
Working With Those Who Have Experienced Sudden Loss Of Loved Ones

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Abstract

People are almost always changed by the traumatic events they face during their lives, but they need not be damaged by those events.

That's how I like to begin my Disaster Mental Health (DMH) presentations to audiences that want to learn more about crisis intervention with victims of disasters and other traumatic life events. Much of this material is drawn from my 1995 book, *Disasters: Mental Health Interventions*, (and revisions to it for an upcoming, expanded second edition), from subsequent chapters in other books (see references), from journal articles, and from my Internet web site – <http://ourworld.compuserve.com/homepages/johndweaver>. This is copyrighted material and it should not be reproduced without proper consent.

Many mental health professionals are adept at diagnosing and treating pathology, but have little idea how to work with trauma victims. In fact, given their “diagnosis and treatment” orientation, many assume the worst outcomes (everyone will get PTSD). Few have learned how to use two of the most significant types of DMH intervention we can offer – defusing and debriefing. Fewer still are comfortable working with people that have grief and loss issues as their primary focus. Those with DMH experience often need to quickly familiarize untrained volunteers with basic DMH principles. Beyond that basic orientation, there is often a need to review tips specific to the best ways to interview victims/survivors, particularly in situations that involve sudden death and mass casualties. Here are some guidelines intended to help all emergency service and disaster workers who might face the task of offering support to persons who have experienced sudden loss of loved ones.

LESS IS MORE (KEEP IT SIMPLE)

This may initially strike some of you as a ridiculous notion, but your mom has probably already taught you many of the main skills you will need in order to be effective in the early stages of DMH intervention. There are many parallels between what moms do when their children get a boo-boo and what we do in defusing and debriefing. For instance, think back to one of those many times you fell from your bike (or somehow had gotten other bumps and bruises) and you sought help from mom (or dad, grandma, grandpa, etc.). Whoever it was doing it, his or her intervention probably began with two simple steps - a hug and a simple question - What happened?

As you got yourself composed and began to tell the dramatic details (the defusing or debriefing), mom would be working with you to clean out the wounds. In many cases, what she was doing was actually making it hurt a little more, in the short run, as soap and water, peroxide, iodine, or Bactine were used to get the messy stuff out and set the stage for proper healing. After the first time or two, you knew it would hurt worse while being cleaned yet you trusted the process. At some level you probably began to realize it needed to be done as soon as possible and it needed to be done right the first time, or there would be worse problems and pain later on.

Mom's work was serious stuff done in simple ways. The key elements of her role were:

1. To listen and get the story out (What were you trying to do?), which served as a nice distraction for her work in step #2.
2. To be sure the wound was properly cleaned and to patch it up.

3. To offer perspective (You could have gotten yourself killed!) and teach valuable lessons about how to avoid similar scrapes in the future (Next time, stop and look both ways!).
4. To consider whether or not you needed a time-out (or rest period).
5. To relieve the emotional pain and offer the support and guidance needed to get you safely back into play (or your other normal routines).

What she said during this encounter was not as important as her calm manner, her ability to listen, and her reassurance. Once it was over, mom was probably an emotional wreck, especially if the potential had been there for a worse outcome. She probably called a friend or went outside and chatted with a neighbor - her peer support - to get her own defusing or debriefing session.

But, mom's work was never done. She had to remain alert and be watchful at all times. Is he climbing in that tree again? Did she look both ways? Is the gate locked? She was your protector - a guardian angel. She could stay out of the way, in the background of your life, but be available for you to check-in. She needed to be there, especially in the early years, for times of danger that may require her to step in. Charles Bruder (1995) presented a paper at the APA Annual Convention in New York on a very similar DMH concept that he dubbed the psychological lifeguard.

Bruder's presentation grew out of his work with recovery efforts following the 1994 crash of US Air Flight 427 near Pittsburgh, PA. There he discovered the value of being able to hang back and let emergency personnel do their jobs while keeping a keen and watchful eye open for signs that some are experiencing difficulties considerable enough to compromise their abilities... (p. 17). Keeping this watchful eye, DMH workers can then step in with crisis intervention and support services as needs arise. With these parallels in mind, let's take a more detailed look at defusing and debriefing.

