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# Darkness Over the Abyss : Supervising Crisis Intervention Teams Following Disaster

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Abstract

This article suggests another way of understanding the experience of the victim and the helper and the fantasy of omnipotence related to the 'magic touch' of parenting evoked by the interrelationship of helper - parent; victim - child. Understanding the experience of the encounter with the' darkness in the face of abyss' may help to explain the powerful psychological effect on the helper, once they get in contact with the abyss and the dark. This in turn may be a partial explanation of compassion fatigue .

## Psychological and Methodological Innovation in Supervision.

The term "compassion fatigue" was suggested by Figley (1995) as an alternative to the earlier concept of secondary traumatic stress disorder (McCann 1990). Both terms describe the influence on mental health professionals of the therapeutic encounter or intervention with victims of disaster suffering PTSD.

Here, I will attempt to document observations from my experience in crisis intervention and in supervision of professional helpers1 who are involved in intervention

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[1] Helpers in this article refers to psychosocial team members intervening in crisis/disasters.

immediately after and following a disaster with victims of emotional trauma. The purpose of the article is to offer new understanding to the phenomena looking at it from a dramatherapeutic perspective, that is the lack of differentiation rituals protection and initiation ceremonies and metaphoric myths. I shall also use psychosocial and anthropological explanations to aid the understanding of these phenomena. These reflections are based on my observations as a supervisor of professional helpers soon after their contact with victims and survivors of disaster and their family members, as well as my personal involvement in such incidents. Let us first look into the term compassion fatigue and what it entails.

In compassion fatigue, symptoms resembling the physiological, emotional, and cognitive symptoms of victims appear among those who administer help to them. In 3% to 7% of cases, these may be so severe that the professional helpers themselves develop PTSD, with all its long-term implications (Hodgkinson & Stewart 1991).

The subject of emotional burnout among mental health professionals has been widely researched (Freudenbeyer 1974; Maslach 1982; Maslach & Jackson 1981; Pines 1993). This literature describes a continuous process of burnout, composed of three principal components: emotional, physiological, and mental (Pines & Aronson 1988). However, while burnout develops gradually, there are advance warnings, and it is expressed in emotional fatigue, irritability, difficulty in concentrating, and other physiological and mental phenomena, compassion fatigue may appear suddenly, with no previous signs (Figley 1995). In addition, Figley (1995) notes that, unlike mental burnout, here there is a strong sense of helplessness, confusion, a feeling of being cut off from support, and psycho- somatic symptoms similar to those of survivors or victims. However, recovery is also usually very speedy.

The term ‘compassion fatigue’ was first coined by Joinson (1992) and later adopted by Figley. Webster’s New Collegiate Dictionary (1989) defines ‘compassion’ as ‘sympathetic consciousness of others’ distress together with a desire to alleviate it’.

**WHO ARE LIKELY VICTIMS OF COMPASSION FATIGUE?**

Figley (1995) indicates two major components that lead to compassion fatigue: empathy and exposure. Without both empathy and exposure, there is a low probability of developing compassion fatigue. In principle, according to Figley and other researchers, work with trauma victims (survivors, family relations, and the injured) subjects helpers and those engaged in intervention to extremely forceful exposure to trauma-inducing factors. This vulnerability is attributed to several causes:

1. Empathy is a central instrument in helping and assessing injury and planning the intervention program. Harris (1995) claims that empathy is the key factor in the ‘penetration’ of a traumatic event among crisis counsellors.
2. Most of those involved in intervention have experienced traumatic events in their lives. Because those who administer help after trauma cope with a variety of events, at some time they inevitably encounter some that are similar to the trauma in their lives.
3. The helpers may have unresolved traumas of their own.
4. The encounter with children in trauma has a particularly strong effect on the helpers (Beaton & Murphy 1995).

Janoff Bulman (1985, 1992) talks about trauma as being a collapse of the structure within the personality which provides a sense of control through awareness of lawfulness in the surrounding universe and self. Such collapse is usually a result of a direct threat to one's life or equivalent. But it may come about also when witnessing someone else's catastrophe, and even more so when investing empathy in the fate of the afflicted individual.

**UNDERSTANDING THE VULNERABILITY OF DISASTER HELPERS**

The following discussion is based on my own observations as supervisor and interventionist and discussions held with professional helpers, who offer psychosocial intervention in Israel (Tel Aviv, Jerusalem, Kiryat Shmona), and the former Yugoslavian states and Northern Ireland.

**INABILITY TO PREPARE OR TO SET THE STAGE**

Disasters usually take place without prior warning. They can happen at any moment, anywhere, and to anyone. Massive, intense penetration of the event into our lives (including direct television broadcasts from the disaster site, voices and primary witnesses) immediately exposes helpers to the disasters that they are meant to go to. Their daily ability to control the setting and the staging is shattered as they are been called to act without appropriate “warm up”.

