision on how to handle the situation. The sharing of information also provides the trauma victim with the opportunity to ventilate his/her feelings.

- **Provide emotional support**

  The trauma diffuser should not only provide emotional support to victims, but also to family members, friends or colleagues who came to the trauma scene to support the victim. It is important to assist victims to establish contact with their support systems. Family members, friends and colleagues may become concerned if they see the reactions of the victims. The trauma diffuser should comfort them and inform them about the possible reactions and further intervention.

- **Provide practical assistance for physical needs**

  The trauma diffuser can help to provide practical assistance for physical needs, for example make phone calls, arrange for tea, offering a blanket/jacket to regulate temperature while their bodies are in shock and alert doctors/medical personnel if a victim needs assistance. When members of the victim's support system arrive, they normally take over the function of practical assistance.

- **Assist victims in regaining control and routine**

  Trauma victims normally feel that they are helpless bystanders while their lives fall apart as a result of the critical incident. The trauma diffuser should assist them to regain same control. This is achieved by giving the victim practical things to do. They can be given small tasks to do, for example request an emotional upset wife to pack a bag for her husband who has to be transported to hospital, or a person to hold the drip while the trauma team is helping his/her loved one. This makes the victims feel less helpless as they feel that at least they are of some assistance.

- **Protect victims against secondary traumatisation**

  The trauma diffuser often has to deal with bystanders at the scene who fulfil absolutely no function but who can be the cause of secondary trauma for the victim. The diffuser can assist to ensure the victim's privacy and make way for emergency workers, family and close friends.

- **Provide clear information about the process**

  An important function of the trauma diffuser is to provide clear information to victims about the process that will follow. Victims of a critical incident experience severe emotional confusion and rarely absorb information given to them. It is, therefore, a sensible idea to identify a family member or a friend who seems to be calm enough to absorb the information given to him/her and to explain everything in detail. The trauma diffuser should provide victims with telephone numbers and details of the trauma debriefing session.

3.6.2 Format of the defusing session

Schulz *et al.* (2000:154) provide a format as a guideline in which the defusing session can be conducted. This format gives more structure to the process and achieves the aims as discussed.

Step 1: Establish common ground

The trauma defuser should get the victim on his/her own, start by introducing him/herself, win the victim's confidence and show that he/she cares.

Step 2: Establish the facts

Ask victims what happened, focus on the facts and not the emotional responses to what happened.

Step 3: Talk about the feelings

Allow victims to express their feelings. The trauma diffuser should use his/her listening skills and show empathy. Focus on how the victim is feeling and nod after hearing the story.

Step 4: Give the victim a future

The trauma diffuser must assist the victim to secure his/her immediate future by establishing what immediate plans he/she has from here onwards. It is important to establish if there is someone that the victim can talk to and confide in when necessary.

Step 5: Checking and closing

Determine what methods the victim intends using to handle his/her situation, mobilise the victim to make contact if he/she feels the need for it and provide him/her with contact details.

The function of trauma defusing is to stabilise the person shortly after the critical incident and to prevent the victim from "bleeding emotionally to death" until the time that a proper debriefing session can be conducted. According to Meichenbaum (1994:183), trauma defusing is a shorter version of trauma debriefing. A trauma defusing session usually lasts less than an hour, compared to the two to three hours of a debriefing session. This implies that to a certain extent the phases of trauma defusing may overlap with those of trauma debriefing.

3.7 CONCLUSION

Chapter 3 explores the concept of a critical incident stress management. The introduction of this chapter gives some background on CISD. This is followed by defining the terms CISD.

The goals and effectiveness of CISD is discussed and the principles of CISD are explained. Trauma defusing as a critical incident stress management intervention is discussed. Some attention is given to the aims of trauma defusing and the format of a defusing session.

Chapter 4
Models in Critical Incident Stress Debriefing

4.1 INTRODUCTION

Different models in critical incident stress debriefing exist and it is evident that therapist uses different models in treating clients exposed to critical incidents. In this chapter different models in critical stress debriefing is discussed in order to provide some insight on the different models, how they work and what are their similarities and differences.

At the Careways group, therapists are encouraged to work according to the Solution Focussed Brief Therapy model in order to ensure that therapeutic goals are reached within a short space of time. Most of these models however have similarities and stem from the original model developed by Jeffrey T. Mitchell.

4.2 MITCHELL'S DEBRIEFING PROCESS

CISD is a specific model of group debriefing which can be used to accelerate recovery from traumatic workplace events. This specific model of psychological group debriefing was developed by Dr Jefferey T Mitchell in the late 1970s. It is a standardised 7-stage model that can be divided into a four-phase debriefing process (Sacks, Clements & Fay-Hillier, 2001:134). According to Roos *et al.* (2003:97), Mitchell divides the debriefing process into four phases:

- Phases 1 – On or near the trauma scene debriefing (defusing)
- Phases 2 – Initial debriefing
- Phases 3 – Formal CISD model
- Phases 4 – Follow up CISD

4.2.1 Phase 1: Defusing

Plaggemars (2000:85) mentions that the process and application of the defusing process are more immediate (often immediately or within the first 24 hours) and less intense due to a

shorter reaction in the reaction phase. The focus of this phase is to give informal debriefing to the people involved in a critical incident or those who witnessed the critical incident. People are given the opportunity to ventilate their emotions and the trauma diffuser should be aware of any acute stress reactions. The main objective of the defusing process is to give support on the scene and to protect survivors from secondary trauma (media, inquisitive people, etc) (Roos *et al.,* 2003:97).

4.2.2 Phase 2: Initial debriefing

According to Roos *et al.* (2003:97), this phase usually starts a few hours after the critical incident and refers to the ventilation of emotions in a natural way. This is a process where survivors discuss the critical incident and emotions resulting from the incident within their support systems.

4.2.3 Phase 3: Formal CISD

The formal CISD process, according to Plaggemars (2000:82), is a group process that which employs early intervention, brief treatment, task-centred and problem-solving techniques, which allow for catharsis around having experienced a critical incident. Additionally debriefing provides:

- Education about stress reactions
- Emotional ventilation
- The promotion of cognitive organisation through a clear understanding of both events and reactions
- Reassurance that the stress response is controllable and that recovery is likely
- Intervention to assist in recovery from traumatic stress
- Decrease in individual and group tension
- Mobilisation of resources within and outside the individual or group process
- Preparation for experiences such as symptoms or reactions that may arise
- Screening for people who need additional support
- Maintenance of employee health and welfare.

Roos *et al.* (2003:97) indicate that the debriefing session is conducted by a trained debriefer and sometimes also with the help of a co-trauma worker. The session preferably takes place

between 24 and 72 hours after the critical incident. In using CISD as a technique, the trauma debriefer goes through seven stages with the victims. The stages consist of an introduction, followed by the fact phase; the thought stage, the reaction stage, the symptom stage, the teaching stage and lastly the re-entry stage.

4.2.3.1 Introductory stage

According to Everly (1995:280),Feuer (1999:500) and Harbert (2000:400), this stage is the starting point of the CISD and begins with an introduction of the CISD team, explanation of the purpose, process and rules, motivation of participants to participate, establishment of confidentiality and selection of leaders. It is important to give feedback on the condition of hospitalised employees as soon possible in the session. Then it is important to establish ground rules such as:

- Everyone should turn off their pagers, cell phones, radios and distracting devices.
- Group members are reassured that they do not have to say anything but are encouraged to state their name and connection with the incident.
- Strict confidentiality is emphasised; generally speaking, whatever is stated in the room should stay in the room. If information is to be taken from the meeting, then participants need to be reassured that it will be handled sensitively and not attributable to individual group members.
- Group members should speak only for themselves.
- The debriefing is not a critique or a tribunal; nor is it a procedural debriefing.
- Group members are warned that they may feel worse during the session and for a while afterwards, as they may be getting in touch with painful thoughts and feelings.
- Participants are advised that the group may proceed without breaks, so they should use ablution facilities if needed. However, a five-minute break may be called by the debriefing team.
- Group members are reminded that they can leave the group if they become too distressed but are encouraged to come back if possible.
- Participants are then given a brief outline of the structure of the meeting and given the opportunity to ask questions.
- Participants are told that one-to-one sessions will be available for everyone after the group session. The sessions will not last more than half an hour. Attendance is not compulsory.

