AN EXPLORATION OF THE EXPERIENCE OF CRITICAL INCIDENT STRESS DEBRIEFING ON FIREFIGHTERS WITHIN A REGION OF THE NEW ZEALAND FIRE SERVICE

by

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ABSTRACT

This study originates from my practice experience working for the New Zealand Fire Service back in the late 1980's and early 1990's as an Occupational Health Nurse where I piloted a Critical Incident Stress Peer Support programme in the No.4 Region. My interest in the area began after attending a seminar on Critical Incident Stress Debriefing based on Mitchell's model of debriefing (1983). I had begun to recognise in my practice what I believed to be work-related stress but was a little uncertain about where this stress originated. After attending the seminar I began to understand that some of this stress was related to Critical Incident Stress (CIS) from firefighters exposure to critical incidents.

This study explores four firefighters experience of Critical Incident Stress Debriefing (CISD) within a Region of the New Zealand Fire Service. It explores the application of CISD as one component of Critical Incident Stress Management (CISM), and the Nurse Researcher's philosophy of Clinical Nurse practice in relation to the application of CISD. The knowledge gained from the analysis of the data has the potential to influence professionals understanding of their experience and affect future practice and that of others working in the field of CISM.

The aim of the study was to gain a greater indepth understanding of firefighters experience specifically in relation to their participation in a Critical Incident Stress Debriefing (CISD) following their exposure to a critical incident. Much of the literature that supported CISD appeared to offer a rather superficial understanding of the firefighters experience in relation to CISD. I chose to use narratives as the methodology, utilising four individual case studies as a method of social inquiry in order to explore the experience of CISD. The narratives were able to creatively capture the complexity and the dynamic practice of CISD.

An overall pattern of the **formalised process** was uncovered through the participants' narratives. Eight dominant themes were highlighted from the narratives which included **safe environment; ventilating the stress reaction; similar feelings; getting the whole picture; peer support; bonding and resolution.** While these themes were common to all the participants, each participant had a particular theme/s which was unique to their experience.

As a Nurse Researcher with dual practice interests in the area of nursing education and Critical Incident Stress Management (CISM), I am in a position to inform practice and service development. It is my belief that the knowledge gained from this study has the potential to be transferred to others working in the field of CISM. The study results are timely, practical and informative at a time of major change in the New Zealand Fire Service.

PREFACE

At the risk of being a large Master's thesis I have chosen to submit at this point in time with the intention of doing further research in the future. As a Nurse Educator, Nurse Consultant and Nurse Researcher, I continually seek to establish deep meaningful relationships with my clients/patients and this is reflected in the text of this thesis. The sections on personal philosophy, philosophy of practice and the history of the New Zealand Fire Service, are very important for me to include as indepth discussion because this positions my role as a Nurse Consultant in the New Zealand Fire Service (which is unique in New Zealand and treasured by myself) so I can deliver a powerful nursing contribution to the Service.

This thesis provides a historical record of a new era in crisis intervention in the New Zealand Fire Service which includes Critical Incident Stress Debriefing (CISD). It demonstrates to other Occupational Health Nurses and others working in the field what my role is and enables an indepth critique of Critical Incident Stress Debriefing.

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This study would not have been possible without all the love, support and practical help that I have received from both my family, friends and colleagues. Many people have walked with me through my house-garden-wilderness.

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I would like to thank the Peer Support Team members, both the current members and those who I have worked with over the last 10 years. A special thank you to Mike Houghton who has walked the journey of CISD/CISM with me since we piloted the programme together in the late 1980's. Also I would like to particularly thank Gordon Balfour, Wendy Mattingly, George Toomer and Gerry Twiss, whose amazing tenacity to stay working in the field of CISD/CISM and to maintain their continued commitment is just amazing. We have all shared this journey together during the last 10 years in partnership and have learnt many lessons along the way.

To Rod Nightingale, Regional Commander/Manager who listened and acknowledged my concerns in relation to the lack of clear leadership and supervision of the CISM Peer Support Team. Thank you for believing in my ability to redevelop the Team and for your ongoing support and assistance to both myself and the current Peer Support Team. A special thanks to Toni Caldwell and Sally White, and the Regional Support staff, for your support in helping me with the day to day behind the scenes activities that ensure the smooth running of the CISM programme.

