Managing Critical Incidents

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Outline of the Session

- Introductions
- Materials
- Definition of a Critical Incident
- The complexity of a child's death
- Supporting the Group & why it's more effective
- Conveying Calm Authority
- The case for psychological debriefing (CID)
    - Theory
    - Practice
- Dealing with Casualties
    - Grief into PTSD?
    - Using CID with individuals
    - Life Events/Life Snakes
    - Impact Intervention
    - Fast rewind
    - Child suicide
- Where are you going from here? (group roundup)

Materials in the pack

- Responding to Critical Incidents
- Children’s understanding of death
- Dealing with bereaved children (adult guidance)
- When someone dies (children’s booklet)
- Post traumatic Stress Disorder (reference to children)
- Child Suicide (some factual information)
- Bereavement counselling scripts (adult & children)
- Fast rewind technique
- Life Snakes

WHY SHOULD WE BE INVOLVED IN SUPPORTING STAFF DEALING WITH CRITICAL INCIDENTS?

SUPPORTING INSTITUTIONS DURING CRITICAL INCIDENTS

INTENSITY OF TRAUMA

	MILD				SEVERE
• Fatality or injury	1	2	3	4	5
• Adult or child	1	2	3	4	5
• Particular circumstances	1	2	3	4	5
• Numbers involved	1	2	3	4	5
• Size of proximity group	1	2	3	4	5
• Location in/outside	1	2	3	4	5
• Risk to others	1	2	3	4	5
• Clarity of information	1	2	3	4	5

LEADERSHIP	Developmental				Paralysed
	1	2	3	4	5
MANAGEMENT TEAM	Involved				Marginalised
	1	2	3	4	5
RESILIENCE OF CENTRE	High				Low
	1	2	3	4	5
PUBLICITY	Informative				Challenging
	1	2	3	4	5

DEFINING A CRITICAL INCIDENT

What is a Critical incident

- An incident resulting in post traumatic stress?
  - A person who experienced, witnessed, or was confronted with an unusually traumatic event/events which has both of these elements:-
    - The event involved actual or threatened death or serious injury or a threat to the physical integrity of self or others
    - The person's response involved intense fear, helplessness or horror (in children this may be expressed instead by disorganised or agitated behaviour)

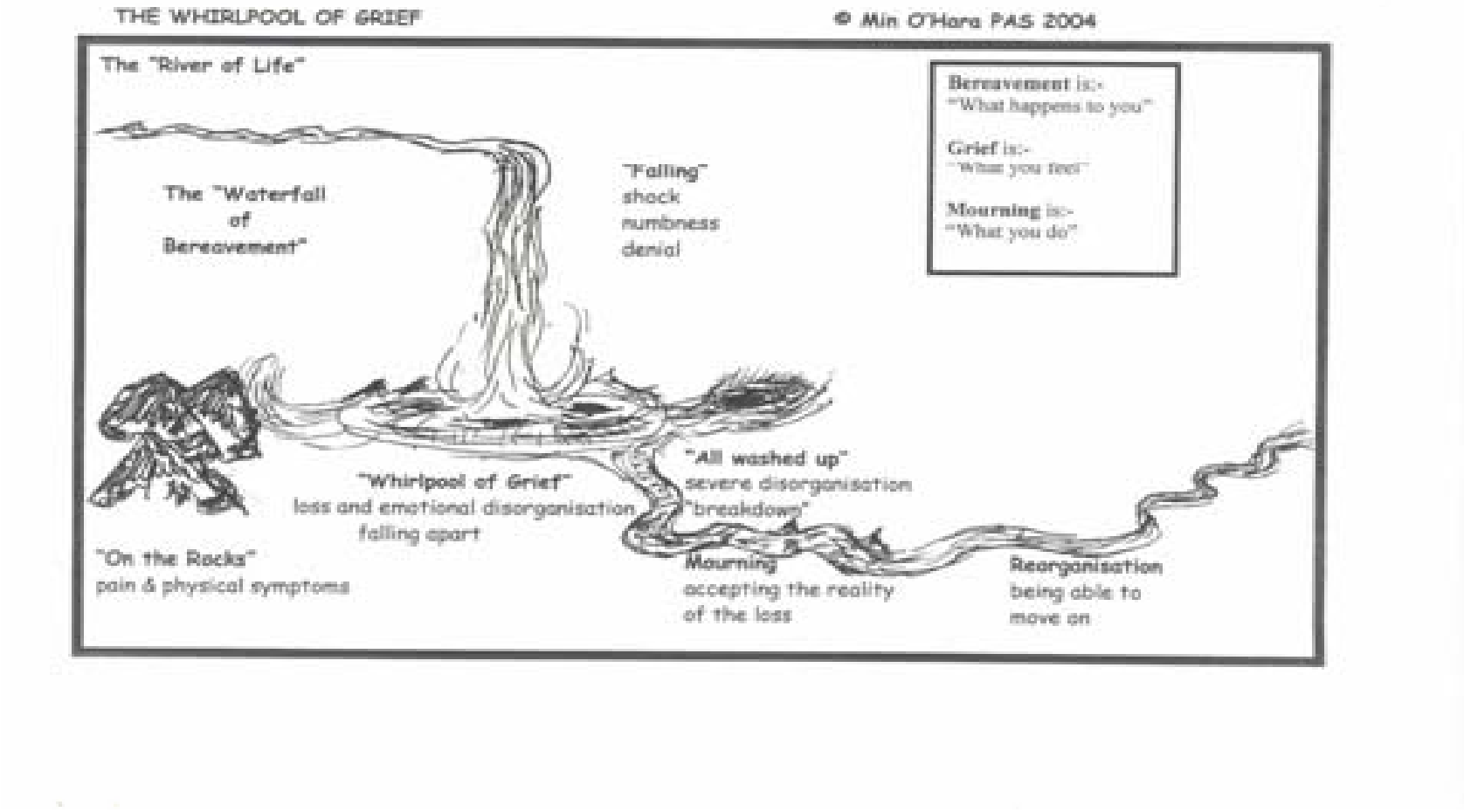
- A working definition (e.g. Cheshire CIT handbook)
  - Handling crises is a normal part of school life. Some incidents, however are of a more critical and overwhelming character in which staff, pupils and parents may experience acute, even prolonged, distress.
  - Cheshire schools have for instance faced:-
    - The murder of a pupil by a stranger
    - The murder of a pupil by a parent
    - Fatal road traffic accidents
    - Serious injuries on school trips
    - Student suicides
    - The consequences of terrorist incidents
    - Major arson attacks
    - Meningitis deaths

THE COMPLEXITY OF A CHILD'S DEATH

What is a “Typical Death?”