Furthermore Plaggermars (2000:84) emphasises that participants should be informed that debriefing is not a logistical analysis of the event. A supportive non-judgemental tone should be established to reduce resistance and anxiety, and to encourage mutuality among participants.

4.2.3.2 Fact stage

During this phase the participants are encouraged to describe the event from their point of view–what they were doing when it happened, where they were and what they think happened. When giving facts, they talk about things outside themselves and, therefore, it is impersonal. It is important for the debriefer to encourage everyone to talk, but to ensure them that if they do not want to talk, it is in order. Some will benefit just by listening to their peers. In the conversations, the debriefer needs to look at body language and other signs of distress such as squirming, eyes down, tears welling up, crying, clenched hands or increased agitation. If a participant starts to express emotions while stating the facts, it is a sign of distress (Evenly, 1995:280; Feuer, 1999:501; Harbert, 2000:401–402). Schulz *et al*., (2000:161) state that the debriefer should ask brief factual cross questions with the aim of establishing an accurate picture of the sequence of the events. Debriefers are interested in eliciting as much contextual information as possible, including sensory information regarding the incident such as what individuals saw, heard, smelled, touched and tasted. Getting people to identify the above can help them to become aware of possible triggers that might precipitate flashbacks. This can reduce anxiety that accompanies "reliving" episodes. According to Plaggemars (2000:84), through the discussion of facts, a collective realistic picture of the event is erected. Since facts are objective by nature, they are the easiest to discuss. This ideally facilitates a subsequent transmission to a more emotional response.

4.2.3.3 Thought stage

After everybody has had a chance to "paint the picture" from his/her angle or experience, the debriefer can ask a question concerning their thoughts once they have realised what is happening to them. This is a transition phase from the factual world outside themselves to a closer look at their own experiences, but still without the necessity of showing their emotions. The debriefer must be very alert for participants' reactions during this stage. They may show anger towards themselves or other group members. (Everly, 1995:280;Feuer, 1999:501; Harbert, 2000:402)

During this stage, the debriefing focuses on the thought processes and decision making. Participants are asked to describe their first or most prominent thought during the incident. The thought stage represents a transition from the cognitive domain to the affective domain, thus preparing the participants for a more personalised response (Plaggemars, 2000:84).

4.2.3.4 Reaction stage

This can be the most difficult and longest part of the debriefing process as individuals identify the most traumatic aspect of the event. Plaggemars (2000:84) describes this stage as the most powerful, seeing that participants are asked to recall the worst or most difficult part of the incident.

This stage is the most important stage for it gives opportunity to open their deepest emotions and ventilate. It is important to give those who feel the need to speak the opportunity to speak freely. Questions that can be asked are the following: "What was the worst thing about the incident for you personally?" and "If you could erase one part of the event, what would it be?" This stage is also the longest (it can last up to 40 minutes), because emotions will flow freely and the debriefer will use his/her therapeutic skills to listen, give empathy and let them feel safe in having these feelings (Everly, 1995:280; Feuer, 1999:502;Harbert, 2000:402)

As emotional responses can be strong, the debriefer's approach is to contain emotions sensitively and quickly and not to use the group format for therapeutic and cathartic purposes. Some emotional release is helpful at this stage, as is the sharing of feelings between other group members. According to Plaggemars (2000:84), the thought and reaction phase bind together. By gradually putting words to what was most difficult to them, individuals begin to expose content that, if not dealt with, in all likelihood can be problematic in the future.

Schulz et al. (2000:156) mention that an individual's emotions shown in this stage should only be explored in a one-to-one session following the group process. It is during this process that debriefers are likely to recognise those who by their reactions, or lack of them, need to be invited to have a one-to-one follow-up session.

4.2.3.5 Symptom stage

When the participants become quiet, it is time to move on to the symptom stage which is yet another transitional stage – this time back to cognitive discussion. This stage redirects

participants to consider the physical, emotional and behavioural symptoms they have experienced (Plaggemars, 2000:85). The thoughts of the participants must be restored to a level where they can relax and resume their normal responsibilities and life. The debriefer focuses the participants' thoughts on their cognitive, physical, emotional and behavioural experiences that may have occurred since the incident. Sometimes participants are unwilling to share these experiences because they think they would be the only ones "thinking crazy thoughts or experiencing a physical reaction". In this stage any signs of suffering and pain that may be early signs of post-traumatic stress are identified (Everly, 1995:281;Feuer, 1999:502; Harbert, 2000:403). Spiers (2001:38) mentions that at this stage many of the symptoms of the PTSD (intrusion, avoidance and increased arousal) may be elicited. Plaggemars (2000:84–85) mentions that the debriefer may stimulate the process by mentioning common stress-related symptoms which participants may have experienced after the critical incident. By discussing these symptoms they may be normalised, which may serve to reduce their frequency and intensity.

4.2.3.6 Teaching stage

This stage puts the participants at ease by normalising and demystifying the incident. It focuses on stress management, coping skills and education that can be used to minimise possible future stress. It is very important for the participants to know that their reactions are normal in the circumstances. Furthermore, the debriefer informs them of symptoms of distress. It is essential to educate the group regarding diet, exercise, rest, talking to important people and each other, supporting each other and avoiding alcohol and caffeine. The reason for giving so much information is to help the individual who is prone to post-traumatic stress realise it and to affirm assistance when help is needed. It is also recommended to let them now share something less painful and acknowledge them for the way they handled themselves during the impact of the incident (Everly, 1995:281; Feuer, 1999:503;Harbert, 2000:404).

Spiers (2001:43)mentions that it is important to highlight the fact that people can cope with a great deal of adversity. Most reactions are normal or typical following such an incident but usually decrease with time.

Plaggemars (2000:85) mentions that information given in the teaching stage engenders a sense of self-control and encourages on going self-awareness and self-assessment during recovery.

Schulz et al. (2000:193) mention that it is helpful to give participants guidelines to assess themselves. Useful guidelines might be to monitor behaviour in terms of:

- If symptoms do not decrease after six weeks
- If symptoms increase over time
- If functioning at home or at work is significantly impaired.

If any of the abovementioned becomes apparent, the participant should seek professional assistance.

4.2.3.7 Re-entry stage

This is the final stage in the CISD process where a summary is made by the debriefer who discusses everything that happened, giving his/her thoughts on how they experienced and observed the CISD process. This is the time of showing respect, encouragement, appreciation, support and final direction. Suggestions of simple tasks to help participants to feel in control again and encourage them to reach out for help from family, friends, co-workers and the EAP. The debriefer should guide them to think about something positive that has come out of the incident and let them know that treatment resources are available (Everly,1995:281; Feuer, 1999:503;Harbert,2000:404).

This last stage provides the opportunity for the group to ask questions or review material presented during the debriefing. It is also the last opportunity within the group setting for participants to bring up new information they would like to discuss before the group adjourns. The debriefer should try to summarise, encourage the use of techniques and strategies, and offer further assistance where appropriate and, to round up the discussion and to tie up loose ends.

Plaggemars (2000:85) suggests that at this point issues for further assistance should be identified. He further mentions that follow-up activities must be identified by the debriefer. This usually entails post-debriefing feedback. Post-debriefing feedback should be solicited

from those who requested the debriefing, usually managers or supervisors. Specific recommendations, for example individual consultation or referrals for counselling, can be made as part of the post-debriefing feedback. Finally, post-debriefing meetings are held. This is referred to as debriefing the debriefers. Debriefers usually benefit from revisiting their responses in the meeting and learning from feedback and suggestions.