Until the Gulf War in 1991, most civilian mental health professionals did not have much direct and immediate exposure to real-time disaster situations. First of all, the approach was that psychosocial helpers met the victims at emergency relief centres**,** or in the clinic or in rare situations they were asked to help families at the cemetery or in their homes. In other words, there was a physical distance from the site of the disaster. Second, as telecommunications technology required a studio, it took time to broadcast a disaster, not to mention print a paper, and thus helpers were spared some of the most upsetting immediate sights. Ethical limitations adopted by the journalists associations, as well as almost absolute government control over electronic media, also prevented some of the pictures from being broadcast. Thus professional helpers working with trauma victims were exposed at a distance of both time and place, limited almost exclusively to descriptions of the horrors by the victims with whom they worked or to written reports and photographs in newspapers or on television.

After the Gulf War, it was decided in Israel that civilian mental health professions (social workers and psychologists) would also come to the scenes of disaster and work according to Salmon's (1919) principles of frontline treatment which were later rephrased by Artiss (1963) as "Proximity, Immediacy, and Expectancy" (PIE), which had been adopted many years earlier by the Israel's defense forces mental health units (Noy, 1987, 1991, 1991a). The idea was that immediate intervention, close to the site of the event, including conveyance of expectations for recovery, would reduce the incidence of posttraumatic stress disorder (PTSD) among victims, survivors, witnesses, and family relatives. This idea was empirically verified for soldiers in the war in Lebanon, 1982 (Noy et al., 1986; Solomon et al., 1986). The psychosocial team was also expected to support the rescue workers. This intervention, which was meant to take place alongside or at the end of the rescue operation, exposes psychosocial helpers to the horrific sights of a disaster on a much greater scale. Furthermore, the CNN model of electronic media, of reaching the site of the event, quickly setting up equipment, and broadcasting live without editing (made possible by modern technology) also became prevalent.

Thus, a situation in which the caregiver who comes into contact with victims in both physical and temporal proximity to the disaster is exposed even before reaching the area to the sights and sounds of the horror. He or she has often 'seen' and 'knows' more than the victims themselves. This almost 'real' exposure of the helpers prior to even being on site, makes even minimal distancing difficult and leads to an immediate identification with the survivors' descriptions not as a listener but as an equal and sometimes more informed partner, with pictures of the event bringing arousal of strong emotions. This increases the degree of empathy, identification, and assimilation of the event by the helper. The fact that these scenes are being broadcast over and over again are often described by helpers as having a semi-hypnotic effect on them drawing them to look at it over and over again. Much like a nightmare the pictures keep coming at them and make them feel as if "they were actors /participants and sometimes 'invisible' survivors of the same incident".

**LACK OF ADMISSION RITUALS AS BOUNDARY - DEFENCE FACTORS OF COMPASSION FATIGUE**

In the daily routine of a mental health professional, there are several rituals that enable differentiation and protection against the penetration of loaded or morbid information into his or her life. These rituals are very helpful in the process of "getting into role". An important ritual is the 'intake', the first stage of contact with the client. In terms of the roles played, it is a ritual of differentiation where the therapist is playing an inquisitive role and the client responds. It is meant for the purpose of setting a clear boundary between them.. *The ritual of acquaintance may or may not be limited in time; they may spread over one or more intake meetings. However, even if there is only one such meeting, the helper's study of the material (after the client has gone home) helps him or her conceptualise the client's problems and thus differentiates between the helper and the client.*

No less important is the ritual of setting of the time – an element that is usually in the sole control of the helper even if the needs of the client are taken into account when scheduling the time, still it will be in the time span that the therapist work (ie normal office hours) and during the week working days. In this ritual, the helper controls a central component, namely, the length and time of the meeting. A related ritual is that of'50 sacred minutes'.

Of similar importance is the ritual of the place. This is totally in the control of the helper. It is usually his office and this territory was designed or at least partially decorated by him thus making it to his or her territory. There are also other rituals such as greeting and saying good-bye.

Immediate intervention in a disaster precludes the use of these rituals. There is no time for an in-depth anamnesis; on the contrary, the professional literature indicates that historic connection with the immediate distress (acute stress reaction, ASR) situations are counterindications of recovery (Witstum 1989). Thus a central mechanism of the differentiation process is eliminated.

Neither does the helper decide where the intervention will take place. Today secondary interventions may begin near the incident site, at the mortuary as happened in Israel since 1995 and lately in Northern Ireland in the Omagh massacre, August 1998. It may include visits to grieving families in their home, neighbourhood, or in the victims' school.

Even the length of the "performance" that is a crucial aspect of every play is undefined. The work shift can be 18 and more hours. Sometimes the intervention takes days with meetings every day or even several times during the day and the work is always very intensive.