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1. INTRODUCTION

The origins of this research began from a need to identify in more depth firefighters experience of stress, so I was better able to work effectively in the area of Critical Incident Stress Management (CISM) in my various roles in the New Zealand Fire Service as a Clinical Nurse Consultant with an educational background and a strong primary health care focus. I have chosen to present this thesis with a discussion on my role and my philosophy of practice which is a central focus to my model of practice. The intention of this document is to inform firefighters and others working in the field of CISM, a model of practice which works in partnership with members of the Peer Support Team and those firefighters who utilise the CISM services in times of significant stress. A discussion in the chapters on the history and culture of the New Zealand Fire Service are critical as they naturally represent my perception and view of the Service and should be read in this context.

Information regarding the harmful effects of exposure to traumatic experiences has been chronicled for centuries (Saigh, 1992). As far back as 1666, the diary of Samuel Pepys, who witnessed the Great Fire of London, records intrusive thoughts and a disturbed sleep pattern still being experienced 6 months post-incident. During the many wars in this century there has been extensive documentation about the psychological effects of war-related trauma. Crisis intervention strategies have been used in military settings since the middle of the First World War for dealing with acute combat psychiatric casualties (Kormos, 1978). As a consequence of the Vietnam War there has been scientific studies of survivors of combat stress who suffer the condition now known as Post Traumatic Stress Disorder (PTSD).

Recognition of the personal pain and suffering of emergency service personnel and health professionals engaged in crisis, trauma and disaster,

has only been seriously acknowledged in recent years. Historically there has been the assumption of the "John Wayne", the "tough cowboy" and the "stiff upper lip" image of emergency service personnel, who were often seen as being hardened to the pain and suffering of others and indifferent to their responsibility for the saving of lives, is well documented (Mitchell, 1983). Many lessons have been learnt from major disasters, particularly in relation to a number of airline crashes in the United States during the 1970's and 1980's that have involved massive input from emergency service personnel in dealing with the loss and rescue of multiple casualties. An important lesson learnt is that emergency service personnel and others involved in crisis, trauma, emergency and disaster do not generally become hardened to the pain and suffering of others or indifferent to their role of saving lives. These rescuers, from whatever service they originate, are vulnerable and suffer from the normal physical, emotional and psychological effects in response to their witnessing the horrors of human tragedy.

Crisis intervention is required in order to mitigate, where possible, the harmful effects of exposure to a traumatic incident and to support emergency service personnel in managing any adverse negative emotional reactions which could have the potential to cause PTSD. Post Traumatic Stress Disorder (PTSD) is the most widely used of the official diagnostic terms employed to denote the psychological sequelae that exist in response to a traumatic event. It was first officially recognised in the psychiatric taxonomy of the American Psychiatric Association's Diagnostic and Statistical Manual Disorders (DSM) in 1980, and has subsequently been retained in editions of the DSM, specifically DSM - 111 (APA, 1987) and DSM - IV (APA, 1994). According to the 1980 taxonomy, PTSD involved the

> *"development of characteristic symptoms following a psychologically traumatic event that is generally outside the realm of human experience" (APA, 1980, p.236).*

It was also indicated that the "stressor" producing this syndrome would evoke significant

> *"symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses or marital conflict" (APA, 1980, p.237).*

Post Traumatic Stress Disorder is recognised by three characteristic clusters of symptoms. The three clusters include intrusive recollective thoughts; arousal and numbing; withdrawal and/or avoidance. The traumatic event or critical incident is one that is markedly distressing to almost anyone and often produces intense fear, terror or helplessness (APA, 1994).

Professor Jeffrey Mitchell, previously a firefighter/paramedic and now a psychologist, pioneered the Critical Incident Stress Debriefing (CISD) concept. **Critical Incident Stress** as defined by Mitchell (1983) is

> *"any situation faced by emergency service personnel that causes them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or sometime later" (p.36).*

Critical Incident Stress Debriefing is a

> *"psychological and educational group process designed specifically for emergency workers with two purposes in mind. First to mitigate the impact of a critical incident on the personnel, and second, to assist in the healing process of the members who are experiencing the normal symptoms and reactions to a stressful event" (Pierce, 1993, p.19).*

In essence it normalises the physical, emotional and cognitive effects on

personnel from an exposure to an abnormal event.