4.2.4 Phase 4: Follow-up CISD/ Trauma aftercare model

Debriefing contains elements of normalisation, promotion of support, encouragement of normal processing of the event as well as exposure through recounting facts and exploiting feelings. The trauma aftercare model is a model for intervention after the CISD for those individuals who need further assistance.

The debriefer needs to have knowledge of the normal responses to critical incidents. McWhirter and Linzer (1994:405) list a few symptoms: tearfulness, shakiness, nightmares, insomnia, irritability, isolation, panic, headaches and gastrointestinal upset. Emotional reactions such as depression, anger, apathy and extreme fear often arise within victims and need to be acknowledged by the debriefer.

The debriefer should be able to critically assess if a client in the CISD procedure will be able to incorporate the event into his/her life and make an emotional recovery. If there is any doubt or if the client is at risk, he/she should be referred for aftercare.

Schulz *et al.* (2000:167) indicate when a client needs to be referred for aftercare:

- If there are any extreme reactions, for example complete withdrawal, no reaction or over-reaction and the inability to control him-/herself.
- Inappropriate reaction and no contact with reality.
- Clients who meet the criteria for PTSD or any other disorders (e.g. anxiety disorders, depression or dependency).
- Inclination towards suicide.
- Clients who have experienced serious problems in the past as a result of an inability to deal with stress and trauma.
- Clients who demand to be referred for therapy or other professional help.

Spiers (2001:101) discusses a trauma aftercare model that is an integrative model in that it is not based solely on one theoretical approach. The model involves searching for therapeutic explanation, but will not necessarily involve retelling of the story of what has happened to the client. The trauma aftercare model owes a great deal to Herman's three stage model. Although this model was designed to work with complex PTSD, the stages are crucial to all trauma counselling. The stages Herman outlines are safety, remembrance, mourning and reconnection. Recovery can only take place within a context of an empowering relationship that enables the necessary work to take place. The task of establishing safety (both mental and physical) is primary and must be achieved before any therapeutic work can be done. Telling the story is seen as essential for integration of the experience, although the need to balance this with safety is stressed. Mourning the losses resulting from the trauma, whatever they may be, is seen as a essential part of reconstruction. The final stage is reconnecting with other people and with the world (Herman, 1992:104–109).

The trauma aftercare model takes into account people's different reactions to trauma and offers ways of working with all of them within the same framework. The framework for the model is outlined within four sessions; however it acknowledges that, depending on the individual’s needs, more or less sessions may be required.

4.2.4.1 Session 1: Making contact

In the first session of the trauma-aftercare model it is important to create a working alliance with client, wherein the client feels safe. It is important that the therapist lays down boundaries and clarifies what happens during the session, stresses confidentiality, sets rules and discusses future options. The therapist's attitude should be holistic, positive, mindful, empathic, congruent, supportive and respectful.

An early task of the session is to normalise the client's reaction to the critical incident and the symptoms he/she is experiencing. Clients get anxious about the fact that they are experiencing symptoms that are distressing and that they do not understand, thus exacerbating the problem. Usually clients are reassured that their experience is entirely normal. Although giving advice is something therapists should be cautious about, it is essential in trauma counselling. As early as in the first session, clients should be advised on how to manage their symptoms effectively, for example on stress reduction techniques.

It is also important to start exposing the client to the traumatic event in the first session, if the client feels ready. The client should be encouraged to express his/her feelings and the client's strengths should be emphasised.

After the first session it might be helpful consolidating the initial assessment and to analyse the process. It is important for the therapist to reflect on his/her sense of what is going on with the client, the therapist's understanding of the symptoms and the therapist's own reaction to the client. The therapist should consolidate relevant history in terms of previous traumas, repeating patterns, coping strategies and shattered beliefs (Herman, 1992:104–109).

It is important not to make any assumptions about any of the above but to be curious about the possibilities and bear them in mind as the therapist proceeds.

4.2.4.2 Session 2: Assessment and the way forward

The second time the therapist and the client meet, the therapist will probably find that he/she has developed a real sense of the nature and the severity of the client's reaction. The therapist may also begin to get a sense of the client's character style and coping strategies, and how effective these are. During this session the therapist assesses the client's progress in terms of the symptoms and decides together with the client on a way forward. The following scenario may be present:

- The client has made a dramatic recovery, symptoms are greatly reduced and there has been a cognitive shift.
- The client has moved forward a bit, but more help is needed. A short-term stress reaction seems likely.
- A strong reaction is evident, intensive support is required.
- Trauma is not an issue.

The therapist should work within a person-centred framework in this session and be guided by the client. If the client is comfortable with talking about what happened, the therapist should explore the thoughts and feelings the client has experienced since the previous session. When the client tells the story, the therapist should observe the client's tone of voice, body language, level of arousal when he/she talks, physical reactions and emotionality.

The therapist may become more aware of coping strategies used subconsciously by the client to deal with the difficult and painful reality. Some clients may withdraw from the world around them, others may suppress their emotions, and others may throw themselves into an all-consuming activity. Clients who appear to be experiencing strong post-traumatic reactions may separate or dissociate from their experience. The opposite of dissociation is hyper-arousal where the client is unable to modulate, let alone "cut-off" from his/her feelings. Clients are overwhelmed by grief, anxiety, fear or terror. Many clients may be confused at this stage, trying to make sense of what has happened to them. The therapist should use continuing normalisation and education as a technique to help the client in a state of confusion. The therapist must identify coping strategies and explain them to the client in order to develop insight. Effective coping strategies in dealing with trauma usually involve strategies facing rather than avoiding pain, for example dealing with emotions and fears, and ventilating emotions. The therapist can help the client to identify more effective coping strategies. If it seems that trauma is not an issue, the therapist can prepare the client for termination in the following session. When the client is still distressed in any way, the next session is used for resourcing and moving forward (Herman, 1992:104–109).

4.2.4.3 Session 3: Resourcing and moving forward

In this session it might be useful to reflect on the client's experience of the counselling process and whether there has been any change since it started. In this session, the therapist should detect which way the process is going. There are three possible ways forward, emerging from the previous session:

- Client is moving forward very rapidly. A client whose symptoms have largely disappeared will be working towards ending the process. The client may be reflecting on his/her learning from the experience, together with finding ways of integrating it and moving forward.
- Client is still working through his/her reaction but still need more help. Therapy can be focused on helping the client to find meaning in what has happened, and to build his/her beliefs about him-/herself and the world.
- Client appears to be developing PTSD. This is a point where the client and the therapist should consider how the client's needs can best be met in the longer term. Factors such as single or multiple trauma, psychiatric history, substance abuse history, fragility, ego strength and co-morbidity should be considered.

A decision based on the abovementioned information should be made in terms of long-term therapy or short-term focused work. If the decision is made that an appropriate referral should be made to best meet the needs of the client, the client should be prepared for this. If it is likely that the client is at risk of developing PTSD, the process should continue and the client should be prepared for it. If the risk is low, the client can be prepared for closure in the next session (Herman, 1992:104–109).

4.2.4.4 Session 4: Ending or preparation for PTSD intervention

If the client experienced a short-term reaction that has eased, the therapeutic process can end. The client and the therapist can review learning from the incident and the reaction. Ongoing support and re-sourcing for the client can be explored.

A client still experiencing post-traumatic stress symptoms more than a month after the incident will probably need additional intervention to resolve them. It is useful to continue to reassure your client that PTSD is a normal response and help is available. The therapist can give more information about PTSD and can explore if another issue is preventing recovery. The client's perception of what is happening and his/her thoughts on progress need to be explored. The client and the therapist should discuss ongoing intervention. If PTSD symptoms subside, intervention can be terminated in the following sessions. If the client continues to be distressed and PTSD symptoms prevail, the client should be referred for alternative therapy, for example, trauma incident reduction (TIR).

