APPENDICES

I. **Hungerford Reflections**

II. **A Menu of Post-Disaster Methods**

APPENDIX I

HUNGERFORD REFLECTIONS: LEARNING AND NEW QUESTIONS

The following themes emerged from the reflections on my work after the Hungerford massacre and its repercussions. At the time, many of these were tacitly held at the time and my work in the years following, and especially once I had joined CARPP, involved bringing them into full awareness, checking out their quality and gaining a deeper understanding of them and their causes.

- **The Gap:** There seemed to be a yawning gap between the people affected by the disaster and those who offered professional and lay support, indicating the difficulties attached to both giving and receiving help of any kind. Many affected people and disaster staff were very resistant to asking for help and felt ashamed to admit they were affected by the disaster
- **Children's needs**: These were forgotten, diminished, disbelieved or managed insensitively. Those who spoke on their behalf were equally marginalised by others.
- **Strength of secondary reactions:** People affected by disaster found that secondary reactions, for example to the reactions of other people and repercussions such as inquests, could be harder to handle and understand than primary stress reactions.
- **The creation of difference:** Disaster quickly polarised attitudes. Reactions and emotions were diverse and strongly held.
- **Victmisation of victims:** Some victims were victimised further
- **Rivalry:** Judgements, blaming and jealousies were quick to surface, within and between communities, within and between agencies.
- **Memorials and Funds:** Fund distribution and decision- making about memorials activated particularly strong emotions for at least ten years and brought out feelings that had previously been repressed.
- **Bizarre behaviour:** The disaster brought out unpredictable behaviour in some people, especially if already vulnerable. Even stable people could feel they were going crazy and as if their worlds had been turned upside down. This was seen in small ways more than in dramatic behaviour, for example in how people related or reacted to others at work, home or phone calls received by officials from the public. Examples of dramatic behaviour included a policeman who tried to rob a bank and the young men who suddenly realised they were mortal and left their families 'to enjoy life while they could'.

- **Quickly forgotten by others:** People outside of the disaster community soon lost interest and had little appreciation of the facts, complexity and the depths of the real experience.
- **Convergence of attention:** A lot of help converged on the most identifiable victims – in the first instance the dead and bereaved, in the second a few of the injured. The wider disaster community tended to be ignored, as did the fact that a large sector of the community was under siege for many hours, not knowing what was happening outside.
- **The ripples of disaster:** these spread further and more deeply than could be measured or imagined.
- **Official v. grass-roots discourse:** The official public discourse about the disaster often differed from the grass-roots version of events and the experiences of front-line disaster rescue and care staff
- **Broken promises**: the promise of 'no expense spared' lasted about a week and assurances that current work could be suspended and 'red-tape' cut were forgotten within a month or so when the next statistical returns or dead-lines were due.
- **Varying measure of quality:** Judgements on the performance of disaster workers could be contradictory, according to the position of the person making them
- **The Middle Manager's dilemma**: Being a middle manager and mediator between the community and bureaucracy was a very uncomfortable position, akin to being a nut in a nutcracker.
- **Disaster: one or many?:** A disaster was not just one finite event in space and time, experienced by everyone in the same way. It contained many experiences, many voices and many stories in the community affected by the disaster. Some of these were given privilege over others, thus setting the scene for future problems
- **Pace of work:** A different style and pace from normal work was needed by professionals dealing with disaster as they needed to be responsive to changing information, needs and resources. They often had to step outside usual work roles and slow bureaucratic processes had to be by-passed. This was also true to some extent for Emergency Services who were not used to working with death and horror on such a large scale.
- **Disaster work changes lives:** the work had a massive impact on rescue and care staff. It changed lives and, in a few cases, precipitated death.
- **Disaster disrupts organisations:** Just as the disaster affected whole communities, not just individuals, disaster response work had a major impact on the wider staff team and organisation, not just on individual staff working directly in the response.