Kfir (1990) suggests in the time close to the event, daily encounter with the victim/s, sometimes for several hours. Thus availability of helpers and intensity of

contact without the appropriate rituals exposes them more forcefully to the intensity of the disaster.

**Geographic Proximity and Psychological Proximity (The Lack of Distancing)**

Psychosocial crisis helpers are often called upon to provide intervention at locations that are geographically close to their place of work or residence. This proximity creates immediate identification and a sense of being a 'near miss', – they could have been the victims, yet they are called to help. This makes it very difficult for the helpers to maintain distance from the event and its immediate threatening significance to themselves and the wellbeing of their dear ones. Because the site is the helper's natural setting, going home may expose the helper time and again (that is even when the event ended) to the scene and experience. It thus may weaken the defence mechanism by continuously reminding him that 'this could have happened to me'. This is called geographic proximity.

Similarity between the victims or their relatives to the helper's life and sometime to his or her peer group or family is called psychosocial proximity and this can also create great difficulty. For instance, the disaster at the Dizengoff Shopping Centre, (Tel Aviv, Israel, April 1996) and the disaster at Apropos Cafe (Tel Aviv, Israel, March 1997) occurred in areas that were familiar to most of the helpers. The victims were similar in age and socio-economic status to those who came to help them (in the Dizengoff Shopping Centre disaster the aspect of injury and death of children, increased vulnerability and in the Apropos cafe the victims were three social workers– friends of the helpers).

Thus the possible similarity between the helper and the victim, considering the random and chance occurrence of the disasters and the geographic proximity noted above, reduces the important aspect of distance and creates greater chance of identification with the victims, and absorption of their story as "part of me".

**The Penetration of the Victim's Story, Identification and Countertransference**

Identification and countertransference are well-known aspects of the therapeutic process, which have been discussed widely, both in training and supervision of therapists in general and crisis interventions as well. However, as explained here, when in contact with disaster victims these two phenomena raise particular intensity and take a heavy toll on those providing intervention.

In their work routine, mental health professionals make a point of coping directly with transference either by direct confrontation with the client or through other ways of processing it. However, when helpers meet with a survivor (or family members) who say 'you remind me so much of my son', or 'you are like a relative to me', it is

difficult for them to deal with it or work through it as transference. In fact, it is typically reported that this is like ‘a blow at the soft spot of my stomach; it makes me feel significant to them, on the one hand, and places a tremendous emotional burden on me, on the other’. The helper goes along with it trying to fulfil a fantastic (countertransferential) role of family member or friend.

The emotional burden of identifying with the victim is often expressed in the development of intense, deep relations with the survivors, victims, and their families. It is expressed in frequent home visits and telephone calls beyond the scope of the intervention or therapy; the helpers explain that ‘it is so important to them; they need me so much’.

This phenomenon is related to a concept which Lifton (1967) calls ‘the imprint of death’. The survivor, victim, or family member becomes very attached, like an imprint, to the image of the first ‘lifesaver’ they happen to meet. The helper goes through a similar process of clinging to the victim. It is often expressed in undertaking tasks that he or she does not usually do for clients, such as spending irregular work hours with the victim or deviating from work definition such as calling all sorts of agencies on behalf of the client. Also there can be great difficulty parting from the victims, family members, and survivors and they may do all sorts of ‘little services’ for them.

Other expressions of the identification process are the development of physical symptoms similar to those suffered by the victims, such as physical pain or intense anger toward institutions, organisations, and service providers with whom these professionals usually cooperate. Some helpers report dreams about the event or about the victims and their families, as well as difficulty in concentrating and apathy toward daily life (phenomena similar to grieving and mild depression).

**How Soon Does Compassion Fatigue Develop?**

I have seen it developing within hours. Helpers are exhausted yet refuse to go home saying or at least thinking, “I can’t leave these people now I am so significant to them. They will not be able too make contact with someone else.” Alternatively, helpers will find themselves calling the families on the phone to see how they are despite the fact that they have just seen them for a few hours and the regular worker has already taken over the case.

On other occasions helpers disclose to me that they became so attached to the family there wasn’t a single day without them visiting the family “just passing by to say hello”.

In one incident the helper, a very experienced social worker learned at the mortuary that the family had just moved house and as it happened did not have any furniture in their living room. When she discovered it was close to her son's flat she took the furniture from there and brought it to the family "just for the seven days of mourning".

However, the most common symptoms are those of physical aches, pains and changes in appetite, sleep disturbances, moods, loss of interest in daily activities and most of all, the routine workload of the office.

These symptoms resemble very much the phenomena of 'combat fatigue'. That is, it develops quickly and the physical and emotional symptoms generally pass after three to four days, although full return to routine often takes longer.