- Death is a normal part of life? (even though we can live forever)
- Most people die in bed
- Most deaths are expected
- We don’t expect our children to die before us
- Unless we are part of some religious groups
  - We don’t know how to behave ourselves
  - With our children
  - With bereaved families
- Normal reactions are extreme, upsetting, frightening & unexpected

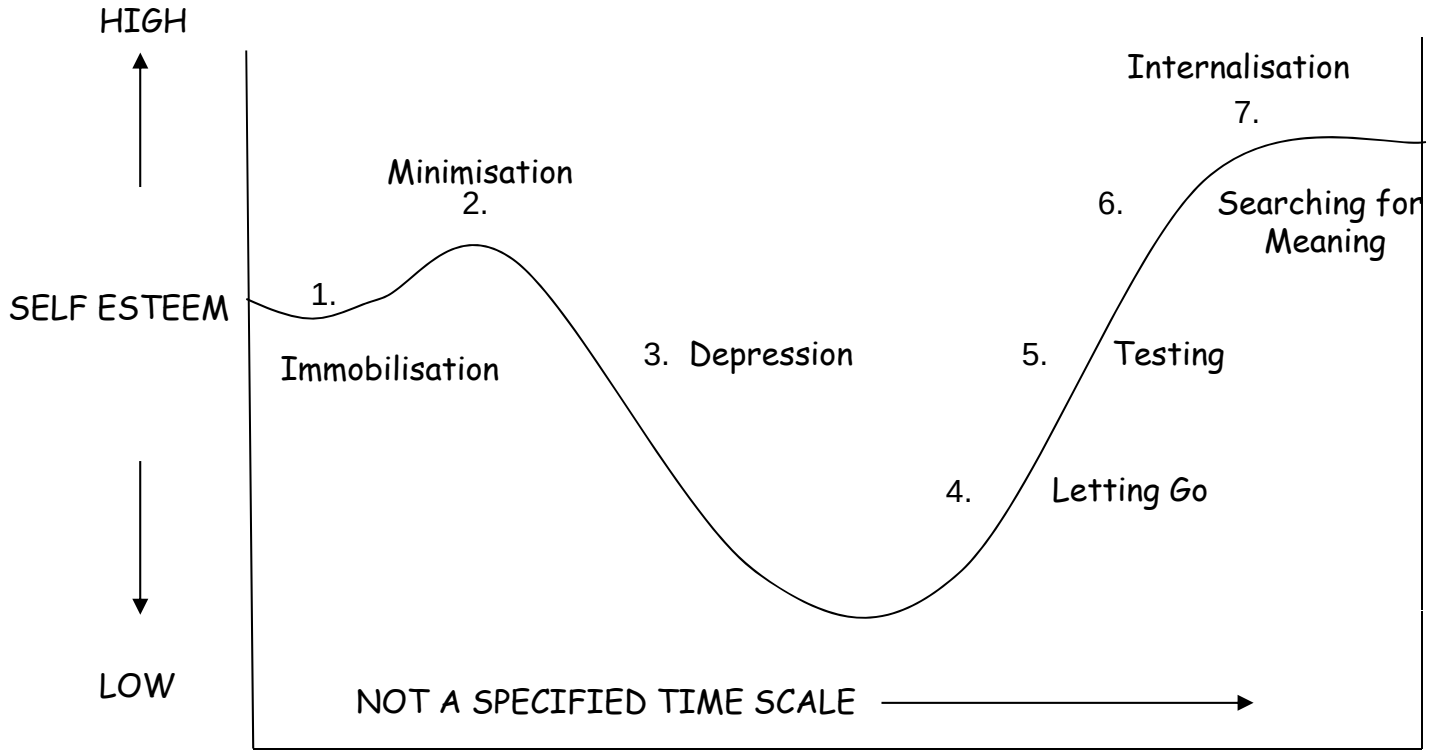
Reactions to a typical death



The Train Crash Metaphor

- The train journey
- The uncoupled carriages (past forgotten/dealt with life events)
- The crash (death/traumatic event)
- Being hit from behind unexpectedly by the uncoupled carriages

STAGES OF ACCEPTANCE OF BEREAVEMENT



STAGES OF ACCEPTANCE

1. **Immobilisation** *Immediate shocked reaction to finding out the person has died. Has been described as "robotic behaviour" (phrases like "I don't believe you….Well I've just spoken to her….I've got t make his tea!!"*

2. **Minimisation** *Appearing not to understand or accept the significance of the person's death (phrases like "It was expected….Well it was bound to happen…I wasn't surprised!").*

3. **Depression** *Intense feelings of pain, sadness and loss which equate with clinical depression (phrases like…"I don't want to go on…Will this pain ever end?…I'll never feel right again!!")*

4. **Acceptance of reality – letting go**
   Beginning to accept that the person has gone and that it has affected you deeply. Talking realistically about them. the way they died, how you think and how you feel (phrases like…."I'm sorry to keep talking about his death, but it's helping me to sort it out in my head!")

5. **Testing** *Challenging the reality of what happened, what people said, what might happen in the future. With children it is particularly related to the consistency of the adults around them (phrases like…"Tell me again why she died?…..Could it happen to you?)*

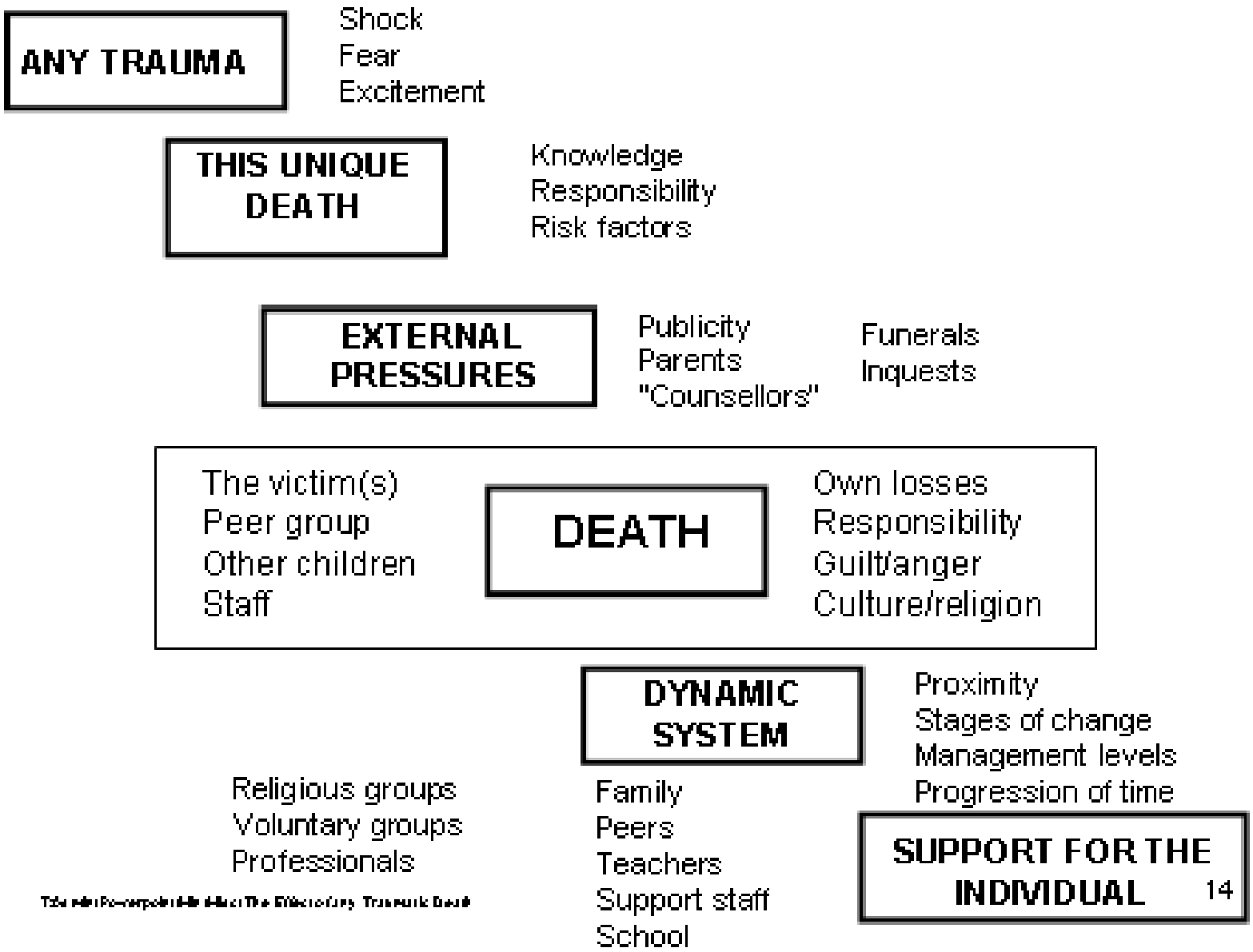
6. **Searching for meaning**
   Looking towards the future in realistic ways. Questioning possible new ways of thinking and behaving. Putting the loss into context and moving on.

