AN INTRODUCTION TO CRITICAL INCIDENT STRESS MANAGEMENT

A Self-Directed Learning Program

State of New Jersey
Department of Law and Public Safety
Office of Attorney General- Division of State Police
Office of Employee & Organization Development

OBJECTIVES

Participants will:

- Become familiar with the key terms and concepts relevant to the field of critical incident stress management
- Understand the psychological nature of terrorism
- Understand the difference between stress-related distress vs. stress-related dysfunction within five expressive categories
- Understand the origins of nature and origins of crisis intervention
- Understand the nature of critical incident stress management as a strategic crisis intervention system
- Understand the role of self-care in crisis intervention

TOPICS

- Overview of Key Terms & Concepts
- The Nature of Terrorism
- Signs & Symptoms of Distress vs. Dysfunction
- The Nature and Evolution of Crisis Intervention
- The Nature of Critical Incident Stress Management
- Stress Management & Self-care

SECTION ONE

OVERVIEW OF KEY TERMS AND CONCEPTS

At the heart of any field of study or practice resides a basic vocabulary. Unfortunately, the field of crisis intervention has been plagued by the lack of a standardized nomenclature. So, we will begin with a review of several key terms and concepts that will help one better understand the materials later presented.

DEFINITIONS

CRITICAL INCIDENTS are unusually challenging events that have the potential to create positive growth, or significant human distress…

FROM THE SYSTEMS' PERSPECTIVE, CRITICAL INCIDENTS HAVE 3 VARIATIONS:

- EMERGENCIES
- DISASTERS
- CATACLYSMS

DEFINITIONS

- EMERGENCY = an event that results in: 1) physical destruction, and/or 2) injury to, and/or loss of, human life. It may serve to challenge, but does not exceed local emergency response capabilities.

DEFINITIONS

- DISASTER = is defined largely by the magnitude of its impact; typically, an event that results in a high magnitude of 1) physical destruction, 2) injury to, and/or loss of, human life, 3) disruption to social cohesion or community function, and 4) exceeds local emergency response capabilities.

DEFINITIONS

- CATACLYSM, CATASTROPHE = defined largely by the magnitude of its impact; typically, an event that results in an extraordinary magnitude of 1) physical destruction, 2) injury to, and/or loss of, human life, 3) disruption to social cohesion or community function, and 4) exceeds ALL emergency response capabilities.

FROM AN INDIVIDUAL'S PSYCHOLOGICAL PERSPECTIVE, CRITICAL INCIDENTS MAY RESULT IN A

PSYCHOLOGICAL CRISIS

DEFINITIONS

The psychological DISTRESS
in response to critical incidents such as
emergencies, disasters,
traumatic events,
terrorism, or catastrophes is called a
PSYCHOLOGICAL CRISIS
(Everly & Mitchell, 1999)

So, what is a crisis?

PSYCHOLOGICAL CRISIS

An acute RESPONSE to a trauma, disaster, or other critical incident wherein:

1. A person's usual coping mechanisms have failed, and,
2. There is evidence of significant distress, or impairment to a person's ability to function effectively at home or at work.

(adapted from Caplan, 1964, *Preventive Psychiatry*)

The key to understanding “crisis,” is understanding it to be a RESPONSE to an event, not the event itself.

This notion helps us understand why there is such a wide variety of reactions within a group of individuals exposed to the same event.

Just how someone reacts to any given critical incident will often depend upon at least two factors:

1. The perceived RELEVANCE of the event, and
2. The perceived IMPORTANCE of the event.

SECTION TWO

TERRORISM:
A Special Case

Research has shown that human-made disasters are more psychologically pathogenic than are natural disasters. Terrorism may be the most pathogenic of all due to its UNPREDICTABLE and UNRESTRAINED nature.

TERRORISM

The explicit goal of this STRATEGIC WEAPON is to create fear, helplessness, and demoralization as a coercive or punitive force...to "break the enemy's resistance."

TERRORISM is…

TOTAL WAR!

"TOTAL WAR..."