**Humpty Dumpty, the Savior Myth or Understanding the Compelling Urges to Put All the Pieces Together Again.**

*Humpty Dumpty sat on a wall*
*Humpty Dumpty had a great fall*
*All the King's horses and all the king's men*
*Couldn't put Humpty together again.*

The wish to put Humpty together again is a great example of the hero or saviour's urge to help but not just intervene but to reassemble the pieces and put them exactly as they were, anew. This phenomenon definitely plays a major role in the compassion fatigue but what is the 'interplay' between Humpty and the king's men-the helpers?

Disaster creates a sudden break in our continuities and shatters the sense of lawfulness which enhances our sense of control over the world (Janoff-Bulman, 1985, 1992; Omer & Inbar 1991; Winnicott 1971). These continuities are the bridges that we build for ourselves in order to ensure that yesterday will predict tomorrow, that we are stable, that life is logical, that the world is a decent, logic, safe place, and that good people may expect good things happening to them.

Disaster breaks our faith in a good world and confronts us suddenly with chaos. Typical reactions are: 'I don't understand what is happening' (cognitive continuity); 'I don't know myself' (historical continuity); 'I don't know what to do, how to act here, what it is to be a bereaved person/an injured and wounded person' (role continuity); 'Where is everyone, I am so alone, where are my loved ones?' (Social continuity).

In my experience, I have found that two contradicting thoughts run through the minds of victims:Consider the following statements coming from survivors: '*This is a nightmare – any minute now I'll wake up and see that everything is as it was'*; and

*'This will only get worse; this is the end, it is horrible, it is a disaster, it hurts more than any pain.'* Because the disaster is real and has actually occurred, the first thought fades quite quickly and the victim often enters catastrophic thinking that everything will become worse.

The tremendous need for someone from outside to organise the person, to anchor him or her in reality, to take him or her somewhere safe, often leads some victims to cling on to the caregivers with very strong emotional and physical force (the death imprint), and like Humpty to project the verbal and non-verbal existential message "help me, tell me it is not true, put things together again".

In parallel, the helper has a similar experience. On the one hand, there is tremendous commitment, with a sense of mission and a desire to help, based on the belief in his or her ability and power 'to put things together again - to stitch it up' (omnipotence); on the other hand there is a feeling of worthlessness. This can be represented as follows:

**Victim:** This is a nightmare, There is nothing to do

. soon I will wake up It will only get worse.

**OMNIPOTENCE < - - - - - - - - - - - - - - - - - - - - - - - - ---> IMPOTENCE**

**Helper:** I can help; This is so terrible. There is

I am very significant. no point. I am insignificant.

The victim projects expectations of omnipotence on the helper, who is a sort of parent figure, and this meets the helper's fantasy of being an omnipotent parent. Valent (1995) uses the term 'attachment', I call it the parent's 'magic touch', comparing the contact with survivors to a parent's calming of a small child who has been hurt. An 'adaptive attachment', crying and a call for help, lead to calming down the need for help by satisfying needs (hugging, kissing, physical contact). The unification with the attachment figure creates a sense of security, satisfaction, and relief. Rutter (1991) claims that ethological theory correctly predicts that stress should enhance attachment behaviour.

According to Valent, attachment can also be directed to a father or any member of a group, and it operates among adults who too feel their vulnerability. It is the universal experience of the parental 'magic touch', the pain relieving kiss and hug of a small child, that in my eyes trigger the helpers' fantasy of omnipotence. Devora Omer, an author of Hebrew children's books, describes this phenomenon in a poetic way. She called her story, "The Kiss that Got Lost", telling about the phenomena that once the mother's kiss was found, it enchanted crying child and pacified him. This experience is closely connected to attachment and in my mind is at the basis of many

a helper's fantasy of the ability to bring things back to where they were. Unfortunately this phenomenon disappears when the magic of childhood ends and even then, when facing trauma or disaster it often does not work.

The victim who projects such great helplessness, pain, and suffering 'looks' to us as helpless as a small child. The fierce desire to protect activates the fantasy of omnipotence related to the experience of the parent's 'magic touch' and makes the helper feel omnipotent. However, the failure of the 'magic' in the encounter with the disaster victim is liable to make the helper feel helpless, empty, and self-doubting. In the literature, this experience is referred to as impotence versus omnipotence. For years I have been involved in emergency intervention and this term always seemed inadequate to me until one day I realised why.

**The Darkness Over the Abyss - A Metaphoric Understanding of The Helper-Victim Interplay.**

In his recent book on traumatic stress, van der Kolk (1996) includes a chapter on the 'black hole of trauma', in which he presents the description of the experience of exposure to traumatic incident as being pulled into a black hole. In my encounters and observations of disaster victims and their family members.I have also often heard metaphoric descriptions, such as 'I am falling into a black hole', 'I feel as though I am diving into a black abyss', 'I am surrounded by black', or 'it is like an endless hole'.