7. **Internalisation** *Finally accepting the loss and being able to go forward with your life. The pain and sense of loss will still be there, but is usually only aware of it when something reminds you or precipitates it.*

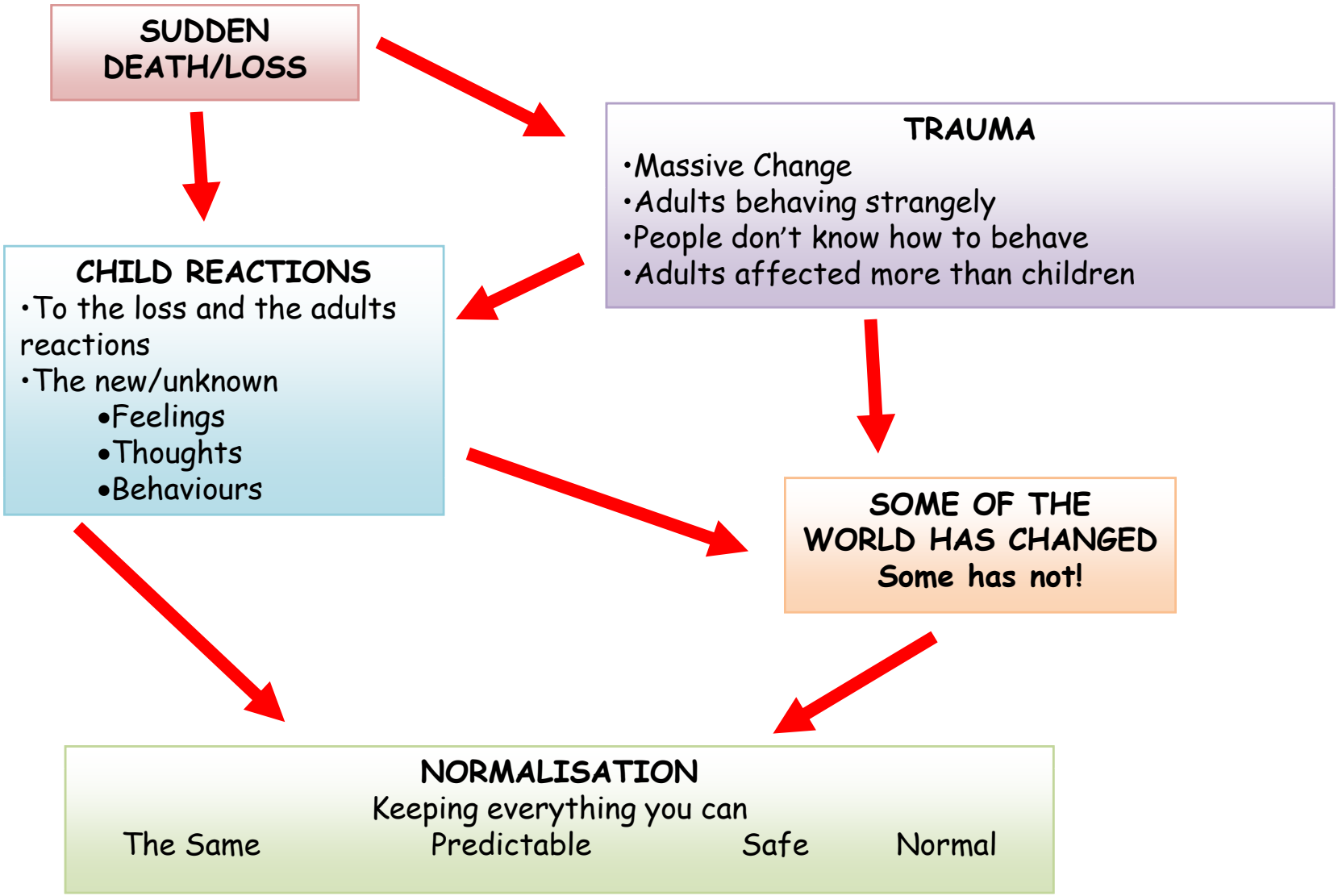
N.B. *The divisions between the stages are not clear-cut Individuals may stay at one stage for months or years, and may even "be locked" at a particular stage Most people gradually move forwards, with a few "slips backward".*

Min O'Hara
Educational Psychologist
2002

THE COMPLEXITY OF A DEATH IN SCHOOL


ANY TRAUMA
Shock
Fear
Excitement
THIS UNIQUE DEATH
Knowledge
Responsibility
Risk factors
EXTERNAL PRESSURES
Publicity
Parents
"Counsellors"
Funerals
Inquests
The victim(s)
Peer group
Other children
Staff
DEATH
Own losses
Responsibility
Guilt/anger
Culture/religion
DYNAMIC SYSTEM
Proximity
Stages of change
Management levels
Progression of time
Religious groups
Voluntary groups
Professionals
Family
Peers
Teachers
Support staff
School
SUPPORT FOR THE INDIVIDUAL

THE PROCESS FOLLOWING A TRAUMA



WHY GROUP SUPPORT IS THE MOST EFFECTIVE APPROACH

Why should we start with Group Intervention?