...a concept introduced by Karl von Clausewitz in a book entitled *Vom Kriege (*On War) and published in 1832.

The concept is simple...attack anything associated with the enemy...attack the sacred, attack the strategic sources of power, kill the innocent, do the unthinkable, demoralize until the enemy capitulates.

THE CHALLENGE

The Psychological Casualties of Terrorism

BEWARE!

THE “ICEBERG EFFECT OF TERRORISM”

PHYSICAL DESTRUCTION & DEATH ARE ONLY THE TIP OF THE ICEBERG

Terrorism, will create more psychological casualties than physical casualties

(Holloway, et al., 1997, JAMA; DiGiovanni, 1999, Am. J. Psychiatry)

A **psychological casualty** may be defined as anyone unable to function in a normal manner due to disasters, trauma, or other critical incidents.

Example 1: 1991 Gulf War

- **Between January 18th and February 28, 1991, 39 SCUD missiles fell upon Israel.**
- **78% of those people who sought medical care presented with psychological / behavioral problems.**

Source: Karsenty, et al., Israel J. Med. Sc. *1991*

Example 2: Post-war Kuwait City

- **Psychometric assessment of Post Traumatic Stress Disorder (PTSD) in 404 adult Kuwaiti citizens 4.5 years post Iraqi invasion:**
  - **28% PTSD-like symptoms in overall sample**
  - **45.6% in university students** (Al-Naser, et al., 2000, Int. J. Emerg. Ment. Hlth)
  - **18.5% in firefighters** (Al-Naser & Everly, 1999, Int. J. Emerg. Ment. Hlth)

Example 3:
Sarin Attacks In Tokyo

- 1995 Aum Shinrikyo released Sarin gas in the Tokyo subway, killing 12.
- **Over 1000 presented with evidence of sarin toxicity, BUT...**
- **Over 4000 sought emergency medical care, but had no objective evidence of exposure.**

Source: Ohbu, et al., Southern Med. J. *1997*

Example 4:
Oklahoma City Bombing

- April 19, 1995 bombing of the Alfred P. Murrah Federal Building; 167 deaths from explosion, including 19 children (1 additional death):
  - **45% of those directly exposed developed a psychiatric disorder (34% PTSD, 22% depression)**
  - **Increased domestic violence**
  - **250% increase in divorce amongst firefighters**

Example 5: World Trade Center Attacks

- September 11th 2001 attacks on the NYC World Trade Center:
  - 5-8 weeks post disaster telephone assessment (1008 adults, Manhattan south of 110th St.) **indicated 7.5% PTSD, 9.7% depression, 20% PTSD south of Canal St.**

Source: Galea, et al., NEJM *2002*

Example 6: September 11th - Airlines

- 2002 psychometric survey of flight attendants indicated **18% with probable PTSD** post 9/11:
  - Psychological contagion was evident in that there was no less PTSD in West Coast based flight crews compared to East Coast based crews.
  - Perceived vulnerability was psychologically contagious.

Source: Lating, et al., J, Nerv Ment Dis, in press

The degree of "psychological toxicity" and psychological contagion associated with terrorism will increase with the presence of certain factors:

10 Toxicity Factors

- **1. A stealth, unpredictable pattern of attacks.**
- **2. Ability to affect large numbers of victims.**
- **3. Intent to harm noncombatants, especially targeting women and children.**
- **4. Ease of weapon delivery.**
- **5. Delay and difficulty in detecting and assessing exposure, especially lethality.**

- 6. Long incubation period, at least several days.
- 7. Potential for contagion, especially if it deters emergency response and/or treatment.
- 8. Potential to scar and disable rather than kill.
- 9. Ability to overwhelm public health and other resources, while altering the accepted and preferential way of life.
- 10. Motivation which is immune to rational, measured deterrence. Willingness to use self-destruction as a weapon. All or nothing strategic thinking.

These factors may be used to obtain a relative estimate of how psychologically troublesome, or “toxic,” a given terrorist attack might be.