The trauma aftercare model presented by Spiers (2001:101–120) is a model of ongoing care after the CISD. This model focuses on clients who are distressed after the CISD or indicate that they need further support. It is a short-term model focused on the needs of the client, and the process can be terminated as soon as the client's symptoms have eased. The process is focused on supporting the client and helping the client to understand and to integrate what has happened to him/her (Herman, 1992:104–109).

4.3 BRIEF THERAPY

Both among professionals and clients there is a vast amount of confusion about exactly what the term "brief therapy" refers to. The term suggests that it is distinguished from other types of therapy which is not brief, for example long-term therapy. For some, brief therapy refers to

a maximum of 10 sessions for others it is up to 25 sessions. In a study by Weakland at the Brief Family Therapy Centre (De Shazer, 1985:4), it is reported that 72% of the cases either met their goal for treatment or made significant improvement within an average of seven sessions.

Brief therapy (Logan, 1996:30) is defined by its time limited nature, from as few as five sessions to as many as ten sessions: "Brief therapy uses active therapist and client cooperation to define and carry out goals, monitor progress and praise accomplishments. Its techniques emphasize solutions rather than symptoms, strengths over pathology and behavioural or action-orientated goals rather than insight into problems". Logan (1996:30) conducted a study to measure client satisfaction with brief therapy offered through an EAP. Results from this study indicate that clients experience brief therapy quite favourably. Based on an analysis of client satisfaction questionnaires, clients indicate their satisfaction with brief therapy at 28,92 out of a possible 32. Ryan (1994:5) defines brief therapy as a group of therapeutic interventions aimed at solving a client's problem in the shortest possible period of time.

In the Careways group where the research was conducted, the preferred model for intervention is the brief therapy model, as this model is focused on reaching identified therapeutic goals within a limited amount of sessions. These characteristics make this model cost and time effective, benefitting both the employee and the company.

4.3.1 Brief therapy and the characteristics of brief therapy

Owing to the need for cost containment, time constraints and the growing need for psychotherapeutic services, short-term therapies have been among the most rapidly expanding areas of growth within psychotherapy and counselling. According to Franklin (2003:198), there are different approaches that use a variety of theoretical orientations none of which automatically lead to a reduction in the number of sessions.

Brief therapy acquires skills to work with clients on a time-limited basis. According to Franklin (2003:199) this will require the therapist to contract very clearly with the client, to use focal techniques that will help the client to stay with central issues and to be realistic about what can actually be achieved in the given time.

According to Franklin (2003:200), there is a misconception that there is one particular theoretical approach to brief therapy. She suggests that there are three main differences that distinguish brief therapies from other therapies, namely:

- They have a limited aim which the patient is made to understand from the beginning
- The number of sessions is limited
- The techniques used are "focal".

Loar (1999:513) supports this view and states that brief therapy has three primary factors that make it unique. "The first is the setting: therapy is intended to be short and in some cases the termination date may also be precisely defined. The two other aspects have to do with the therapeutic stance: therapeutic focus and the professional's activity in maintaining the focus." This implies that the therapist is responsible for keeping in mind the aim and focus, and bringing the focus back to the presenting problem.

Brief therapy aims to stimulate, guide and strengthen the client's problem-solving efforts; the task-centred model requires that the targeted problems are alleviated through the client's own actions (Reid, 1989:72). Although there is no set rule to the time frame in which brief therapy should be concluded, Gingerich and Eisengart (2000:478) are of the opinion that brief therapy normally lasts less than six sessions.

Butcherana and Koss (in Franklin, 2003:199) report that structured time-limited interventions can be as effective as less structured, open-ended interventions. They outline common characteristics across brief therapy approaches:

- Limitation of therapeutic goals
- Directive management of session by the therapist – therapist is active
- Centering the therapeutic content in the present
- Rapid early assessment
- Promptness of intervention
- Flexibility on the part of the therapist
- Ventilation or catharsis as an important element of the process
- A quickly established interpersonal relationship to obtain therapeutic leverage
- Appropriate selection of clients, since not all clients can profit from a brief therapeutic contact

- Therapeutic management of limitations.

4.3.2 Solution focused brief therapy (SFBT)

Solution focused brief therapy (SFBT) is an approach that lends itself perfectly to time-limited therapy. It incorporates the techniques based on the principles of systemic family therapy. The key characteristic of SFBT is that the primary focus is on the development of solutions rather than the exploration of problems (Franklin, 2003:201). According to Gingerich and Eisengart (2000:478), this therapeutic intervention is primarily focused on creating solutions instead of resolving problems. The main therapeutic task for the therapist is to help the client imagine how he/she would like things to be differently and what it will take to make it happen. Miller (1997:21) states that SFBT enables clients to "assume that their lives will get better and provides them with interpretive 'lenses' for seeing their lives in new ways".

In SFBT, contracting is freer and less formalised, and there is less emphasis on exploration, history taking and understanding. In the solution focused interview there is minimal focus on problems and problem-free and solution talk is encourage where possible. The therapist uses techniques such as the "miracle question", "problem-free talk" and exception finding to describe systematic goal setting and action planning, which are normally used in cognitive and behavioural therapy (Franklin, 2003:201).

According to De Shazer (1991:54), SFBT assumes that the solution lies in the changing interactions in the context of the unique constraints of the situation. It is believed that new meanings can be created for at least some aspect of the presenting problem. The SFBT approach, according to Stalker, Levene and Coady (1999:469), focuses on the symptom or problem and aims to help the client to set up some conditions that allow for the spontaneous achievement of the stated goal. Setting a concrete goal elicits the expectation of change, and provides criteria for success. Seeing that a lot of emphasis is placed on goal setting, specific techniques for identifying concrete goals and to de-emphasise the problem have been developed. These questions (called miracle questions) may include: "How will you know that the problem is solved?", "What will be different when the problem is solved?", "How will others know that the problem has been solved?" Behaviourally, specified answers to these forms of the "miracle questions" become the goal of SFBT. Stalker *et al.* (1999:469***)*** mention

that in SFBT gathering information about the past is seen as problem talk and is limited in order to minimise pre-set ideas.

SFBT assumes further that clients have the necessary resources to change. "Every client carries the key to the solution: The therapist needs to know where to look" (De Shazer, 1986:95).

In SFBT the therapist develops compliments or "clues". Stalker *et al.* (1999:470) mention that those compliments are statements based on what the client is already doing well and has achieved. The compliments are aimed at encouraging the client to strengthen positive behaviour, and to normalise personal difficulties. Clients are encouraged to perceive that the therapist is on "their side", improving the client's willingness to accept "clues" about possible solutions. Dryden (1995:3) states that the client undergoing SFBT should be able and willing to present his/her problems in a specific form and set goals that are concrete and achievable. He further highlights the inter-active role of the client in the therapeutic process; through empowerment in the therapeutic process the clients takes responsibility for resolving his/her own problem. De Shazer (1991:57) mentions that SFBT is seen as a "mutual endeavour involving therapist and client together constructing a mutually agreed upon goal".

4.3.2.1 SFBT versus long-term therapies

Neff, Lambert, Lunnen, Budman and Levenson (1996:71) distinguish between the ideologies of long-term and short-term therapeutic approaches.