Several years ago, when reading the Book of Genesis I had a very profound experience and suddenly had an insight as to what is this darkness over the abyss. The darkness that so many victims of traumatic incidents experience describes their plea for a glimpse of light, hope and recovery. If we look for a minute at the description of the experience of the encounter with "chaos" as described in Genesis 1:2:

*"And the earth was without form, and void; and the darkness was upon the face of the deep"…The continuation in verse 3, "And God said, 'Let there be light'".* And then, God starting making order in the chaos by separating between sky and earth, etc.

The experience of chaos described by so many victims is well depicted by the encounter with abyss and darkness. The sudden break in the continuities that the disaster victim experiences increases the feeling of destruction of the order called chaos in Genesis. This is the experience of the victim, the survivor, and family members described earlier. The helpers are not at that distance as they are 'stand at the edge of abyss, peeking into the eyes of darkness'.

Peeking into the darkness at the abyss involves not only a sense of impotence. I believe that it is also an existential confrontation with immortality, fear of death and injury, and concern for one's loved ones, values and beliefs.

Further study of Genesis tells us about the establishment of order and the elimination of chaos, lending further insights into the dynamics between the helper and the victim. According to Genesis 1:3, in the confrontation of the darkness and the abyss, there is a need for an omnipotent entity to bring the light. In other words, it is the encounter of the victim with chaos that triggers his/her plea for the omnipotent and to beg for light and in my view, visa versa. The helplessness and chaos nurture the omnipotent urge of the helper. There is a fascinating dynamic of the 'omnipotence' of the helper, which grows stronger through the needs of the victim, a dynamic that makes the helper want to bring light, however weak and dim it might be. Because the task of creating light is a task for the Almighty, the Omnipotent (and therefore not possible for a helper), the question arises what then, is the role of intervention?

Study of the process of the biblical creation of order led me to the realisation that since the creation of light is beyond our power, perhaps to 'restore order' by starting from the end, in other words to be 'human' first. It seems to me that this maybe is a clue to the help that we can give the victim, namely: in the beginning (of the encounter with the victim) first and foremost you need to be a compassionate person, not all-powerful.

It is interesting that when the term PTSD was first introduced in DSM 3 (1980), the authors used the concepts of disorder, which is parallel to the Latin term chaos. Therefore, perhaps inadvertently, they coined a concept that describes the chaos that arises as a result of the encounter with a traumatic event. Sometimes it remains with the victim, his/her family or survivors forever. So, I believe that we are talking not only about impotence but maybe on a much broader experience, our human vulnerability.

**Supervising the "King's Men" or, How Can Helpers Be Helped?**

Literature from throughout the world (Harris 1995; McCammon 1995; Pearlman 1995; Mitchell 1985; Dunning 1988; Dyregrov & Mitchell 1992;& Shepherd 1994) and from Israel (Shacham 1997; Lahad & Ayalon 1997; Klingman 1991) describes a number of approaches to helping helpers in order to protect themselves. Most of these mean either structured procedures like the CISD (Mitchell, 1985), supervision or spontaneous recovery. These approaches can be classified according to the multidimensional BASIC Ph Model (Lahad 1993):

**B** Belief – belief system, hope, self-esteem, locus of control

**A** Affect – direct or indirect emotional expression

**S** Social – friends, role, family

**I** Imagination, creativity

**C** Cognition, logic, realism and cognitive techniques

**Ph** Physical – physical activity, relaxation and activity

Of course, some of the recommendations relate to more than one category. The beliefs and value system is related to giving the event a new meaning, cultivating the belief system that has been injured, finding meaning in suffering (Ayalon & Lahad 1990; Frankel 1970; Lahad & Ayalon 1994; Perlman & Saakvinte 1995 ; White 1990).

Affect refers here to encouraging speaking, ventilation, and legitimisation of direct and indirect emotional expression after the event (Dyregrov & Mitchell 1993), Lahad & Ayalon 1994.)

The social aspect includes social support, taking a role, belonging to the organisation (Ayalon & Lahad 1990, Mitchell 1993, Elraz & Ozami 1994). Hodgkinson & Stewart (1991) emphasise one particular role and that is the role of the team leader as manager of the event, the one responsible for emotional health and physical needs of the team.

The person responsible for work schedules referrals for rest, the organisation of talks, provision of official recognition of the effort and helping create distance.

Imagination refers to the use of creativity, acting, guided imagery, relief, and distraction (Lahad & Ayalon 1990; Breznitz 1983, Shacham & Ayalon 1997 Moran & Collers 1995).