REGARDING THE SCOPE OF TERRORISM, THE INSTITUTE OF MEDICINE HAS STATED:

- "The committee finds that terrorism and the threat of terrorism will have psychological consequences for a major portion of the population, not merely a small minority" (p.ES4).
- "The stress associated with the direct impact and lingering threat of terrorism raises obvious psychological concerns, particularly for...first responders..." (p.ES2).
- (Institute of Medicine, 2003, *Prep Psyc Conseq Terrorism*)

REGARDING THE DURATION OF TERRORISM…

"The violence of the attacks against the Twin Towers and the Pentagon has revealed an abyss of terror that is going to haunt our existence and thinking for years and perhaps decades to come"

(Borradori, *Philosophy in a Time of Terror*, 2003, p. 21).

SECTION THREE

SIGNS & SYMPTOMS OF DISTRESS VS. DYSFUNCTION

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THE BASIC ASSUMPTION

- THE MAJORITY OF INDIVIDUALS EXPOSED TO A TRAUMATIC EVENT WILL NOT NEED FORMAL PSYCHOLOGICAL INTERVENTION;
- HOWEVER, THAT DOES NOT NEGATE THE OBLIGATION TO RESPOND TO THE NEEDS OF THOSE WHO COULD BENEFIT FROM ACUTE PSYCHOLOGICAL SUPPORT

THE BASICS:

STRESS =

"Fight or Flight response"
(W. Cannon)

"Sum total of wear & tear"
(H. Selye)

A normal survival reaction.

EUSTRESS vs. DISTRESS

There are two intensity levels of stress:

EUSTRESS & DISTRESS

Eustress = Positive, motivating stress

Distress = Excessive, debilitating stress

DISTRESS vs. DYSFUNCTION

DISTRESS

Signs or symptoms that may be normal responses or abnormal ones. All may call for observation, but supportive attention or more definitive crisis intervention will depend upon the degree of severity.

DYSFUNCTION

Signs and symptoms that are, by definition, of greater severity and require mental health interventions

DOMAINS OF SIGNS & SYMPTOMS SEEN FOLLOWING A DISASTER

- An essential aspect of critical incident stress management involves being able to recognize simple distress (observe) vs. dysfunction (intervene). These signs and symptoms may be manifest in 5 basic domains:
  - Cognitive
  - Emotional
  - Behavioral
  - Physical
  - Spiritual

These lists are not designed to be comprehensive, but are designed to give you a sense of their variety and nature. When in doubt, seek professional medical or mental health guidance.

COGNITIVE (Thinking) DISTRESS

- Time Distortion
- Confusion
- Inability to Concentrate
- Difficulty in Decision Making
- Transient Guilt
- Preoccupation (obsessions) with Event
- Inability to Appreciate Consequences of One's Own Behavior

COGNITIVE DYSFUNCTION

- Suicidal/ Homicidal Ideation
- Paranoid Ideation
- Prolonged Disorientation
- Persistent Diminished Problem-solving
- Distressing Recurrent Dreams
- Disabling Guilt
- Hallucinations
- Delusions
- Persistent Hopelessness/ Helplessness
- Psychogenic Amnesia
- Dissociation

EMOTIONAL DISTRESS

- Acute Anxiety
- Irritability
- Acute Anger
- Mood Swings
- Acute Depression
- Fear, Phobia, Phobic Avoidance
- Posttraumatic Stress (PTS)
- Grief

EMOTIONAL DYSFUNCTION

- Panic Attacks
- Chronic Feeling of being Overwhelmed
- Persistent “Flat” Affect, Chronic Numbing
- Infantile Emotions in Adults
- Immobilizing Depression or Major Depression
- Posttraumatic Stress Disorder (PTSD)
- Despair

POSTTRAUMATIC STRESS (PTS)

VS.

POSTTRAUMATIC STRESS DISORDER (PTSD)

Posttraumatic stress (PTS) is a normal survival response; Posttraumatic Stress Disorder (PTSD) is a pathologic variant of that normal survival reaction.