> *"Most reactions to trauma are normal and do not indicate pathology or collapse" (Buckle & Hill, 1995, p.34).*

Debriefing following exposure to traumatic stress was also developed by Dyregrov (1989) referred to a "psychological debriefing" and more informally by Raphael (1986). The debriefing aims in all models were to reduce the effects of the traumatic incident by supporting and encouraging the processing of the event in a group setting, piecing together information surrounding the event, and normalising the personal effects in a supportive environment. It attempts to speed up the recovery of personnel exposed to a traumatic incident before more serious stress reactions have an opportunity to interfere with their professional, family, health and social life (Mitchell, 1983; 1988a; 1988b; Dyregrov, 1989).

1.1. AIMS AND PURPOSE

As a primary health care nurse clinician, I have walked alongside and worked with firefighters for the last 10 years and it is my belief that reducing stress, particularly occupational stress, greatly maintains the productivity of firefighters. It is important to provide stress management strategies that are acceptable, appropriate and accessible to emergency workers who are at risk of specific health problems related to their exposure to critical incidents such as Post Traumatic Stress Disorder.

The research seeks to elicit the experience of debriefing through in-depth interviews. As the researcher, my goal is to explore some of the meanings attached to the debriefing process, particularly in relation to how the debriefing has assisted the firefighters to deal with a specific critical incident that they are asked to recall.

In this research, I will attempt to uncover and understand firefighters

experience of CISD so that it may further add to the development and knowledge of studying the effects of critical incident stress and stress management strategies over a wider group of people in the population.

In the research proposal my stated aims was to explore, within the New Zealand context, the experience of CISD on firefighters following attendance at a critical incident (CI). The purpose was to gain contextual meaning and understanding of the experiences of firefighters who have participated in a CISD based on Mitchell's model of debriefing (1983).

The goal at the end of the study is to make recommendations based on research findings that will clarify the value of CISD in order to sustain, refine, reshape or suggest a rationale for its removal from use as a model within the New Zealand Fire Service. The research findings may provide further information which could have broader applicability to a wider group of other emergency and health care providers who provide a similar debriefing process or who are planning to implement stress management policies in the future.

I developed indepth questions to explore the meaning of CISD for firefighters from their perspective, using in-depth discussion between the researcher and the firefighters. Freire (1972) defines this communication as

> *"a two way inter-communication, a horizontal relationship between persons who are engaged in a joint critical search" (cited in Reason and Rowan, 1981, p.350).*

I was able to frame the research questions in such a way as to elicit the firefighters' stories in the interpretive paradigm. Knowledge and understanding of this stress experience is not possible without describing the human experience as it is lived by the firefighters themselves. Therefore the methodology for this research links the narrative of the event to understand the phenomenon of the specific life event, Critical Incident

Stress Debriefing. Narrative was the eventual approach of choice because of its potential to explain or to express, to analyse or to understand (Reason & Hawkins, 1988). It revealed the "realness" and depth of the experience for the participants. Like phenomenology, which was my initial choice of methodology, the narrative does not claim to offer effective theory in order to explain and/or control our world. It is a philosophical position, a lens on the world and a tool that offers us real insights into the everyday world of peoples' experiences (Van Manen, 1990). In the future I would like to explore other questions such as the timeliness of debriefing.

I have been passionate in my exploration to understand firefighters' experiences related to Critical Incident Stress and the debriefing process. Previously I have discussed ideas and issues within education and peer debriefing sessions with firefighters. I have utilised surveys and questionnaire evaluations and reflected indepth over many years. However, I had reached a point in my practice where I wanted to formally discuss in greater depth firefighters experience of the debriefing process. Narrative is a particularly useful methodology for nurses to uncover the experience of the storyteller, in order to share poorly understood details of this information with others who may have a similar experience.

> *"Nursing practice involves diagnosing and treating human responses to actual and potential health problems and since humans respond as whole persons, knowledge of the lived experiences of health and healing are legitimate topics of nursing inquiry" (Swanson-Kauffman & Schonwald, 1988, p.97).*

Following conversations with colleagues and after the pilot interview, I developed the following open-ended questions to generate further discussion. The questions invite a response, especially in the form of a story. The questions were:-

"Tell me about your experience related to participating in a recent Critical Incident Stress Debriefing".