SUPPORT FOR INSTITUTIONAL TRAUMA

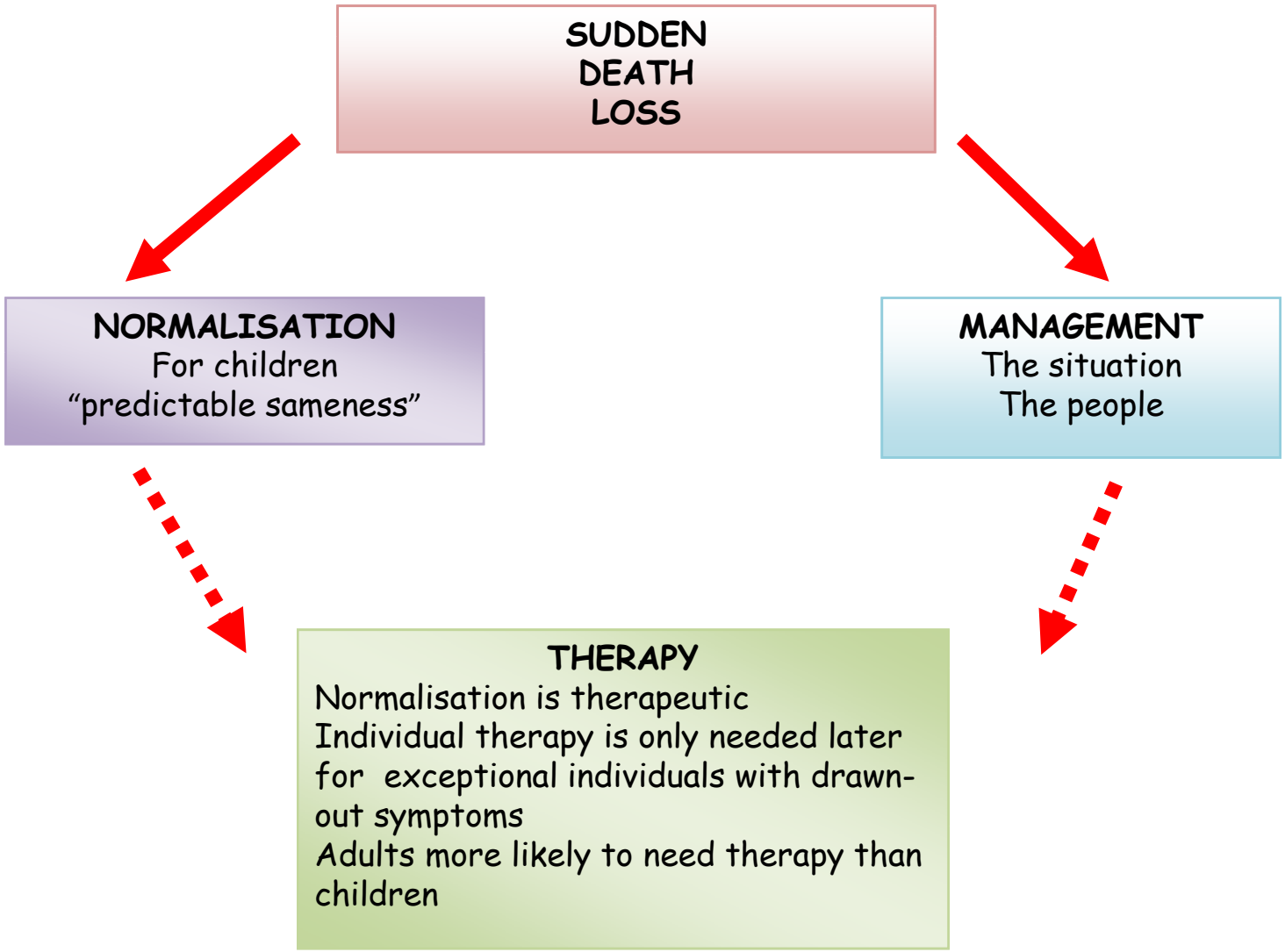
Unsuccessful Model of Intervention

Individual Treatment	**Possible Interventions**	**Outcomes**
Individual Staff	Personal counselling Professional support	Pathologise symptoms Become "victims" Feel themselves a "failure"
Individual Children	Individual treatment Provide confidentiality	Increase dependency "Individualise" the problems Increase "contagion" effect
Individual Parents	Provide support Listen and empathise	Validate criticisms of decision Separate from others
Group/Centre Effects		**LOSS OF COLLECTIVE FEELING** **INCREASE IN REFERRALS** **DISEMPOWERMENT** **MORE CASUALTIES FOR SERVICES TO TREAT**

Successful Intervention Model

Group Support	Possible Interventions	Outcomes
Staff	Awareness raising of change process Prepare and support for leadership Develop coping strategies They support children through change	Accept the difficulties faced Acknowledge their feelings Empower them as leaders They work collectively
Parents	Awareness raising Share coping strategies for change Indicate that treatment is available	Acknowledge and support Support the child in the family General advice not "hands-on"
Children	Supported by parents and staff Peer-support by de-briefing	Collective "problem" (not pathology) Increased empathy and care
Casualites will emerge (staff, parents, children)	Only after the above strategy	Individual treatment available MAINTAIN GROUP TO THE LAST LIMIT THE INDIVIDUAL DAMAGE DOES NOT PATHOLOGISE INDIVS REDUCES CASUALTIES

MANAGING SUDDEN DEATH/LOSS



Principles of Group Work

- What is a Group?
    - 2 or more people
    - 7 (plus or minus 2)
    - Each has its own identity
    - Overall “group effect” is greater than the sum of the people (Gestalt effect)
    - Need to conform (belong) is a powerful tool
    - Any Trauma will be an unique shared experience
    - The group has a life before and after the trauma
    - Children are likely to have a long-term shared association

- What is the Aim of Group Work?
    - To meet some of the needs of everyone
    - Not all the needs of any one individual

What institutional or group intervention looks like

MODELS OF SUPPORT FOR TRAUMATIC INCIDENTS

GROUP RESPONSES

TRAINING
preparing the staff
awareness raising

ACTIVATING
facilitating the leaders
empower and guide

PEER SUPPORT
psychological debriefing
mobilise group support

INDIVIDUAL RESPONSES

TREATING "CASUALTIES"

post-traumatic stress

counselling model

support the supporters

SUPPORTING THE SUPPORTERS

COMPASSION FATIGUE

prevention

treatment

The overall message to staff about supporting bereaved children (see booklets)

- Try to maintain the child's feelings of **security**, of being cared for, of being loved.
- Try to maintain all the necessary **practical care** for the child. (e.g. ensuring that they are eating, caring for themselves, sleeping etc).
- Keep up the **routines** (of home/and school) so that "life goes on", but be prepared to accommodate some outbursts or extreme reactions by providing "time-out".
- Be **honest** with yourself and the child (at the child's own level of understanding.)
- Continue to **listen** (even if the same questions reappear), to talk and communicate.
- Do **not pretend to believe** what you don't believe, about what has happened.
- Try to **understand the child's feelings** (as a child of their particular age) and reassure where possible that their reactions are perfectly normal.
- Don't be afraid to say '**I don't know!'** You can't be expected to have all the answers.
- Don't be afraid to **share your own feelings**, even if you get a bit upset. It will help to explain that adults also have these deep and confusing feelings (which we normally keep private).
- Remember there are **others who can help**. Find another adult to offload to on regular basis (i.e. a person who can listen, understand and comment) Supporting a child can be upsetting and emotionally very demanding, and it is very important to get this personal support.
- Don't be afraid to admit to colleagues, family and managers that **you can't cope** at any particular time.
- **Support** for you or the child can come from inside & outside agencies.