The cognitive aspect refers to preparation of the staff in advance for what may happen, updating them in the course of the process, guidance and problem solving, use of prepared programs and the CISD(Mitchell & Bary 1990; Lahad & Ayalon 1994; Binyamini 1984; Cherney 1995).

In the physical aspect, the focus is on physical activity as a stress reliever, resting, sleeping, and using relaxation and proper diet (Kfir 1990; Figley 1995).

**Multidimensional Supervision in-Vivo - Accepting the Fact That the Pieces Can Not Be Put Together Again**

I met these nine helpers a few days after they had been involved in a disaster. This was their third incident in the past five months. All of them had been through CISD sessions, but the group showed signs of fatalism, tiredness and apathy. Some were in constant contact with individual and families of previous disasters despite the fact that it was not their official role. Some were manifesting anger and discomfort,

but all were very dedicated to their role as helpers and continued to report at any incident.

The atmosphere at the start of our meeting was a combination of“ He (me, the supervisor) will solve all our problems “ and “What can really be done – it is a hopeless case”. I immediately registered in my head the parallel processes between them and their clients moving on the continuity between despair and omnipotence.

I decided to start with movement (they have talked enough) putting on the different sides of the room the words: Hope, Despair, Fear, and Courage. The instructions were to move around the room and whenever they neared the signs either to stop or reflect to write or draw anything, or make a movement or a sound.

Then I asked each of them to choose one of the corners and meet the other members that chose the same place. (If anyone found it difficult to choose a place s/he was encouraged to find a position between the two signs depicting the feeling at that moment). Everyone found a corner except for one person who positioned himself between courage and despair.

The next step was to communicate for about five minutes without words(signs, sounds, and movements) the feelings, thoughts, sensations that this corner brings up. Then they were to share two to four sentences each, making a joint lyric or prose and stage it as a choir. They had to decide on the rhythm tempo or use a known melody. This took about half an hour.

Then they were asked to perform the outcome and whilst watching and listening to write down anything that came to mind or any image or sentence they liked from that performance.

The mood in the group shifted to the Ph, S and I; that is active social and imaginative, but still many tears were shed, even at that stage.

When they were asked to share what happened, some said that the poems and moreover the melody or rhythm put them in touch with their impotence. Dark, darkness and dark colours were very apparent in the images and words. A few members were in tears talking about the permission to grieve. They said that the poems and moreover, the time they were by themselves but still with others gave them for the first time permission to express sorrow and grief publicly. The helper who was in between the signs talked about impotence and inability to choose; he cried and laughed at the same time and when asked to share that, he said: “crying is about my own loses in life, laughing is the relief to be able to share that without fear”.

The next session was opened by reading the poem from *Alice in Wonderland*. They all knew Humpty Dumpty but did not connect it to their experience. The purpose of bringing the poem was to look into their need to put all the pieces together, how

frustrating and impossible task it is, and all their anger toward the ‘king’ who in their mind expect them to put Humpty together again.

They were encouraged to take different roles and experiment with different inner and outer dialogues. For most of them it was the first time they realised the impossible role they were putting themselves in, the need to fix things for others, their fantasy of replacing the irreplaceable and the enormous pressure it put on them. The ‘king’ was demystified and there followed great attacks and expressions of anger and frustration were directed at the ‘king’ who expected so much of them. The last part of the session was a guided imagery leading to a meeting with Humpty Dumpty and sharing with him what I can and can’t do for him”. Sharing these thoughts in the form of a letter was the end of the session.

The third session was dedicated to re-entry, to sharing skills or activities useful in order to reduce symptoms, feelings or other bothering issues.

We put a huge basket in the middle of the room and asked each one to write on a separate piece of paper one thing that still bothers them. Each one could put as many papers as s/he wants.

Then we asked them to take a paper from the basket randomly and react to it, passing it to the next person to add ideas. If anyone took out his/her own paper they could either respond to it or put it straight back. However when the paper finally came back to them, they were to keep it.

This was a very busy session, but at the end many of the ‘problems’ received some ideas and answers, some in the form of cognitive advice, others with practical ideas yet some ‘just’ with words of comfort and support.

Then the participants were encouraged to either keep the ‘answer’ or ‘throw it away, get rid of it by symbolically throwing it to the garbage or destroying it and saying goodbye to it.

Only three out of nine participants opted for the second option. We concluded the session by talking about ‘compassion fatigue’ and how to prevent it. Training the participants in self–relaxation, ended this last session.

**Summary**

I have tried here to characterise what happens to helpers who are involved in intervention at times of disaster. These thoughts are based upon my personal experience, observations, and discussions with professionals whom I supervise and guide.

I have pointed to components related to the absence of professional defence rituals, the event’s penetration into consciousness through media exposure, geographic and psychological similarity between those performing intervention and

their clients. I have also noted the phenomenon of the death imprint and its influence on the helper.