- **Organic v. mechanical approaches:** The concept of working with process was not well understood. Concrete solutions and fixed tasks were wanted immediately before thorough assessments of the situation and needs had been made.
- **Organisational hierarchy of importance:** This was marked amongst the agencies involved in the response. The emergency services and parts of the medical profession were at the top with social services and clergy leading the helping professions. Services working within the community such as Health Visitors, Youth Workers, Librarians and Teachers were not seen as having a specific response role even though they were in contact with far more people in the affected community.
- **Not a disaster just for Hungerford alone:** Services tended to be concentrated in the community where the main events occurred in Hungerford, even though many people involved came from elsewhere and did not feel they had access to services. They felt excluded because they did not live or work in the town.

From these observations, **three questions** formed and have been developed throughout my research, which in turn has been fuelled by my search for answers:

1. *"How can the gap be bridged between the disaster community and those with experience and expertise?"* This stimulated subsidiary questions such as *"How can the people in the wider 'ripples' of the disaster impact be reached?"* and *"How can the stigma of accepting help be broken down?"* In particular, *"How can children, young people and other marginalised groups be offered support?"*
2. *"How can the human impact of disaster be managed in a way that does not create further trauma and stress to the community and disaster workers?"*
3. *"How can I make sense of my seemingly illogical reactions as a worker, not a direct victim, and how do these compare with others caught up in disaster in many different ways?"*

APPENDIX II

A MENU OF POST-DISASTER METHODS

The following is a list of methods that I can draw on in my post-disaster work. However, rather than using single methods, there is a need for a strategy of choices used in a timely way. I have made a distinction between methods designed for individuals and those designed for groups, organisations and communities. With the proliferation of methods promoted on the internet, sorting out the choices can itself be a major source of stress for people.

RESPONSE METHODS FOR INDIVIDUALS

Any type of post-trauma support tends to be popularly described as trauma counselling, but this term covers a confusing range of responses. Counselling and therapy in their true sense (on-going therapeutic relationships with an agreed contract) are not usually appropriate immediately after a traumatic incident but may be invaluable later. Whatever method is used, there should be an agreement with the client so they are clear about the aims of the method, what they want to achieve and the emotional depth to which they will work. Clients need to understand that there is a process to be worked through, often using a range of methods, and it will not always be comfortable if real work is to be done. The methods described below, taken from a leaflet I use for clients, are those generally available in non-medical settings.

Group 1: Immediate and Medium- term Methods for Individuals

Immediate crisis response methods. Immediately after an incident, the 'Void' phase of the Trauma Process model, methods aim to construct 'safe' gathering grounds. They focus on:

- the most important practical needs of clients for survival in the immediate future.
- making the person safe physically and emotionally
- the here and now and the next immediate step
- finding a metaphor to connect the event to the past and the future

Spontaneous expression of feelings will be acknowledged but help will be given to calm and control overwhelming emotions. Deeper or hidden feelings will be left alone. Ensuring the client is safe and has access to other support is paramount. A simple, brief **defusing** procedure may be used which is brief, direct and focussed on helping

the client regain full control of their own decisions and choices. Acute symptoms may require medical help.

Preventative education and problem solving: Once the client has reached a position of some personal control and vision of 'the next step', then they may benefit from sessions that give them time for reflection and information, support and encouragement to develop coping strategies and learn about other support agencies. A balance has to be struck between building coping and safety while dealing with on-going repercussions and processing the incident and past unresolved trauma that is fuelling them. Preventative education is often given to parents, teachers and carers as a means by which children can be supported in the crucial early days after an incident when beliefs and behaviour can become fixed.

Telling the story: A client may want to explore their experiences of the disaster by telling their story. This is done in a safe setting to a person who can cope with the horrors and trauma within it. For some this will be all they wish to do, but telling the story without gaining some insight or taking action is seldom enough.

Processing the story (sometimes called stress 'debriefing'): There is a lot of confusion about the term debriefing because it is often used wrongly for work with individuals rather than staff teams. There are many ways for processing the story, some have rigid protocols, some use a more flexible approach. Essentially they help the client:

- tell their story by giving a framework, such as a set sequence of questions
- identify and acknowledge their emotions, without in-depth exploration of them
- mobilise their existing coping strategies and support network
- learn new coping strategies
- formulate some action for personal or other change and learning.

A follow-up session to check progress should always be arranged. Further sessions or referral for more specialist treatment may follow. Non-verbal methods have been devised for work with children and people who do not want to tell the story verbally.