Table 3: SFBT versus long-term therapy

Long-term ideology	Short-term ideology
1.Seeks change in basic character.	1.Prefers pragmatism and does not belief in the notion of "cure"
2. Believes that significant psychological change is unlikely in everyday life.	2. Maintains perspective from which psycho-logical change is viewed as inevitable.
3. Sees presenting problem as reflecting more basic pathology.	3. Emphasises patients' strengths and resources; presenting problems are taken seriously.
4. Wants to be there when client makes significant changes.	4. Accepts that many changes occur after therapy.
5. Sees therapy as having "timeless" quality.	5. Does not accept the timelessness of some models of therapy.
6. Unconsciously recognizes the fiscal convenience of maintaining long term client.	6. Fiscal issues often muted either by the nature of the organisation of the therapist practice or by the organisational structure of reimbursement.
7.Views psychotherapy as almost always benign and useful.	7. Views psychotherapy as being sometimes useful and sometimes harmful.
8.Seeing clients being in therapy as the most important part of their lives.	8. Sees being in the world as more important than being in therapy.

Whether planned short-term interventions offer a more effective practice strategy than less structured, open-ended approaches to intervention in part depends on the nature of the problems and objectives of the intervention. Ideally the appropriate method will depend on the nature of the client's particular problem and the therapist's assessment. There are, however, external influences (e.g. time, money, resources) that in reality mean that the therapist has less choice than he/she wishes.

According to Franklin (2003:202), SFBT should not be seen as an expedient counselling approach but used skilfully where and when appropriate. It is not suitable for all situations. If the approach is inappropriate, a client's mental state can be further "damaged". Sensitivity is required to determine if a client's problem would be more appropriately addressed in a long-

term approach intervention. The importance of skilled assessment in the first session is emphasised. If the case material is not suitable for SFBT, then the therapist should be clear from the start why he/she may not be able to take the case.

4.3.2.2 Strengths and weaknesses of SFBT

According to Wells and Phelps (1989:21), one of the strengths of SFBT is that it can be applied to a broad range of problems over a large range of the workforce. It effectively deals with problems such as depression, anxiety, low self-esteem, difficulties in relations and sexual problems. Gingerich and Eisengart (2000:477–492) refers to well controlled studies where SFBT proved to be effective in the management of depression, the teaching of parental skills, emotional assistance in the rehabilitation of orthopaedic patients, reducing recidivism in a prison population, anti-social behaviour in adolescents and couples therapy.

Anderson-Klontz, Dayton and Anderson-Klontz (1999:114) mention that SFBT is a model that can be effective in many different contexts with diverse populations and can be integrated with other therapeutic traditions such as experiential family therapy. The SFBT model is time limited and focused; the client is helped by the therapist to achieve maximum benefit from the therapeutic session in the minimum time. Gingerich and Eisengart (2000:477) mention that more companies and government sectors started to embrace SFBT because it is short term and relatively inexpensive with successful outcomes and a high client satisfaction rate. Anderson-Klontz *et al.* (1999:115) state that SFBT provides a solid framework in which the client can reach achievable goals within a limited time period. They further state that SFBT focuses on the positives, solutions and goals. Change is facilitated in the right direction if the client is focused on the positive, the solution and the future. Franklin (2003:200) mentions that there can be several advantages using a time-limited counselling approach. Some clients may find the conscious understanding that therapy will be short term reduces their anxieties in terms of potential dependency, thus enabling them to enter the therapeutic process. Clients may also feel more in control because they know exactly how long the counselling will last and this can assist them to focus on their chosen goals. Where the client's motivation or ability for change is minimal, it becomes apparent to the therapist quite quickly and it can be helpful in managing case loads and appropriating time constructively. Stalker *et al*. (1999:473) mention that SFBT puts more emphasis on the strengths of the client and the importance of collaboration. These authors, however, mention that although SFBT can be very effective and make therapeutic services more accessible, the SFBT model cannot take

all the credit. The SFBT is based on a variety of models and uses the strengths of a variety of therapeutic models, for example cognitive therapy, psycho-dynamic therapy and strategic therapy.

This model has successfully identified techniques and strategies that are affective in a time-limited space. Although there are many advantages of SFBT there are also some disadvantages. The SFBT model is not effective in treating all kinds of problems. Stalker *et al.* (1999:473) mention that studies have shown that SFBT is less effective than longer-term therapies with regard to clients with severe problems.

This challenges SFBT precepts that the therapist does not need to know anything about how the problem developed, that the client story does not need to be heard and that the most difficult problem, for example trauma or abuse, can be overcame quickly. A major concern about SFBT is the neglect of client history and broader assessment (Stalker *et al*.,1999:474).

SFBT does not allow opportunity for a therapeutic relationship between the therapist and the client due to time limitations. The fact that time is limited, as well as the lack of emphasis on a therapeutic relationship, limits the opportunity of the client telling his/her painful story. The limited client catharsis can be viewed as one of the major weaknesses of the SFBT model. Moreover, Falker (2003:200) mentions that some clients may experience time-limited counselling as frustrating and disappointing. Having had access to a therapeutic process, the client becomes more aware of related connections to their presenting situation, only to find that opportunities to work through and to resolve those issues are limited. The client may also experience referral for long-term therapy as negative due to the fact that he/she started to trust and open up towards the therapist.

In the field of EAP and the constantly increased demands for therapeutic intervention, the SFBT, in spite of the criticism, plays a valuable role. The SFBT model, with general emphasis on collaboration and client strength as well as the many techniques to facilitate the development of solutions, has clear utility in the field of therapy.

4.4 TRAUMA INCIDENT REDUCTION (TIR)

The therapeutic goal for a victim of a critical incident who developed PTSD is to move from the chronic stage of victimisation back into the previously unsuccessful acute stage since that

is the stage where assimilation and accommodation were present. Gerbode (1995:436) states that what must be assimilated and accommodated from a traumatic event are one's reactions to the incident, including one's thoughts, sensations, feelings and perceptions. He further states that a trauma only remains emotionally charged or unresolved if the victim has perceived the critical incident incompletely and has not made sense of it. French and Harris (2000:8) mention that TIR is based on the assumption that there is a primary traumatic root incident in a person's experiences that other subsequent traumatic incidents, or sequences, are dependent on. In other words, trauma is inextricably linked to and conditioned by the root incident. Trauma symptoms, therefore, are "powered by" the emotional charge associated with the root incident, one which may be far removed in time from the most recent experience of the symptom. He further suggests that the greater the number of sequences, the less likely it is that the victim will necessarily consciously associate them with the primary traumatic root incident. That is, the root can be far enough removed that a particular trauma response appears to be more directly affiliated with one or more recent sequents. Moore (1993:119) states that is why PTSD is so difficult to treat. In the absence of addressing the root directly, there is always an emotional charge present to be triggered. The theory behind TIR is that, where past traumas have never been fully faced, they retain an emotional charge and can be triggered by later incidents. Spiers (2001:122) mentions that TIR is a method of enabling people to confront their past traumas by exploring the recent incident and linking back. This is achieved by going through a critical incident repetitively, enabling the client to engage with it and to work out links with previous repressed but re-stimulated incidents.

TIR is a procedure intended to render benign the consequences of past traumatic events. If this procedure is used correctly and in suitable circumstances, it eliminates virtually all of the symptoms of PTSD as listed in the DSM (IV) and is capable of resolving a host of painful and unwanted feelings and emotions that have not surrendered to other interventions (French & Harris, 2000:14). TIR usually leads to spontaneously client-generated insight, personal growth and empowerment. According to French and Harris (2000:14), the therapist's role in TIR consists of keeping the session and client's attention tightly focussed. The therapist always consults the client in deciding what to address in a given session. Once started, the session continues until the presenting incident or target symptom (called "theme"), which the client and the therapist have agreed to address in the session, has been concluded or brought to an "end point". At this point the client typically experiences at least a sense of peace, respite or relief. The therapist creates a safe environment in which the client can

confront and explore his/her trauma, and manages the session by guiding the client through the procedure. Sessions have no fixed length and can continue until the appropriate theme reached an end point (Spiers, 2001:122).