By studying chapter 1 of the Book of Genesis, and consideration of the concept of chaos, I suggested another way of understanding the experience of the victim and the helper and the fantasy of omnipotence related to the 'magic touch' of parenting evoked by the interrelationship of helper - parent; victim - child. Understanding the experience of the encounter with the 'darkness in the face of abyss' may help to explain the powerful psychological effect on the helper, once they get in contact with the abyss and the dark. This in turn may be a partial explanation of compassion fatigue.

Finally, I have used the multidimensional BASIC Ph model to classify the methods that have been found effective in helping care givers to reduce compassion fatigue and demonstrated it with an example of group supervision. Naturally, these are only initial suggestions, and as far as I know, the first attempt to use creative methods in supervising crisis intervention teams and to use a dramatherapy approach in this context. These ideas need to be followed up and further researched. However they do provide insights that I believe give us a direction for understanding and coping with the incidence of compassion fatigue.

## References


American Psychiatric Association. (1980) *Diagnostic and Statistic Manual of Mental Disorders*, 3rd Ed. Washington D.C.

Artiss, Kenneth, (1963). Human behavior under stress, from combat to social psychiatry. *Military Medicine,* 128, 1011-1019.

Ayalon, A. & Shacham, A., (2000). Helping the Helpers: Teaching the salutogenic approach to colleagues coping with war trauma. In Klingman, A., Raviv, A., Stein, B., (eds.), C*hildren Under Emergency and Stress: Characteristics and Psychological Interventions. Jerusalem, Israel,* Ministry of Education, Service for Psychology and Counseling. (Hebrew).

Ayalon, A. & M. Lahad (1990). *Life on the Edge*. Haifa: Nord Publishers (Hebrew).

Beaton, D.R. and Murphy, S.A. (1995) Working with people in crisis: research implications. in Figley, Ch. (Ed.) *Compassion Fatigue*. New York: Brunner/Mazel.

Binyamini, K. (1984) the psychologist in the field tent: Introduction to professional camping. *Israeli Journal of Psychology and Counseling in Education*, pp. 35-54. ( Hebrew).

Breznitz, S. (1983) *The Denial of Stress*. New York: University Press.

Cherney, M. (1995) Treating the "Heroic Treater".in Figley, Ch. (Ed.) *Compassion Fatigue*. New York: Brunner/Mazel. pp.131-149.

Dunning, C. (1988) Intervention strategies for emergency workers. in Lystad, M. (Ed.) *Mental Health Response to Mass Emergencies*. New York: Brunner/Mazel.

Elraz, I. & R. Ozami (1994). Use of Supporting resources: during a progressive war incident, *Psychology*, vol. 4, pp. 1-2. ( Hebrew)

Figley, Ch. (Ed.) *Compassion Fatigue*. New York: Brunner/Mazel.

Frankel, V. (1970). *Man in Search for Meaning*. Tel Aviv: Dvir. (Hebrew)

Freudenbeyer, H.J. (1974) Staff burnout. *Journal of Social Issues*. 30 (1). pp.159-165.

Harris, C.J. (1995) Sensory based therapy for crisis counselors. in Figley, Ch.(Ed.) *Compassion Fatigue*. New York: Brunner/Mazel.

Hodgkinson, P. & Stewart, M. (1991) *Coping with Catastrophes*. London: Routledge.

Hodgkinson, P. & Shepherd, M. (1994) The impact of disaster support work. *Journal of Traumatic Stress*. 7(4).

Janoff-Bulman, Ronnie, (1985). The aftermath of victimization: Rebuilding shattered assumptions. in Charles R. Figley (ed), *Trauma and Its Wake*, Vol. I, The Study and Treatment of Post Traumatic Stress Disorder. Brunner/Mazel Psycho-social Stress Series No. 4.

Janoff-Bulman, Ronnie, (1992). *Shattered Assumptions: Towards a New Psychology of Trauma*. The Free Press, A Division of Macmillan, Inc. New-York.

Joinson, C. (1992) Coping with compassion fatigue. *Nursing*. 22(4). pp.116-122.

Kfir, N. (1990). *Like Ripples in the Water*. Tel Aviv: Am Oved. (Hebrew)

Klingman, A. (1991). *Psychological and Educational Intervention in Disaster*. Jerusalem: Ministry of Education. (Hebrew)

Lahad, M. (1995). Masking the gas mask: Brief intervention using metaphor, imagery, movement and enactment. In A. Gersie (Ed.), *Dramatic Approaches to Brief Therapy*. London: Jessica Kingsley

Lahad, M. & Ayalon, A., (1994). *On Life and Death*. Haifa: Nord. .( Hebrew)

Lahad, M. & Cohen, A. (1997) (Eds.) *Community Stress Prevention* 1&2. Kiryat Shemona: Community Stress Prevention Centre.