CONVEYING CALM AUTHORITY

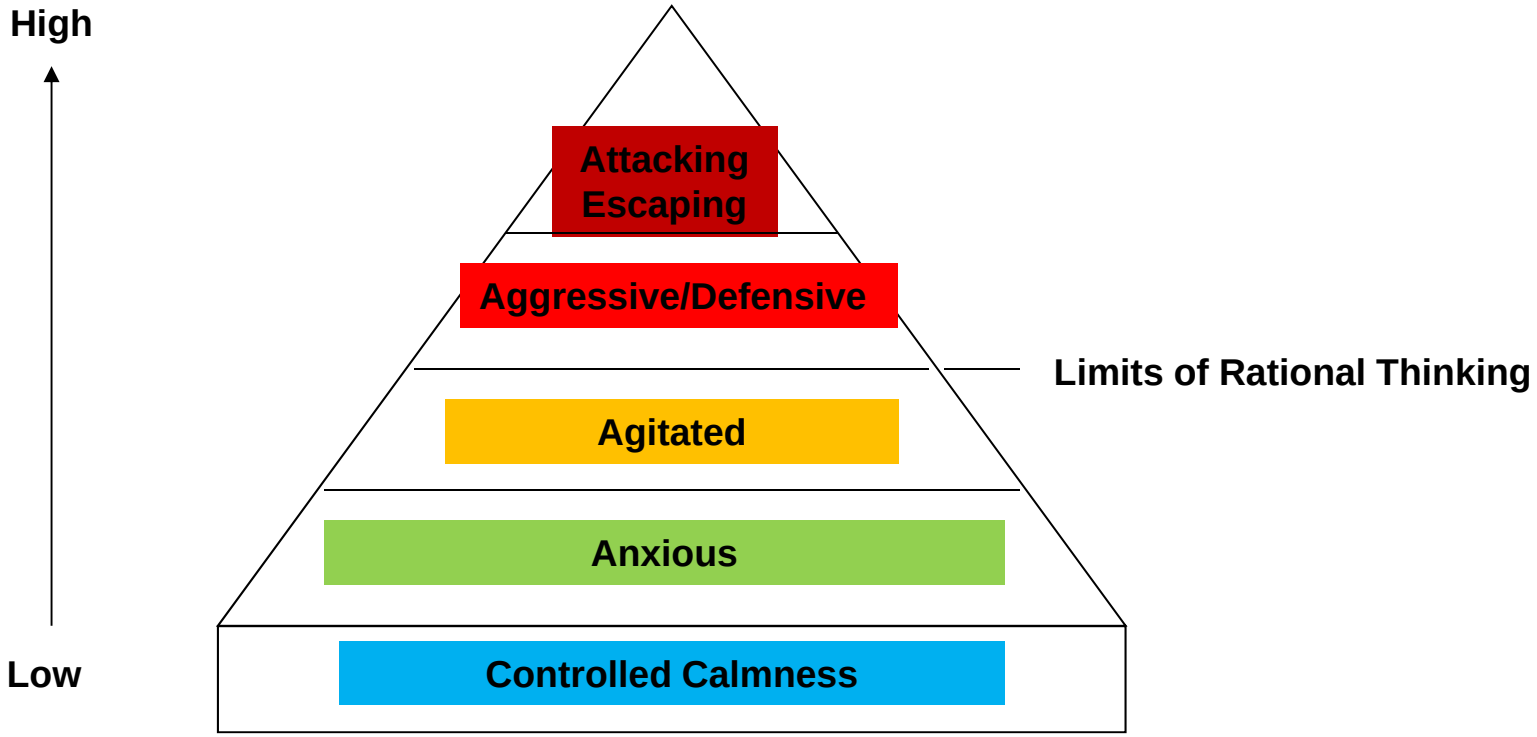
The “Conviction Test”

- People who “do trauma!”
- The “Trauma Buzz-Kid” overexcited enthusiasm
- The “Trauma Technician” academic distance
- If I were a Headteacher dealing with a critical incident – would this person be a convincing figure of authority and support?
- “Serene-authority” knowledgeable & trustworthy
- How to develop “CALM AUTHORITY”?

MODEL 1

CONTROL BY CALMNESS

STAGES OF AROUSAL



FEATURES

- Our behaviour changes according to our level of arousal
- At some point in the Agitated State – we stop being rational
- Our state of arousal fluctuates during a social interaction
- We can easily increase or decrease an individual's state of arousal

RESPONSES

- If we respond at a high level we will become irrational
- Self-control is essential in managing interactions
- Mirror the other person then decrease their arousal
- End the interaction when the person is attacking
- Concentrate on reducing the persons state of arousal

WHY DO RESPONSES NEED TO BE MANAGED?

(why are some demands unreasonable?)

- A first-response, intensive-direct-involvement leads to some naturally grieving individuals being pathologised
- Group facilitation is more effective than individual case work
- An open access system cannot respond equally to all requests
- There is a need for a filter (triage) system to identify the "most needy"
- There will always be a limit to capacity
- The demands of the presenter is not always related to the significance of the problem
- Presenters are often in a highly stressed (irrational) state
- There are often inappropriate expectations of what the service is capable of
- Many presenters want to pass the problem (rather than share the problem) to someone else

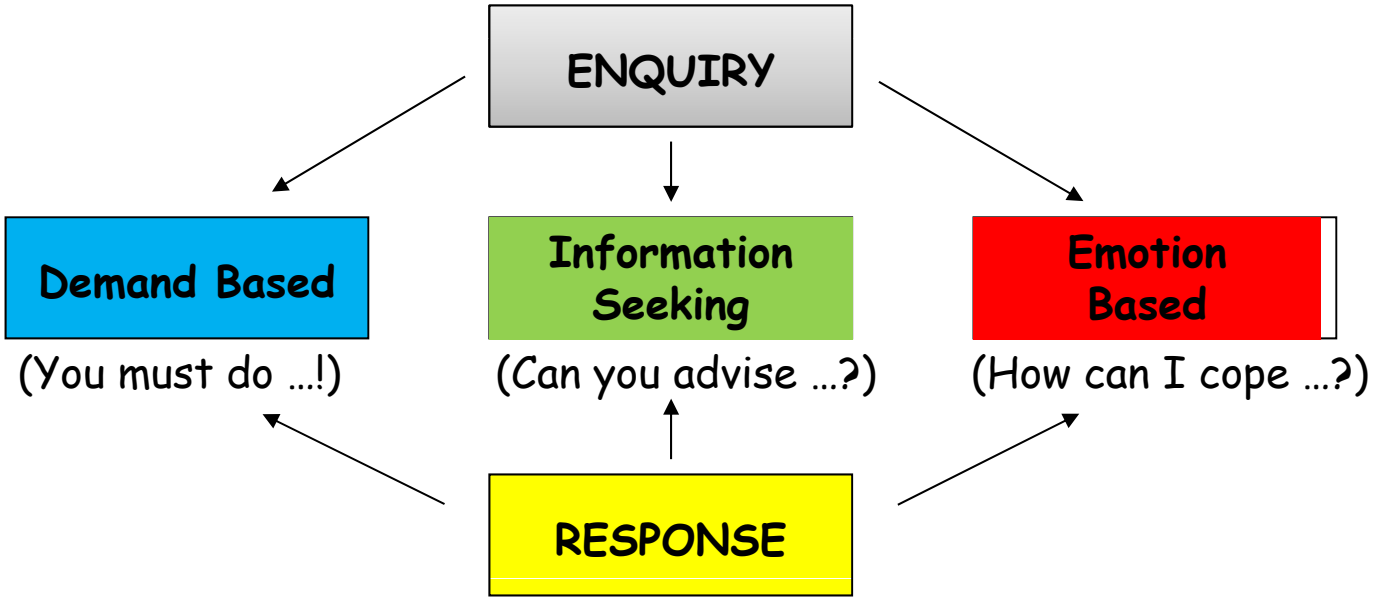
MODEL 2

SOLUTION FOCUSED MODEL

10 Principles of Solution Focused Approach

1. The problem is the problem – not the person
2. People have unique ways of solving their problems
3. People have the necessary resources to make changes
4. Small changes in any aspect of a problem – can initiate a solution
5. A focus on future possibilities – enhances change
6. Co-operation enhances change
7. If the person does not sign-up to the agreement – there will be no change
8. The possibilities for change are infinite
9. If it works – do more of it. If it does not – do something different
10. Keep one foot in pain – one foot in possibility