SUDDEN LOSS REQUIRES A RETURN TO BASICS

All DMH approaches tend to begin from a conversational base using strong active-listening skills. The best way to make people aware of your interest and concern is by attending to what they are saying. In fact, establishing eye contact is often enough to have the stories begin to pour out.

Sound too easy? Just think of how many times you have managed to get details of peoples' lives while you were waiting in the checkout line at your favorite grocery or department store - unsolicited information, but you somehow got it anyway, without even asking for it. Just by looking at them, you managed to open a door and allow ventilation/communication to begin.

Use reflection, paraphrase, and ask open-ended questions that will draw out more detail about the things people have mentioned. Be empathetic, and validate the feelings others are expressing. When speaking, be both self-assured and reassuring in your comments and your delivery. Try to vary your voice tone and inflection. Clarify what others are saying, focus your attention, and check your perceptions of what is being said with the person's intended meanings.

Share hope and encouragement, and your belief in the strength and resiliency of the human spirit. Take care, however, not to convey the message that the person must also feel "strong" and "hopeful". Coming across as too optimistic in the presence of acute pain can give the message that you don't want to hear or cannot tolerate the person's present suffering.

Take your time when starting a conversation. Use small words and phrases at first until you have established that the persons to whom you are speaking are properly able to understand your questions and assimilate the information you have to offer. They may need to think and reflect for a moment before giving an answer. Remember, if others are still in shock, their thinking will be slowed and rather concrete. They may become lost in conversations they formerly would have easily understood.

Everly and Mitchell (1999a) offer this list of communication techniques that are essential to developing an effective approach to crisis interviews:

- Silence - avoid intrusion and facilitate uninterrupted catharsis;
- Nonverbal Attending - monitor body language;
- Restatement - check and clarify terms and listening accuracy;
- Paraphrasing - summarize main points of conversation;
- Reflection of Emotion - mirror and acknowledge emotional reactions;

- Open-end Questions - what, why, how, describe, tell me...; and,
- Closed-end Questions - where, when, did, can, should, could, ... (pp. 41-43)

While the use of these techniques will get most people talking, they urge caution with non-communicative persons (and persons who decline opportunities to talk). If they appear to pose no danger to self or others, it is often best to leave them alone. If, on the other hand, you sense trouble, stay close by and monitor how they are doing.

But let me repeat that, in sudden loss and mass-casualty situations, **LESS IS MORE!** Begin with this fundamental premise:

There is nothing you can say or do that will quickly end the shock, ease the pain, or make survivors feel better...

But there are lots of things you can say or do that can make them feel (or act) worse!

Examples: I know what you're going through or Everything is going to be fine. Either comment may seem innocent enough, yet these types of comments often result in an angry response.

Many times Passive Listening is the best approach – use attentive silence and keep responses to a minimum. Overreaction on the part of the listener may be counterproductive to cathartic ventilation. By speaking too much, responding too quickly, or falling into any of the other nervous interviewing patterns, the novice or nervous DMH worker often shoots himself or herself in the foot. The next section gives you an idea about one such pattern of helper behavior that is often counterproductive.

HOW DO YOU FEEL? (DON'T ASK!)

When survivors are ready to talk, there is no way to avoid getting their feelings. Still, I frequently see well-meaning, novice DMH people try to begin their conversations with the quintessential question, **HOW DO YOU FEEL?** (or some similarly intrusive variant that goes straight for victims'/survivors' gut feelings). Following the July 17, 1996, TWA Flight 800 crash off the coast of Long Island, hundreds of well-meaning, untrained DMH volunteers assaulted survivors with that same question. Volunteers who are only available to serve for a short time are often impatient – wanting to make something meaningful happen during their short time on the job. In their eagerness to be

helpful, however, they quite likely are turning people off.

How do you feel? is often perceived to be the stereotypic psychobabble that TV and movies use as shorthand for all mental health counseling. It is also the same bluntly intrusive question many media representatives use to get their 15-30 second sound bites of traumatized people in pain. Avoid it! There is no need to go abruptly and insensitively after the feelings in any counseling situation, let alone one as sensitive as sudden death scenarios. Once you begin opening up a dialogue about the facts, the feelings will follow, with you rarely needing to ask for them.