POSTTRAUMATIC STRESS DISORDER (PTSD)

- A predictable pattern of psychological, physiological, & behavioral consequences to severe injury-inducing or life-threatening events
- Thought of in context of a “survival” mechanism
- Consists of:
  - Re-experiencing event
  - Withdrawal, numbing
  - Stress arousal
- Must persist >30 days + impairment

BEHAVIORAL DISTRESS

- Impulsiveness
- Risk-taking
- Excessive Eating
- Alcohol / Drug Use
- Compensatory Sexuality
- Sleep Disturbance
- Withdrawal
- Family Discord
- Sustained Hypervigilance
- 1000-yard Stare

BEHAVIORAL DYSFUNCTION

- Violence
- Antisocial Acts
- Abuse of Others
- Lasting Compulsive Acts
- Diminished Personal Hygiene
- Immobility
- Persistent Sleep Disturbance (e.g., nightmares)
- Self-medication
- Exacerbation of pre-existing conditions
- Substance abuse

PHYSICAL DISTRESS

- Tachycardia (Rapid Heart Beat)
- Headaches
- Hyperventilation
- Muscle Spasms
- Psychogenic Sweating
- Fatigue / Exhaustion
- Indigestion, Nausea, Vomiting

PHYSICAL DYSFUNCTION

(Indicate need for urgent/emergent medical evaluation—high likelihood of having traumatic physical injury)

- Chest Pain
- Persistent Irregular Heartbeats
- Recurrent Dizziness
- Seizure
- Recurrent Headaches
- Delirium
- Blood in vomit, urine, stool, sputum
- Collapse / loss of consciousness
- Numbness / paralysis (especially of arm, leg, face)
- Inability to speak / understand speech

SPIRITUAL DISTRESS

- Anger at God
- Challenging of One's Faith

SPIRITUAL DYSFUNCTION

- Cessation from Practice of Faith
- Religious Obsessions
- Religious Compulsions
- Withdrawal from Faith-based Community
- Religious Hallucinations or Delusions

SECTION FOUR

THE NATURE AND EVOLUTION OF CRISIS INTERVENTION

In response to the acute mental health needs of those in crisis, the field of CRISIS INTERVENTION was born.

Crisis intervention grew out of both military and civilian sectors.

Crisis intervention…

- Early 1900s gave birth to suicide prevention initiatives. Later, interest was focused upon community mental health services.
- World War I gave birth to combat stress control initiatives as a result of the recognition of “shell shock” amongst soldiers.

LESSONS LEARNED FROM THE MILITARY

- SALMON (1919, NYMedJ) "Nothing could be more striking than the comparison between the cases treated near the front and those treated far behind the lines...As soon as treatment near the front became possible, symptoms disappeared...with the result that sixty percent with a diagnosis of psychoneurosis were returned to duty from the field hospital" (p. 994). "War neuroses...could be controlled by scientific management rather than allowing nature to takes its course" (p 994).

- KARDINER (Am. Hdbk. Psyc, 1959). “Those on field duty found it to be most advantageous to the soldier, and to the army, to recognize exhaustion and the fear but not to remove the soldier to the rear” (p. 248). “By and large, the prognosis…varies directly with the time factor...The great issue…is not to permit the syndrome to become entrenched...” (p253). “The most effective implement is to keep alive the [causal] relation between the symptoms and the traumatic event” [as opposed to attributing symptoms to weakness in character] (p 254). In addition, Kardiner noted, to a significant degree, the soldier’s expectation of outcome predicts recovery from war neurosis.

LESSONS LEARNED FROM COMMUNITY MENTAL HEALTH

- **Early Psychological Intervention may reduce the need for more intensive psychiatric services.** (Langsley, Machotka, & Flomenhaft, 1971, Am J Psyc; Decker, & Stubblebine, 1972, Am J Psyc)
- **Early Psychological Intervention may mitigate acute distress .** (Bordow & Porritt, 1979, Soc Sci & Med; Bunn & Clarke, 1979, Br. J Med. Psychol;Campfield & Hills, 2001, JTS; Everly, et al., 1999, Stress Med; Flannery & Everly, 2004, Aggression & Violent Beh.)
- **Early psychological Intervention may reduce ETOH use.** (Deahl, et al, 2000, Br J Med Psychol)

So, what is crisis intervention?