Lifton, R.J., (1967). *Death in Life: Survivors of Hiroshima*. New York, Random House.

Maslach, C. & Jackson S.E. (1981) The measurement of experienced burnout. *Journal of Occupational Behaviour*. 2(2). pp.99-113.

Maslach, C. (1982) *Burnout: The Cost of Caring*. Engelwood Cliffs: Prentice Hall.

McCann, L. (1990) Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*. 3 (1) pp.131-149.

McCammon, S.L. & Allison, E.J. Debriefing and treating emergency workers. in Figley, Ch.(Ed.) *Compassion Fatigue*. New York: Brunner/Mazel.

Mitchell, J. (1985) When disaster strikes...the critical incident stress debriefing process. *Journal of Emergency Medical Services*. pp.36-39.

Mitchell, J. & Bary, G. (1990) *Emergency Services Stress*. Englewood Clift. N.J.: Prentice Hall.

Mitchell, J. & Dyregrov, A. (1993) Traumatic stress in disaster workers and emergency personnel. in Wilson, J. & Raphael, B. (Eds.) *The International Handbook of Traumatic Stress Syndromes*. New York: Plenum Press. pp .905-914.

Moran, C. & Colless, E. (1995) Positive reactions following emergency and disaster responses*. Disaster, Prevention and Management*. University Press. 4 (1) pp.55-60.

Noy, Shabtai, (1987). Combat psychiatry: The American and Israeli Experience. In Belenky, G.L. (ed.), *Contemporary Studies in Psychiatry.* Westport, CT., Greenwood Press.

Noy, Shabtai, (1991). C*an't Take it Anymore: Combat Stress Reactions.* Tel-Aviv, Ministry of Defense Publications. (Hebrew).

Noy, Shabtai, (1991a). Combat Stress Reactions. in Gal, R., & Mangelsorf, A. D., *International Handbook of Military Psychology*. John Wiley, London.

Omer, H. and H. Inbar (1991). Mass disasters: The role of the emergency team. *Sichot, The Israeli Jouranl of Psychotherapy,* 2 (3): 157-170.(Hebrew)

Omer, D. (1978) *The kiss that got lost* .Sherbrak, Tel Aviv.(Hebrew)

Perlman, L. & Saakvinte, K. (1995) Treating therapists with vicarious traumatization and secondary traumatic stress disorders. in Figley, Ch. (Ed.) *Compassion Fatigue*. New York: Brunner/Mazel. pp.150-177.

Pines, A.M. (1993) Burnout. in Goldberger, L. & Breznitz, S. (Eds.) *Handbook of Stress*, 2nd Ed. New York: Free Press. pp.386-402.

Pines, A.M. & Aronson, E. (1988) *Career Burnout Causes and Cures*. New York: Free Press.

Salmon, T.W. (1919) The war neuroses and their lessons. *New York Journal of Medicine*. p.109.

Solmon, Z. (1993) *Combat Stress Reaction, The Enduring Toll of War*. New York: Plenum Press.

Solomon, Z. (1995) From denial to recognition: Attitudes towards Holocaust survivors from World War II to the present. *Journal of Traumatic Stress*.Vol 8. pp. 229-242.

Solomon, Z., Benbenisti, R.,Mikulincer, M., (1988). A follow-up of Israeli casualties of combat stress reactions (Battle Shock) in the 1982 Lebanon war. *The British Journal of Clinical Psychology, 27 (2), 125-135.*

Solomon, Z., Benbenishti, R., Spiro, S., (1986). Evaluation of the effectiveness of forward treatment in Combat Stress Reactions in the Lebanon War. Israel Defense Forces, Medical Corp., Mental Health Dept., Research & Evaluation Branch. (Hebrew)

Valent, P. (1995) Survival strategies: A framework for understanding secondary traumatic stress and coping in helpers. in Figley, Ch. (Ed.) *Compassion Fatigue*. New York: Brunner/Mazel.

van der Kolk, B.A. (1966) The black hole of trauma. in Van Der Kolk & McFarlane, A.C. & Weisaeth, L. (Eds.) *Traumatic Stress*. New York: The Guilford Press.

Webster's Encyclopedic *Unabridged Dictionary of the English Language*. (1989) New York, Grainevay.

White, M. (1990) *Narrative Means to Therapeutic Ends*. New York: Norton.

Witstom, A. (1989). Crisis intervention and short-term psychotherapy. In H. Dasberg, I. Isaacson, G. Shefler, *Short-term Psychotherapy*. Jerusalem: Magnes, pp. 53-66. ( Hebrew)

Winnicot, D.W. (1971) *A Play and Reality*. London: Tavistock Publication.