INFORMATION MANAGEMENT



PROBLEMS

- Not listening/responding to 3 areas
- Responding exclusively to 1 area
- Not shaping up the demand/enquiry
- Increasing the emotional (irrational component)

SOLUTIONS

- Responding appropriately to all areas
- Shaping up the enquiry objectively
- Acknowledging to but not responding at the same emotional level
- Giving specific advice which is manageable

THE SOCIAL SKILLS APPROACH

Background

John Robertson “Effective Classroom Control” shows:

Authority – is conveyed by “calm stillness”
Enthusiasm – is conveyed by “dynamic physicality”

Task

How do we convey “**Calm Authority**”?

- Separate yourself from the setting – being objective and de-personalised
- Talk sense – be knowledgeable about our subject (agree service principles)
- Your voice is an instrument
  - tone of voice
  - rate of voice
  - quality of language
  - timing & using silence actively
- Purposeful listening (i.e. what is most effective in local consultations)
  - listening interactively
  - listening before making judgement
  - clarifying
  - reframing
- Not taking the problem away
  - acknowledging the person has a problem
  - give achievable tasks/advice to produce minimal change
- Always give An Objective Judgement – not a personal perspective

THE CASE FOR PSYCHOLOGICAL DEBRIEFING

(CRITICAL INCIDENT DEBRIEFING)

Critical background to Psychological Debriefing

- Long history of Psychological Debriefing being used following major disasters
- Insurance claims USA from groups (e.g. bank clerks) who did not get debriefing
- Major critical article Cochrane Review 1998 – 2003
  Follow up of single session psychological debriefing
  - did not reduce psychological distress
  - did not prevent post-traumatic stress disorder
  - did not reduce depression or anxiety
  - absence of psychological model
  - not take account of individual differences
- Major critical articles in Clinical Psychology academic journals
- Ethical limitations of follow-up research in my own work
  - “Excuse me, have you got a problem?” (approx 250 children)

Critical background to Psychological Debriefing (cont)

- ‘Casualties’ come from individuals with ‘pre-existing conditions’
  - in population 5 – 15 years 9.5% will have a mental health disorder (Office of National Statistics 2000)
  - in population 11 – 15 years 11.2% will have a mental disorder
  - bereavement an issue in counselled children (70% had this as an issue Salford 1998 - 2000)
  - someone close dying most upsetting event (Salford Year 6 survey 1998 O’Hara)

- Facilitating Group Support (Min’s Model)
  - Atle Dyregov’s (leading European exponent) research and working practice
  - Mike Stewart Centre for Crisis Psychology (Skipton) international service
  - Abervan, Liverpool (post Hillsborough), Dunblane
  - Personal case work - traumatic deaths. Individual case work, school closures

- Significant positive feedback
  - being available and reassuring
  - separating ‘normal from exceptional responses’
  - emanating ‘calm-controlled’ aura

- Practice in the area leads to more interventionist approaches to family support

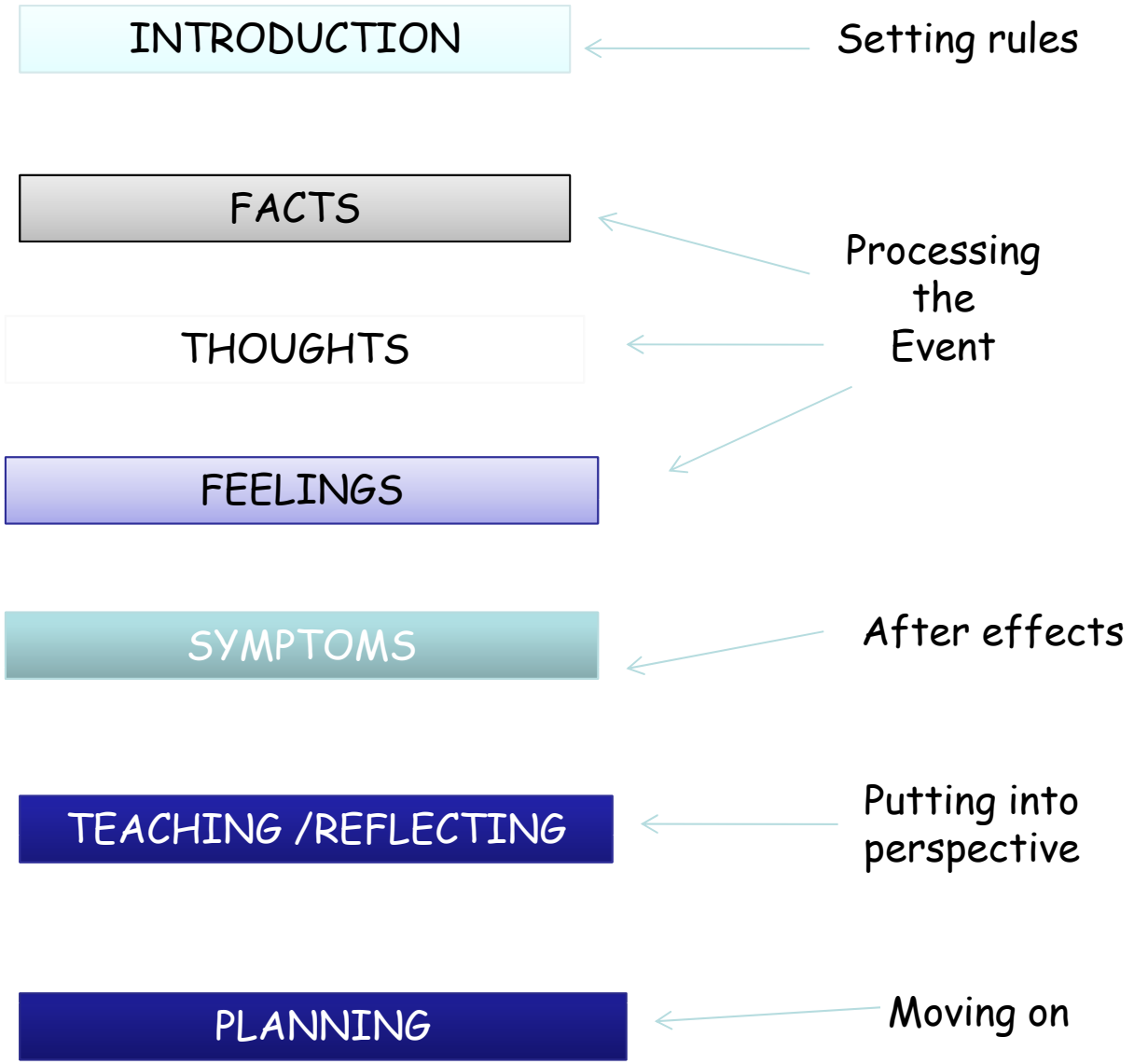
What is Psychological Debriefing?