CRISIS INTERVENTION

Is a variation on the theme of
psychological/emotional “first aid”

Goals:

1. Stabilization - intervention designed to keep symptoms from worsening. If successful, then...
2. Symptom reduction - interventions designed to improve functioning, resulting in a...
3. Return to adaptive functioning, or further intervention, eg,
4. Facilitation of access to the next level of care.

(adapted from Caplan, 1964, *Preventive Psychiatry*)

THERE IS A CONSENSUS...THAT PROVIDING COMFORT, INFORMATION, SUPPORT, AND MEETING PEOPLE'S PRACTICAL AND EMOTIONAL NEEDS PLAY USEFUL ROLES IN ONE'S IMMEDIATE COPING..."

(Litz, et al. 2002)

CRISIS INTERVENTION (CI): KEY POINTS

- Crisis intervention (CI) has a rich history having been developed along two evolutionary pathways:
  1) psychosocial reformation and suicide intervention, and
  2) military psychiatry.
- Crisis intervention is not a form of psychotherapy, nor a substitute for psychotherapy.

- As physical first aid is to surgery, crisis intervention is to psychotherapy
- As described herein, crisis intervention is not intended to be the practice of psychiatry, psychology, social work, nor counseling, per se, it is simply psychological/emotional first aid
- As described herein, consistent with federal “crisis counseling” models, crisis intervention may be practiced by mental health clinicians, as well as, community volunteers (although mental health guidance, supervision, or oversight is essential)

As a greater understanding of emergency mental health interventions was accrued, and as the need for crisis intervention services expanded and became more complex, the nature of crisis intervention changed, as well.

SECTION FIVE

THE NATURE OF CRITICAL INCIDENT STRESS MANAGEMENT

WHERE ARE WE NOW?

IN 1990, THE BRITISH PSYCHOLOGICAL SOCIETY RECOMMENDED THAT CRISIS INTERVENTION SHOULD NOT CONSIST OF SINGULAR, STANDALONE INTERVENTIONS. RATHER, CRISIS INTERVENTION SHOULD BE MULTI-COMPONENT IN NATURE.

CRISIS INTERVENTION (CI)...

Should be one aspect in an overall continuum of care. As a specialized aspect of mental health intervention, it requires specialized training.

The CHALLENGE, therefore, becomes not only developing clinical skill in the application of crisis interventions, but ALSO in strategic planning. More specifically, the challenge becomes knowing how to select and implement the most appropriate intervention to best meet the needs of the situation.

Recent recommendations for early psychological intervention include the use of a variety of interventions matched to the needs of the situation and the recipient populations!

(Source: NIMH, 2002, Mental Health and Mass Violence)

The palette of methods and techniques available to the interventionist must be commensurate with the unique features of the person or group for whom the methods and techniques are intended.

[Adapted from: Millon, et al. (1999) Personality guided therapy. NY: Wiley.]

The practice of
CRITICAL INCIDENT STRESS MANAGEMENT (CISM)
is the selection and implementation of the most appropriate crisis interventions to best respond to the needs of the situation at hand.

(Source: Everly & Mitchell, 1997, 1999; Everly & Langlieb, 2003)

It is beyond the scope of this introduction to operationally define all of the intervention options available to the crisis interventionist.

Nevertheless, the following list enumerates the common interventions that may be employed from a critical incident stress perspective.