The first step in TIR is to identify the issue or "item" that is going to be addressed. According to French and Harris (2000:15), this may be the client's description of a "presented incident" – a specific incident identified as troublesome by the client – or a description of some content or theme that is common to a sequence of incidents experienced, that is, a "thematic" item. These two types of items – themes and presented incidents – are treated somewhat differently with TIR. Spiers (2001:123) mentions that clients are encouraged to imagine the incident happening as if they were watching a video, that talk through what they have seen, repeating this procedure until some resolution occurs. Resolution may take the form of a cognitive shift, a distinct relaxation, or a sudden return to the present. The therapist does not interpret what the client says, but listens intently, enabling the client to feel held and accompanied on his/her journey. The client connects with his/her feelings as he/she moves through the process, enabling him/her to be discharged. Additionally, he/she is usually able to make a cognitive shift, achieving a different, more constructive perspective of the incident.

4.4.1 Basic TIR

French and Harris (2000:15) mention that if a severely traumatic incident or a presented incident is readily accessible, it is a good idea to address it first, with a procedure called basic TIR, before trying to address thematic themes. In the process it may or may not turn out that this is a sequence of earlier incidents underlying a presented incident, but the presented incident can often be handled by itself, without reference to earlier related material. Having selected a specific incident in which the client is interested, the therapist may lead the client to go through the incident a number of times in his/her mind, reporting after the run-through what happened in the incident and any thoughts or reaction the client may have while reviewing the incident. French and Harris (2000:15) report that the client "will generally experience great relief".

4.4.2 Thematic TIR

French and Harris (2000:15) say it is safe to assume that a high percentage of all negative feelings, attitudes, or undesirable impulses clients have and wish to be freed from will be

found to be themes, for example "fear of men" or "woman are not to be trusted". These themes, feelings (i.e. fears), emotions, sensations, attitudes, beliefs and even some physical pains in turn will be found to be contained in a sequence of separate incidents linked by a common theme(s) triggered or re-stimulated in the client. Many of the incidents in such sequences will be secondary trauma, because in themselves they are not a trauma that causes primary pain but they are linked to the trigger/primary pain that causes traumatisation. Such sequences will be found to originate in root incidents that typically do contain primary pain – a real, or untriggered independent source of trauma. By thoroughly working through the root incidents, the emotional charge that hold the theme which is linked to later incidents will be released.

The therapist works through a theme by asking the client to identify an incident, any specific incident in which the specific theme is present. If a client is affected by, for example, a fear of men, the therapist can ask her to identify a specific incident that she can recall that contains a fear of men. The therapist then takes her through the incident several times until no further emotional charge is released from the incident and the client reaches an end point, or her attention moves and can be redirected to an earlier incident containing the same theme (fear). The same process is then used to work through that incident until there is no charge. The therapist eventually encounters the root incident, and at the review of that incident the client, at the minimum, experiences a feeling of relief, usually coupled with one or more realisations or insights regarding her own behaviour or functioning. After this the therapist usually moves to a next theme.

French and Harris (2000:17) mention that it is very important to understand the concept of an end point. At the end point of an incident certain characteristic "indicators" appear. When TIR reaches an end point, the following indicators in the client are observed:

- The client feels and manifests a sense of relief from what was problematic
- The therapist sees the client relax and "lighten up" visibly
- The client's attention redirects from the past to the present
- The client often has some kind of significant insight.

It is important that the therapist is aware of these indicators and that the TIR process is not terminated while the client is feeling miserable or if there still is an emotional charge. Flexible session times are important to allow for the process to reach an end point. It is important for

the therapist to be able to continue a session until a client has reached an end point, at which he/she feels relieved because something has been resolved. It is equally important for a therapist to be able to stop when an end point is reached. When the client feels confident that the therapist will allow for anything to be resolved that is encountered in the session, the client willingly moves into highly charged areas. The time to work through an incident or a thematic sequence is highly variable and it may take anything from five minutes to three hours to reach an end point. French and Harris (2000:18) mention that clients may need more than a single session to reach an end point. It then may happen that some of the work that goes into the attainment of the true end points may take place between sessions. It is, therefore, important that the therapist starts a session by asking the client about particular thoughts, feelings or insights he/she has had since the last session. This gives the therapist the opportunity to asses if a client has reached an end point between sessions. It is important that the therapist assesses the emotional charge of the critical incident and not terminate TIR therapy while the client is still feeling miserable or "locked into" the incident. On reaching an end point, the client reclaims the personal power that was tied up in maintaining the incident or sequence as part of the present.

In the session, as a client approaches an end point, the therapist generally witnesses the client's indicators improving and that the incident that are being worked through will be getting "lighter" or less painful. Gerbode and Moore (1994:30) refer to an emotional scale (see Figure 3). The client moves upward on this emotional scale when reaching an end point. The therapist should wait until the client has full positive indicators, involving expressions of relief and a feeling of peace with the issue that has been addressed. The client ideally expresses a realisation, or mentions a decision at the time of the incident. This shows that the client has come into contact with an aberrant belief or intention – one made or adopted at the time of the incident that since then became inappropriate – and is now coming into contact with that realisation. An expression of such a realisation is a good indicator of an end point. If these signs are not present it may be necessary to review the incident again until an end point is reached. It is important not to interrupt a client while there is still emotional charge. If the client is still looking inward, it is likely that the client has not reached the insights needed to come to an end point.