PSYCHOLOGICAL DE-BRIEFING MODEL

This model has been developed from crisis and trauma support, as a way of helping victims start to make sense of what has happened.

It is also called cognitive re-structuring (or re-ordering) and by sequencing events and separating thoughts and feelings helps individuals deal constructively with the meleé of emotions which they are dealing with.

The framework is a useful one to de-brief anyone following an upsetting event, loss or separation.


INTRODUCTION
Setting rules
FACTS
Processing the Event
THOUGHTS
FEELINGS
SYMPTOMS
After effects
TEACHING /REFLECTING
Putting into perspective
PLANNING
Moving on

PSYCHOLOGICAL DE-BRIEFING FRAMEWORK

SESSION ONE (2 HOURS)

1. Introductory Phase
2. Fact Phase
3. Thought Phase
4. Reaction Phase
5. Symptom Phase
6. Teaching Phase
7. Re-Entry or Planning Phase

Stages of debriefing

STAGES OF DE-BRIEFING

1. Introductory Phase

Set the scene and establish rules of trust and confidentiality

2. Fact Phase

Establish a factual sequence of events, ie:

Before – During – After the Event

(What happened? – What did you do? – What did others do?)

3. Thoughts Phase

What thoughts did you have?

Before – During - After

4. Reactions Phase

During the event:

What feelings did you have?
What did it feel like for you?
What was the biggest reaction for you?

Stages of debriefing 2

5. Symptoms Phase

Since this has happened:

What has it left you with?
How has it changed you?
Have you noticed anything different about your behaviour?

6. Teaching Phase

Review each of the stages and put into context.

- Facts – give objective summary
- Thoughts – exaggerated by the stress
- Feelings – normalise and share with others
- Symptoms – made worse by internalisation
  entitlement to external support

Stages of debriefing 3

7. Re-Entry or Planning Phase

Runs naturally from the teaching phase.

- Identify and develop personal coping strategies
  - individual work
  - network

- Identify support system/techniques

- Identify any organisation changes
  - admin responses to the incident
  - protocols for future prevention
  - health and safety issues

- Closure
  - end the session
  - plan Monday morning issue
  - agree outcomes

DEBRIEFING The teaching components

STANDARD ISSUES

- Shared experience
- Lifelong effects
- Confusion
  - Facts
  - Opinion
  - Rumour
- Shared information now
- Value to talking/listening
- Changes in a sequence
  - Before
  - During
  - After
  - In future

The Shared Story
FACTS PHASE

UNIQUE ISSUES

- Reduce confusion
- Agree facts
- Develop responses
- Share responsibilty
- Reduce individual guilt

STANDARD ISSUES

- Extremes of reaction
- No correct way of behaving
- Can be extremely painful
- Everybody is different
- Will get "less bad"
- Talking & listening can help
- Group understands more 'cos of shared experience

Normalisation

THOUGHT PHASE
REACTIONS PHASE
SYMPTOMS PHASE

EXCEPTIONAL ISSUES

- Group support an individual
- Extra support as needed
- dealing with a special issue

Consolidated group identity
PLANNING/RE-ENTRY

STANDARD ISSUES

- Memories are precious
- They need to mark a "space"
- What are they doing collectively?

UNIQUE ISSUES

- Try not to interfere
- May suggest what others have done

CID Process issues

- 2 Group Leaders
    - Trust
    - Planning
    - Deal with group process & individuals
- Different organisational models
    - 1 Leader & 1 Facillitator
    - Turn Taking as Leader
    - 1 Leader & 1 Summariser
- Meet some of the needs of all the group
- Decide how and when to support individuals

Scenario to illustrate the debriefing process

Nursery Centre Staff Team

Billy had been placed in the nursery three months before, following a CAF initiated by the Health Visitor who was concerned by Billy's lack of progress, apparently distressed behaviour and the abusive nature of mother's latest partner.

It was decided not to put Billy on the Child Protection Register, but to place him at the nursery and to ask them to monitor his progress.

Staff had formed a good relationship with his mother, who was non-assertive, but willing to implement strategies about stimulation, language development and play skills. She regularly stayed and worked collaboratively with staff.

Her partner's contact with the nursery was sporadic and was "overly familiar" with the management and aggressive with care staff.

Billy had progressed in all areas of his development. There had been concerns three times during this period:

- when he had become withdrawn
- when his mother showed signs of being physically abused
- when he was kept home for a week with no real explanation.

Billy did not appear for a week and was discovered dead as a result of a severe beating.

HELP ME

TO GO THROUGH

THE MANAGEMENT OF A

REAL ONGOING

CRITICAL INCIDENT

CHRONOLOGICAL SEQUENCE OF SUPPORT

13 year old boy found
Hanging by his sister

Management support 2.
Sister's school

Staff team support 3
Mum's school

Whole school 1.
Support (his school)

Interview
of
Sister 8

Family
Support?
Parents 6
Parents & sister 7

DSH 4
Workshop

Debriefing 9
Group? ?

Debriefing 5
Group ?