Common Elements of CISM

- Pre-incident education, preparation
- Assessment
- Strategic Planning regarding implementation of…
  - Large Group Crisis Intervention:
    - Demobilizations (large groups of rescue/ recovery)
    - Respite Sectors
    - Crisis Management Briefings - “town meetings” with large groups of primary, secondary (emergency personnel), and tertiary victims (family, co-workers)
  - Small Group Crisis Intervention:
    - Defusings (small groups)
    - Critical Incident Stress Debriefing (CISD); HERD; NOVA; and other small group intervention models)
    - Small group Crisis Management Briefings - informational
  - One-on-one crisis intervention
  - Family CISM
  - Organizational/ Community intervention, consultation
  - Pastoral crisis intervention
  - Follow-up and referral for continued care

As noted earlier, the field of crisis intervention has developed along two evolutionary pathways:

1) psychosocial reformation and suicide intervention, and

2) military psychiatry.

Historically, these initiatives have enjoyed empirical success as attested to by decades of continued practice and the former by randomized controlled trials in the 1960's-1970's. HOWEVER…

Not all mental health professionals agree that crisis intervention / early psychological intervention is useful.

It is IMPORTANT to note:

In the following discussions, the term "debriefing" is often used as a synonym for *individual* crisis intervention, for *group* crisis intervention, for disaster mental health, for early psychological intervention, and for emergency mental health. This has predictably created a condition of considerable confusion and impaired interpretation of some research findings!

Major concern over the applicability of early psychological intervention arose largely from the Cochrane Reviews (1998, 2002) from the United Kingdom.

Other negative reviews (van Emmerick, et al., 2002; McNally, et al., 2003) were based largely upon Cochrane data sets.

COCHRANE REVIEW (2002)

- Reviewed 11 randomized studies of 1:1 counseling (referred to as “debriefing”) with medical/ surgical patients , “loosely based” upon outdated (1983) group crisis debriefing model
- The authors concluded… “single session individual debriefing did not reduce psychological distress nor prevent PTSD”
- The authors further added…“We are unable to comment on the use of group debriefing, nor the use of debriefing after mass traumas.”

Concerns, based on the Cochrane Review, have caused some to recommend waiting 1-3 months post event before initiating formal psychological intervention and then using 4-12 sessions of individualized Cognitive Behavioral Therapy (CBT).

A CLOSER LOOK AT THE DATA:

- A review of 25 controlled (70 total) studies of “psychological debriefing” concluded...
- Group debriefing as originally prescribed found effective with public safety personnel
- **[Source: Arendt & Elklit (2001) Acta Psychiatrica Scandinavica]**

- A randomized trial of group critical incident stress debriefing found early intervention superior to later intervention
- [Source: Campfield & Hills (2001) Journal of Traumatic Stress]

- Critical Incident Stress Management (CISM) was found to be effective in reducing distress in response to robberies (Richards, 2001) and in reducing assaults and related distress upon healthcare staff (Flannery, 2001)
- 10 year analysis of ASAP CISM reveals method to be consistently effective (Flannery, International J. Emerg. Ment. Hlth, 2001)
- Stapleton (2004) found crisis intervention with medical and surgical patients generally effective

"THE EVIDENCE THAT A DEBRIEFING MAY LEAD TO LESS SUBSEQUENT ALCOHOL ABUSE SUGGESTS THAT COPING STYLES MAY BE ENHANCED BY THIS EARLY INTERVENTION"

(Source: Litz, et al., Clin, Psychology, 2002)

REASONABLE CONCLUSIONS

- More, better controlled, research needed
- Care must be taken during any crisis intervention
- Data reviewed support use of group crisis “debriefing” with emergency services personnel (see NIMH, 2002, tables 2-3; Arendt & Elklit, 2001)
- Data reviewed tend to support use of group “debriefing” subsequent to disasters, war, robbery (see NIMH, 2002, tables 2-3)
- Data unclear regarding single session individualized interventions after medical, surgical distress
- NIMH (2002), Institute of Medicine (2003) recommend acute phase “psychological first aid”

DEBRIEFINGS (PD)

"SINCE PD IS FULLY ACCEPTED AS STANDARD PRACTICE FOR EMERGENCY SERVICES PERSONNEL AND WELL-RECEIVED BY GROUP MEMBERS AND ORGANIZATIONS, IT IS HARD TO FIND FAULT IN ITS APPLICATION IN A MASS DISASTER SUCH AS THE TERRORIST ATTACKS...ON SEPT. 11, 2001."