Other processing methods – the 'power' trauma methods: These reduce, anticipate and manage the flashbacks and distressing reminders of the incident**.** Several new techniques, the 'power therapies', deal with specific trauma symptoms

such as recurring images. These need to be given within a therapeutic process to be fully effective.

They attract criticism from some people and adulation from others. The effectiveness of the following therapies has been documented by Deitrich et al, (2000):

- Traumatic Incident Reduction (TIR, www.tir.org), a method of telling and retelling the story in great detail (Gerbode, 1995 & www.tir.org)
- Neuro-linguistic Programming (NLP) techniques such as the visual-kinaesthetic dissociation 'rewind' method (Bandler and Grinder, 1979, Andreas & Andreas, 1989. & www.nlp.org)
- Thought Field Therapy (TFT), a method devised by Roger Callahan using tapping on acupressure points (Callahan, 2002 & www.thoughtfield.com)
- Eye Movement Desensitisation Reprocessing (EMDR), an information processing method stimulating right-left movements using eyes, sound or touch to change negative into positive images (Shapiro, 1995 & www.emdr.com). www.mailer.fsu.edu/~trauma)

Group 2: Long-term Methods for Individuals

These are usually used if self-help and other early response methods are insufficient. Reactions may have been complicated by other past or current stresses and the on-going repercussions of the disaster.

Counselling and psychotherapy. There is much overlap between these but counselling tends to help people solve problems within their existing belief system while therapy goes much deeper and allows an investigation of underlying beliefs and assumptions, like reprogramming the hard drive of a computer. Some styles of counselling and therapy appeal to those who like a rational and systematic approach (such as cognitive-behavioural therapy) and some to those preferring a creative, spiritual approach.

Medical referral. Medical help through a referral to a clinical psychologist or psychiatrist may be a useful adjunct, or next step, to therapy especially for clinical conditions such as depression, mental illness or addiction. A residential environment may help complex cases or cases of alcohol or drug dependency.

'Power Therapies' (e.g. EMDR, NLP, TIR) described earlier may be used for dealing with persistent stuck images and perceptions.

Work with young people. Children and young people may benefit from an indirect approach where other physical and creative activities such as play, drama and art act as mediators for their distress or where education and support is provided to a co-ordinated network of parents, teachers and other carers.

RESPONSE METHODS FOR GROUPS

These may be undertaken in conjunction with methods for individuals.

Group 1: Immediate and medium-term crisis response methods for groups

Group Defusing: a rapid procedure usually used in work situations after distressing work to encourage peer support and ensure a safe journey home. It helps detect acute reactions.

Group processing or debriefing: this provides a forum, usually for staff teams, to ensure that everyone has the same facts and a common understanding about an incident. It is NOT therapy but can act as a base from which other help can proceed. We use the style of debriefing most suitable for the group and the needs of the situation, or the CCME version called Critical Incident Review and Action.

Work with children and young people, especially school-based work: Response strategies can be devised to reach these groups using existing systems in established institutions such as schools and youth organisations, if their community has been affected by an internal or external disaster.

Group 2: Longer-term methods for groups

Group therapy: requires commitment to a group and usually operates over at least 6 sessions. It may be available in community settings but is more often found in mental health centres. Some groups are residential but only a few exist in the UK, including one for complex trauma sufferers at The Priory Hospital, Ticehurst House, East Sussex.

Family therapy: therapeutic work with families, as a group and with individuals.

Grief Camps: usually for children and teenagers using group work combined with traditional youth work methods through which children are helped to deal with their reactions and problems while having a lot of fun with children in a similar position to themselves. Camps are backed by individual and family work and sessions for parents. They are usually run by charities with links to Health and Social services

COMMUNITY BASED METHODS

These are methods for promoting a healthy recovery environment in communities and other systems.

Self-help or special interest groups: There are many forms of self-help trauma and bereavement groups and groups linked to different types of trauma. Disaster Action (www.disasteraction.org.uk) is an umbrella group for self-help groups linked to specific major disasters.

Community methods building on existing strengths and structures to create community information and support systems to encourage a healthy environment in which recovery is supported. These have been described in section D4:237-8.