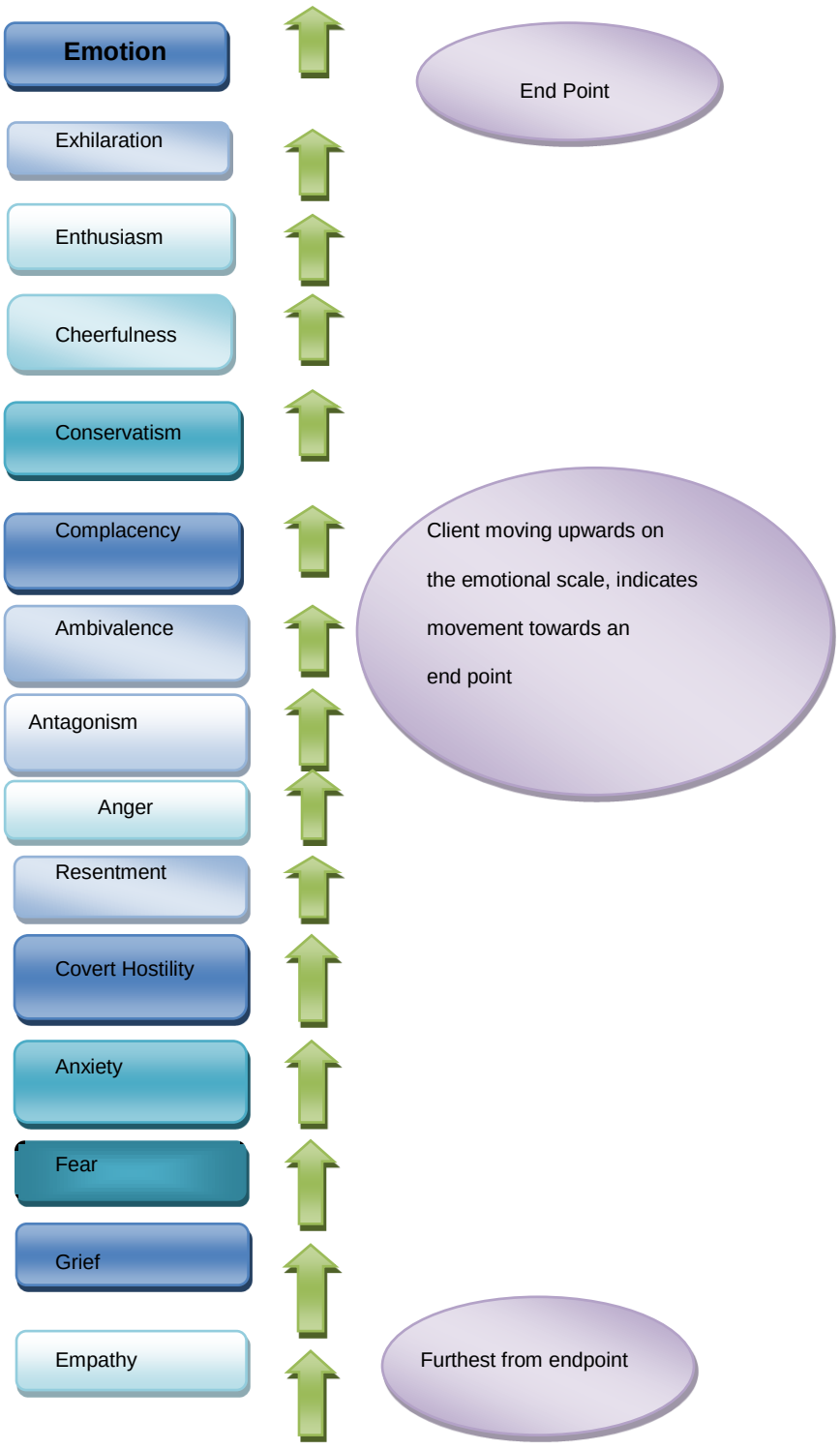

Figure 3: Emotional scale (Gerbode & Moore, 1994:3)

4.4.3 Change in emotional scale

According to French and Harris (2000:21), the various emotions we experienced in life can be arranged to form a scale (Figure 3). The higher emotions on the scale tend to relate to success while the lower emotions on the scale indicate failure. In any given moment a person can occupy two or more emotions on the scale, referred to as chronic and acute emotions. If a person is by nature anxious and anxious most of the time and only cheerful when, for example playing golf, the chronic emotional is anxiety and cheerfulness is the acute emotion. An emotion, depending on its nature, acts to provoke or inhibit certain reactions from us, for example:

- Promote the happiness and well-being of ourselves and those around us
- Impair or frustrate the happiness and well-being of ourselves and those around us.

When the emotion is chronic, it actually structures or dictates the world we live in, acting as a self-fulfilling prophesy. The TIR therapist is interested in both the client's acute and chronic emotions. The chronic emotion dictates the overall case plan and the strategy, and the acute emotion dictates the therapist's immediate actions and the tactics at any given moment in the session. The chronic emotion indicates how the client experiences his/her world and how he/she views life. The chronic emotion of a person suffering from PTSD typically is on the bottom half of the emotional scale. The goal of the therapist is to allow that to change and, to the degree that the therapy is successful, it does. Three things happen, according to French and Harris (2000:22) that are visible by the therapist and the client:

- The chronic emotion gradually moves up on the emotional scale
- The client experiences a feeling of well-being
- The client responses to reactions from the world are experienced as positive.

4.4.4 Steps in TIR

According to French and Harris (2000:23), basic TIR consists of certain steps. Before these steps are followed the therapist should have determined if TIR is an appropriate tool to use for the specific client.

The steps in basic TIR, according to French and Harris (2000:23–24), are as follows:

Step 1 "Consulting your client's interest and selecting an incident to address."

This assessment is essential and done before the therapeutic process begins. The presenting incident is the one the therapist will start with.

Step 2 "Find out where the incident happened."

Responses such as "it happened at home", "when we were living in Cape Town", or "when we were on vacation" are common. Any indication of a place is acceptable.

Step 3 "Determine how long the incident lasted."

Any responses indicating the time are acceptable, for example "it lasted for 20 minutes", "only for a few seconds" or "it was just long enough for me to smoke a cigarette".

Step 4 "Have the client focus on the moment the incident occurred."

This is preparing the client for the TIR process by focusing the attention on the beginning of the incident.

Step 5 "Have your client close his/her eyes (if he/she is comfortable to do so)."

Closing the eyes helps the client to "see" the incident more clearly in his/her imagination, eliminating distractions from the environment.

Step 6 "Ask your client to describe the scene at the moment the incident begun."

This begins the description of the incident, but is only the beginning moment (to set the stage).

Step 7 "Have your client silently review the incident from beginning to end."

This is a silent reviewing process that helps the client to put the incident in perspective before he/she begins to tell what happened.

Step 8 "Have the client tell you what happened."

The client's response to this request may be a broad outline of what happened or a very detailed description.

Step 9 "Repeat steps 4, 7 and 8".

From this point the therapist facilitates the viewing by letting the client repeat the cycle of going to the start of the incident, reviewing it silently to the end and then telling what happened (steps 4,7 and 8) until the client reaches an end point. The steps for basic and thematic TIR are basically the same and have little to do with the principle differences between basic and thematic TIR. The questions and instructions given to the client remain the same.

4.4.5 Rules for facilitating TIR

According to French and Harris (2000:59), the therapists are bound by certain rules. Although these rules may seem simple, the importance cannot be overstressed and the adherence to these rules is important and essential to attain consistently successful results in the TIR process.

There are 12 rules of facilitation (French & Harris, 2000:60–64):

4.4.5.1 Do not interpret

The therapist should resist all temptations to interpret what the client is seeing or experiencing. Interpretation is the client's job, and the therapist should regard the client as the only valid authority on matters he/she experienced and should only accept and acknowledge the client's data. The therapist does not have to agree or disagree with the client's statement or view point. The possibility exists that this statement, if neither reinforced nor disputed but only acknowledged by the therapist, will change in the course of the session.

4.4.5.2 Do not evaluate

Negative or positive feedback is evaluative. Validation draws attention to a specific observation or response of a client; if one of them is validated all of them should be validated. The absence of validation may be perceived as disapproval by the client. Successfully avoiding evaluation can be very demanding as even the finest gesture or smile at the wrong moment can capture the client's attention and thereby take the client "out" of the session.

4.4.5.3 Maintain complete confidentiality of session data

No real therapy can occur without confidentiality. The therapist must, therefore, make ethical decisions on how to protect his/her clients and information shared in the session.

4.4.5.4 Maintain control of the session at all times, but do not overwhelm the client

TIR work in a relatively fixed and predictable framework, by which it enables the client to discover his/her own answers and insights and enhancing the degree of "safety" for the therapist.

4.4.5.5 Ensure understanding of what the client is saying

The therapist should never imply that he/she understands something the client has told him/her, when he/she in fact does not understand it. People tend to feel misunderstood when they are. When seeking clarification, always assume responsibility for not having understood, never imply that the client was at fault.

4.4.5.6 Be interested, not interesting

This might be the single most important rule. The therapist's interest, if genuine, is felt clearly and valued highly by the client. The perception that the therapist shows genuine interest makes it possible for the client to confront issues he/she needs to work through in order to attain his/her goals. The therapist who is interesting to the client significantly impedes progress at its best and undermines successful TIR results.

4.4.5.7 Therapist's primary intention must be to help the client

The therapist intention must be to help. In the TIR session the client must be the therapist's primary motivation.

4.4.5.8 Ensure that the client is well fed and rested and not under the influence of any psychoactive drug

When the client is experiencing any physical phenomenon (e.g. hunger, exhaustion or physical pain) or under the influence of a psychoactive drug that might dull or attract attention, the TIR process is disturbed.

4.4.5.9 Ensure that the session is being given a suitable space and with appropriate time available

The therapist should create an environment that is comfortable and free of distractions. As a TIR session can be long, it is important that the client is seated comfortably. Neither the therapist nor the client should be under time pressure that could force the session to be interrupted prematurely. The traditional 50-minute session may be unsuitable for TIR seeing that the session is terminated only when an issue has no emotional loading left.

4.4.5.10 Act predictably

The client needs to trust the therapist and be confident that the therapist would not cut him/her off when the client needs a longer-than-expected session. If the therapist finds it necessary, the next client may be kept waiting because a current session is taking longer than anticipated. When the client knows what the therapist's action would be, there is more trust and he/she finds it easier to open up.