(Litz, et al., Clin. Psyc. 2002)

"In all the controversy, criticism and research debate on the merits of debriefing [early intervention], certain constants are emerging. The most effective methods for mitigating the effects of exposure to trauma..., those which will help keep our people healthy and in service, are those which use early intervention, are multi-modal and multi-component. That is, they use different 'active ingredients' ..., and these components are used at the appropriate time with the right target group."

Dr Hayden Duggan

International Association of Fire Chiefs' ICHIEFS on-line resource, Sept 1, 2002

Critical incident stress management not only involves taking care of the psychological needs of others after critical incidents and mass disasters...

...an important aspect of critical incident stress management involves taking care of yourself.

It has been said that taking care of **yourself** is the best way to take care of others.

You are best prepared to take care of others and to perform your duties when you are physically and psychologically healthy.

Taking care of yourself is not selfish, nor is it a luxury. Taking care of yourself is an OBLIGATION that you have to all those who depend upon you!

Personal stress management, Employee Assistance Programs, peer support programs, as well as a wide variety of critical incident stress management interventions are all options that you and your family may consider in the wake of critical incidents, terrorism, and mass disasters.

Section Six

STRESS MANAGEMENT and Self-Care

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Taking care of yourself not only involves staying physically fit and tactically competent, it involves managing stress.

Methods for Managing Stress

- Exercise
- Proper nutrition
- Learn to relax
- Relaxed breathing techniques
- Get enough sleep and rest
- Manage your time well
- Nurture and maintain friendships

- Communicate with family and friends
- Gain support from family and friends
- Avoid self-medication
- Be willing to express your feelings
- Realize counseling is a strength, not a weakness

Practicing stress management may enhance your RESILIENCE.

RESILIENCE refers to your ability to “bounce back” from adversity.

5 STEPS TO ENHANCE RESILIENCE

- 1. UNDERSTANDING THE ADVERSITY
- 2. GAIN SUPPORT FROM OTHERS
- 3. FIND MEANING IN LIFE
- 4. GIVE YOUR LOSSES MEANING
- 5. TAKING CONTROL OF THE THINGS YOU CAN

1. UNDERSTANDING THE ADVERSITY...Information is Power!

- LEARN ABOUT THE NATURE OF TERRORISM
- LEARN THE MOTIVATION OF TERRORISTS
- UNDERSTAND THEIR WEAPONS

2. GAIN SUPPORT FROM OTHERS

- SEEK SUPPORT FROM FRIENDS AND FAMILY
- UTILIZE OTHER SUPPORT NETWORKS: hotlines, work, governmental agencies, others similar to yourself, support groups
- COUNSELING

3. FIND MEANING IN LIFE

- FIND MEANING / GROWTH IN THE ADVERSITY
- FAITH (that which helps us accept what we cannot understand)
- MAINTAIN A FUTURE ORIENTATION
- IDENTIFY WITH SOMETHING BIGGER THAN YOURSELF (national pride, humanitarian initiatives, justice, religion, etc.)
- MAKE IT PERSONAL: Accept adversity as a personal challenge

4. GIVE YOUR LOSSES MEANING

- HONOR THOSE LOST BY REMEMBERING THEM
- HONOR THOSE LOST BY SEEKING SUCCEEDING
- HONOR THOSE LOST BY MAKING A DIFFERENCE

5. TAKING CONTROL OF THE THINGS YOU CAN...

gives you a sense of strength and security; but avoid the mistake of trying to control things which you have no control over.

SERENITY

"God give us the grace to accept with serenity the things that cannot be changed, courage to change the things which should be changed, and the wisdom to distinguish the one from the other."

(Reinhold Niebuhr, 1934)

SERENITY: A VARIATION

"...grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the only thing I can change is MYSELF."

AND...

The one thing over which you have control is the way you think about things.

“Men are disturbed, not by things, but the views which they take of them.”

Epictetus

END

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