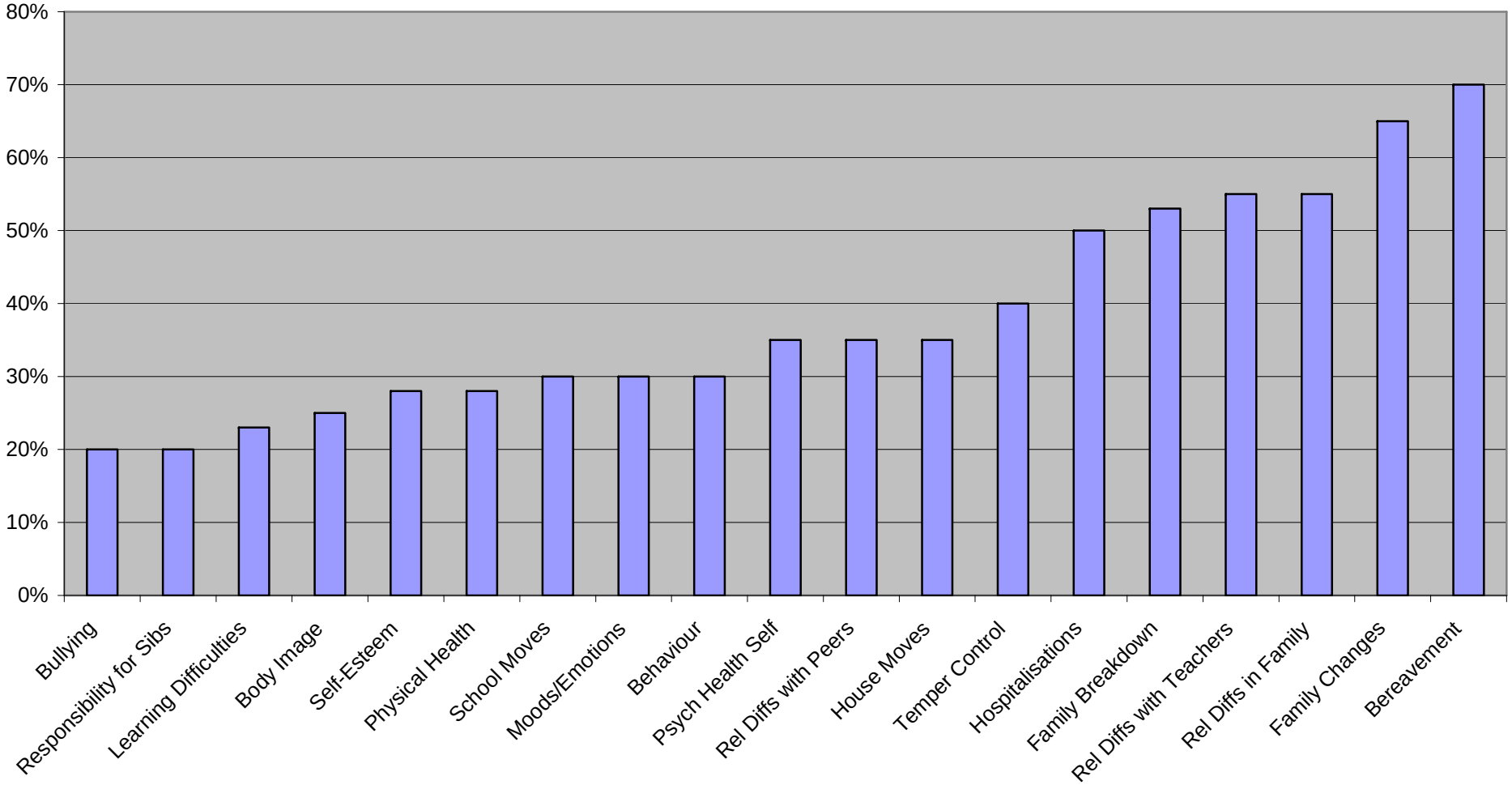
Circle of friends

Individual
Support? 10

Circle of friends

DEALING WITH "CASUALTIES"

Problems Presented by Children in Counselling - Salford 1998-2000



Post-Traumatic Stress

- **ASSESSMENT CHECKLIST FOR POST TRAUMATIC STRESS DISORDER**
- **CONDITIONS REQUIRED FOR PTSD TO OCCUR**
- * The Person **has experienced a traumatic event**.
- * They may be **re-experiencing** the event **for longer than a month afterwards**.
- * There may be **avoidance and numbing**.
- * The person has **increased arousal** during or after the re-experience.
- **Re-experiencing (the person repeatedly relives the event in <u>at least 1</u> of these ways)**
- **(**frequency found in the research is indicated in brackets)
- 1. Intrusive, distressing recollections (thoughts, images) (34%).
- 2. Repetitive playing out of experiences in children (23%).
- 3. Repeated distressing dreams (31%).
- 4. Flashbacks, hallucinations or illusions, acts or feels as if the event were recurring (39%).
- 5. Intense psychological distress in reaction to internal or external cues that symbolise or resemble the event (51%).
- 6. Physiological reactivity (e.g. rapid heart beat, raised blood pressure, hyperventilation) in response to these cues.
- **Avoidance and numbing (the person <u>shows 3 or more</u> of the following)**
- 1. Tries to avoid thoughts, feelings or conversations associated with the event (24%).
- 2. Tries to avoid activities, places or people concerned with the event (32%).
- 3. Inability to recall an important part of the event (12%).
- 4. Marked loss of interest or participation in activities which were important to the person (36%).
- 5. Feels detached or isolated from other people (25%).
- 6. Restriction in ability to love or feel other strong emotions.
- 7. Sense of foreshortened future feels life will be brief or unfulfilled (lack of marriage, job, children etc) (16%).
- **Increased arousal (<u>at least 2 of the following</u> which were not present before the traumatic event)**
- 1. Difficulty falling asleep or staying asleep (29%).
- 2. Irritability or outbursts of anger (23%).
- 3. Difficulty concentrating (41%).
- 4. Hyper-vigilance (25%).
- 5. Exaggerated startle response (28%).

Individual support approaches

- Supervision debriefing (task)
- Life Snakes
- With families

LIFE EVENTS IMPACT ON CHILDREN'S LIVES

Using Life Snakes to Explain

Home Life	Life Snakes	School Life
First child Traumatic birth In Special Care 2 weeks Difficult baby Bonding difficulties	**AGE** **0** **Birth**	
Not yet independent High level of attention-seeking	**Birth of sister** **18 mths**	
	3 yrs **Nursery placement**	Severe separation problems Major behaviour problems
Behaviour settled at home	**School place** **5 yrs**	Successful transition Close nursery/reception liaison
Disrupted family life Regression to earlier attention-seeking	**7 yrs** **Parental separation**	Short period of disruption Quickly settled to routine
Loss of home, friends Adjusting to new school Major behaviour problems	**8 yrs** **Change of home** **Change of school**	Major disruption Difficulties of adjustment
	11 yrs **Move to secondary school**	Gains in stability are lost yet again
	13 yrs **Drugs and delinquency**	Out of school peers group more important

Impact Intervention Model

FAMILY PRESENTING

WITH MAJOR ISSUES

Preventing accessing support services

Impeding/constraining their effectiveness as parents

Issues which overwhelm their thinking and behaviour

Leading to them being judged as unable/unwilling to help their children

These may be stated or implied

ED PSYCH NEGOTIATES

SHORT-TERM CONTRACT

With co-worker

With parents (both)

Openly stating purpose

Using detailed social history

Purposeful listening

Psychological debriefing

Motivational interviewing

Solution focussed

FAMILY CONTINUES TO

ACCESS SUPPORT

Formal system?

Extended family

Co-worker continues support

Ed psych acts as consultant

FAST – REWIND

A Technique to help Adults and Children to Control Flash-Backs

Child Suicide

- Is the death a suicide?
- The implications of suicide on the survivors (an aggressive act)
- The contagion effects?

Children's understanding of Death

- **Birth to Two Years**
  Do not understand the finality of death
  Can miss the presence of primary caregiver
  Will react to loss by crying, altering eating/sleeping habits
  Can become detached

- **Two to Five Years**
  Do not understand the finality of death
  Believe death is reversible
  Do not always have vocabulary to express grief
  Feelings may be acted out in behaviour and play
  May have an interest in dead things
  May ask some questions over and over again
  React in light of their own experiences of death

- **Six to Nine Years**
  Beginning to understand finality of death
  Believe death only happens to others
  Death is personified as ghosts or monsters
  Engage in magical thinking, and may feel they caused death
  Have strong feelings of loss
  May lack vocabulary to express feelings
  Often need permission to grieve, especially boys

Children’s understanding of Death (cont)

- **Nine to Twelve Years**

  Understand finality of death
  Have curiosity about the physical aspects of death
  Have vocabulary to express feelings, but often choose not to
  Need encouragement to express feelings
  May identify with deceased by imitating mannerisms
  May have short attention spans

- **Thirteen to Eighteen Years**

  Have an adult understanding of death
  Can express feelings, but often choose not to
  Philosophise about life and death
  Search for meaning of death
  Death affects whole life – school, home, relationships
  May appear to be coping well when they are not
  Are often thrust into role of comforter
  Participate in dangerous behaviour like drugs and alcohol

GROUP ROUNDUP

What impact has this exercise had on you personally?

Did it meet your initial objectives?

What parts are you going to use in your work?