4.4.5.11 Never attempt a session with a client who is unwilling or protesting

The aim of therapy is to reduce stress. Forcing a client increases stress. If a client is forced by the court, a spouse or parents to attend sessions, the therapist first has to convince the client to willingly engage in therapy. The client has to be motivated before there can be any hope for success in the sessions. It is important that the therapist never takes up an issue because the therapist, and not the client, has decided to address the issue.

4.4.5.12 Take each issue in any session to a positive end point

The therapist should make every effort never to leave a client "triggered" or "locked into" any significant degree of re-stimulation. Clients arrive at valid end points within a single session of TIR if they are permitted to and sessions are kept open ended within wide limits to facilitate this. It is the therapist's responsibility, and not the client's, to end the session at an appropriate time.

TIR is a long-term therapeutic process aimed at resolving not only the current trauma, but also previous sequences of trauma until the root trauma is reached. It may be necessary to re-visit incidents several times until there is no emotional load left. TIR is a process that is not restricted by time. The client needs to know that he/she will be able to finish a specific issue, even though it may take longer than the traditional 50-minute session. TIR is an effective intervention where a client has been diagnosed with PTSD and symptoms continue to affect functioning long after the critical incident.

4.5 CONCLUSION

A client who becomes victim to a critical incident, specifically in the workplace, can be exposed to a range of interventions in order to assist or debrief him/her. Usually the first intervention is defusing, where the focus of the intervention is to contain and protect the client

from further emotional and physical harm and then to link up or to refer to further interventions such as CISD. CISD is the next step in crisis intervention. This is a formal debriefing process consisting of certain stages according to Mitchell's model. This phase follows 24 to 72 hours after the critical incident and aims at debriefing the client by ventilating emotions, educating regarding possible reactions, normalisation and focusing on problem-solving techniques. This process is usually a group intervention where the debriefer uses the group interaction as a tool to ventilate emotions and focus on reactions. If a client indicates the need for further help, or if the client is significantly distressed or if symptoms related to the critical incident increase or do not decrease after six weeks, the client needs to be referred for individual therapy. The trauma aftercare model is aimed at assisting the client after being debriefed but who is still affected by the critical incident. In therapy as part of the aftercare model, the client can be assisted by a therapist on an individual basis. Aftercare is usually necessary where there is a risk that the client might develop PTSD.

SFBT fits well into the aftercare model because of the model's tendency to focus on resolving the symptoms and moving on. The SFBT model is a short-term model focusing on early assessment, intervention and referral for long-term therapy if needed. The SFBT model is focused on developing solutions; it is a short-term model which is goal orientated and time limited. This model is aimed at empowering the client and strengthening the client's natural coping abilities through the therapeutic process. If a client is still affected and symptoms do not decrease, it is important that the therapist using the SFBT model should identify early on that there is no progress and refer the client for longer-term therapy. A longer-term therapeutic model that is effective in the intervention of victims of critical incidents is the TIR model. This model is effective in treating victims who have developed PTSD by moving them back from the chronic stage of victimisation to the previous acute stages where assimilation and accommodation was present. This model is helpful where the client is still affected by previous traumas and previous traumas still have an emotional load. TIR is a method that enables the client to contact past traumas by exploring the recent critical incident and linking back. TIR is a long-term model focusing on the client's emotional catharsis and it is not restricted by time. The process of TIR is terminated when the root incident has been worked through and an end point was reached – resulting in the client developing significant insight in his/her emotional functioning and experiencing a feeling of well-being.

Schematically the researcher summarized the process by illustrating the process as follows.

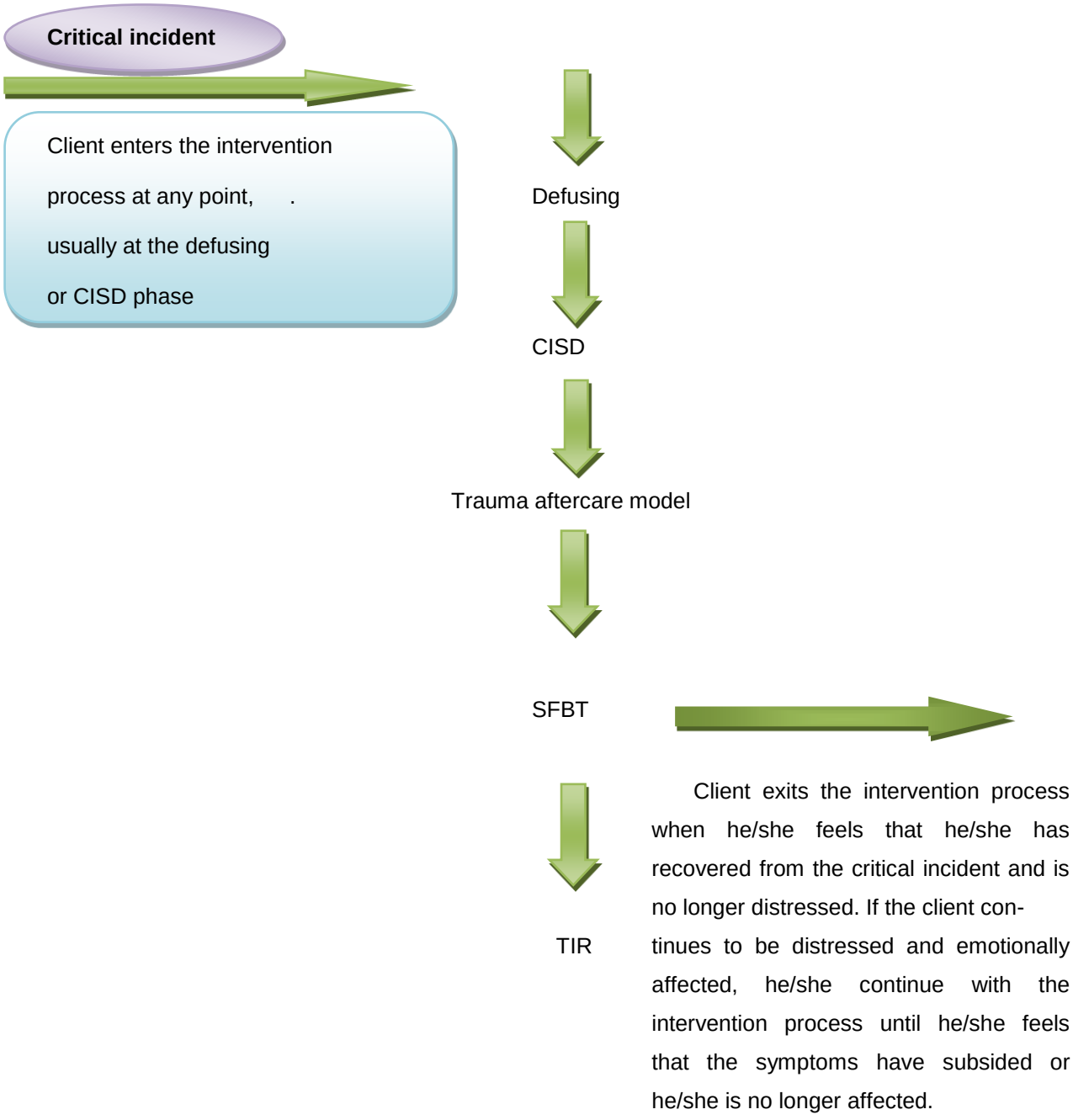

Figure 4: Trauma intervention process (illustrated by researcher)

After being traumatised by a critical incident, the client enters the trauma intervention process either by a defusing session or CISD session or by seeking help as a result of being distressed. The client remains in this process until the symptoms resulting from the critical incident are cleared or he/she is no longer distressed. If the client continues to be distressed, he/she moves forward into the trauma intervention process until trauma is appropriately

addressed and the client no longer feels distressed and feels ready to exit the trauma intervention process.