SOME POSSIBLE TALKING POINTS

Rather than go for feelings, try these useful talking points to help you guide the conversation:

1. When did you and your family get the news of the death(s)? (awakened; called while away from home)
2. Was support available to you when you got the news?
3. How were you notified? (who told them)
4. Who else did you have to notify? (especially check for children and grandchildren)
5. What have you learned about the circumstances of the death(s)? (gory details; fears person suffered; body fragmentation)
6. What must you do next? (prepare to travel; gather records to help with ID; etc.)
7. Is there someone who can help you with those tasks? Would you like to call them now? (or, if the person is very overwhelmed, would you like me to call them for you?)

If time allows, you may want to continue with the following questions. Don't get into these areas if your time is limited, because you may have to end the conversation while the person is discussing some difficult feelings.

1. What was the nature of your relationship with the deceased? (close or distant; friendly or quarrelsome)
2. What happened during your last contact with lost loved one(s)?

If the last contact was not a positive one, try to take them back to another one that was positive and work with them to establish that as the lasting, final memory. If the relationship had been destructive or abusive, this will not be possible in a brief conversation. Acknowledge the fact that the relationship was destructive or unhealthy, and that grief and bereavement may be complicated for the person. Don't be afraid to suggest a referral for counseling or psychotherapy to help the person with a complicated bereavement.

In our contacts with coroners, government agencies, relief organizations, etc., emergency services and DMH personnel often get more information than may initially be made public. Sometimes you may be able to add factual information to what survivors have been told by others, before they hear it (or read it) from the media. Factual information can often be comforting to survivors. DMH personnel may also assist survivors in obtaining information from official agencies. For example, in recent airplane crashes the Red Cross DMHS team has provided support to survivors when they attend the National Transportation Safety Board's daily informational briefing sessions for family members.

OFFER EDUCATION ABOUT WHAT IS TO COME

Coming to terms with and restructuring lives in the wake of sudden death involves major changes. The next few pages contain a handout that can help to educate and support survivors on the rough road that is ahead.

This paper was originally presented as "Working with Sudden Death Situations in a July 6, 2000 teleconference call presentation to the National Center for PTSD & Readjustment Counseling Service (Bruce Hiley-Young, moderator)

ABOUT THE AUTHOR

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Psychology Department of Northampton Community College, both in the Lehigh Valley, PA. In addition to his direct-service work, noted above, Weaver is a founding partner of EYE OF THE STORM, Inc., a private consultation and education group practice specializing in disaster mental health, crisis intervention, and risk management related training and support. He served as a DMH consultant to Operation Help (the FEMA crisis counseling grant program in PA resulting from the January '96 blizzard and subsequent flooding, FEMA-1093-DR).

Weaver received his undergraduate degree in Psychology from Moravian College, Bethlehem, PA and his Masters Degree in Social Work from the University of Pennsylvania, Philadelphia, PA. Throughout his career he has written several articles and two books. He recently served as an expert reviewer for crisis management guide for schools. Weaver is frequently is invited to present seminars and papers at national conferences in social work (including NASW '90 in Boston, '95 in Philadelphia, and '96 in Cleveland), psychology (APA '95 in New York), counseling (ACA '96 in Pittsburgh and '97 in Orlando), and nursing (ACAPN '97 in Philadelphia).

He has been an active volunteer with several organizations including the Mental Health Association and the American Red Cross (ARC). Weaver currently is ranked as a DMH Coordinator and has assisted at several local and national disasters including service during the Great Mississippi River/Midwest Floods of 1993, the 1994 airline crash in Pittsburgh, and the 1996 airline crash in the Everglades. He is also a volunteer DMH instructor for ARC and travels the country several times each year to help teach their two-day classes and expand the level of preparedness. In recognition of his service to the organization, ARC has presented him a Clara Barton Honor Award for Meritorious Volunteer Leadership. Weaver is donating half of his royalties from *Disasters: Mental Health Interventions* (1995, Sarasota, FL, Professional Resource Press; phone 1-800-443-3364) to the American Red Cross National Disaster Relief Fund and his publisher, Larry Ritt of Professional Resource Press, is matching his donation.

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To view more information about DMH and disaster preparedness, see Weaver's Internet web

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