"What did you find most helpful in terms of assisting you to discuss the incident?"

"Tell me how being involved in a CISD has affected you."

These three questions were asked consistently of the four participants and served to elicit specific storying. This thesis presents an analysis which I have done continually from the proposal and pilot interview through all stages of the research. In the interpretive approach, the aim is to focus on the interviews exploring the experience of CISD while actually collecting and analysing the data (Glesne & Pleshkin, 1992). This created a spiral effect as each subsequent interview, while unique, added to my indepth understanding of the process of debriefing. This process will be described in detail in Chapter 7. I then chose to relate each participant's narrative as a case study in it's own right in order to

> *"seek out what is common and what is particular about the case, but the end result presents something unique" (Denzin & Lincoln, 1994, p.238).*

I have chosen to relate my experience of the New Zealand Fire Service briefly in the introduction but will develop it indepth and will include my own life story for a number of reasons. The style of "working with", in partnership with my clients/patients, that is nursing as an Occupational Health Nurse brings me into close contact with people. My own personal family and educational history shaped my beliefs, work philosophy, subsequent practice and vision in the New Zealand Fire Service dramatically. For this reason I have recounted personal details to reveal my role in developing a Critical Incident Stress Management programme in such a significant time in the history of the New Zealand Fire Service.

1.2 BACKGROUND TO THE STUDY

In 1989 I attended a seminar facilitated by Dr.Robyn Robinson, a clinical psychologist from Melbourne, Australia, on Critical Incident Stress Debriefing. I had recently taken up a position as an Occupational Health Nurse with the New Zealand Fire Service and I was beginning to recognise in my practice some of the effects of traumatic stress. I suspected this may have been related to the firefighters occupational exposure to repeated rescue and disaster work. Examples of what I was seeing in my practice were alcohol and suspected drug abuse; high levels of smoking at a time when smoking was decreasing in the general population, high marriage breakdown and a high incidence of sick leave, both illness and accident related. Dr.Robinson had established a Critical Incident Stress Debriefing (CISD) team in Melbourne for emergency service personnel and had educated personnel on Critical Incident Stress (CIS) and ways of preventing this in emergency service personnel and others exposed to critical incidents that were likely to cause significant stress or distress in their lives.

After attending this seminar, I spent time researching, reflecting and discussing with others who had a longer work history with the Fire Service than myself, about the appropriateness of introducing such a concept into the Fire Service. I will discuss my reflections as to the eventual outcome in a later chapter.

1.3 MY PERSONAL BACKGROUND

It is important that I discuss my background as it has enabled me to be confident in my work to formulate my own philosophy which underpins my present practice. My personal background has assisted me to have the ability to understand the relationship of firefighters' professional lives, their upbringing, training, life choices, fears, failures and achievements in a broader context when we meet.

I was raised in an Irish-Catholic close knit family where I was the youngest of three children. My father was from a working-class background with minimal education though he achieved well academically until he left school at age 14. He married my mother who was from a middle-class background who left school at the age of 15 years to work as a Secretary in a bank until she married at 21. Her life has been spent bringing up her family, supporting my father who became a very successful businessman at an early age, and even though she has travelled widely her life has very much focussed around her home and family. My two brothers attended a private boys boarding school and their education and academic attainment was seen as being of more importance than my own. They both achieved well academically at secondary school. However, neither went on to attain any tertiary qualification as they both joined my father's business in their early twenties.

My parents are both very loving and caring parents, but like many of their generation they did not view academic attainment as being as important for their daughter For most of my education I attended an all girls Catholic school. I do not have very fond memories of school particularly in relation to academic attainment. Throughout my schooling I was a very average student and always seemed to be placed in the middle stream classes with little encouragement from my teachers that I could achieve at a higher level. I decided in my second year of secondary school to take a combined general and commercial course. I achieved highly in the commercial subjects always being in the top stream. Even though I enjoyed the commercial subjects I did not plan to pursue a long term career in this area. I remained uncertain about what career option I would choose upon leaving school and had thoughts of being a Karitane nurse, who looked after children in their homes, not unlike being a nanny. I also considered being a kindergarten teacher. However, it was my girlfriend's mother, Sheila, who had a real interest in education who counselled me about my options and encouraged me to consider a career in nursing. My father was not all that encouraging as I think he thought the life would be too harsh and maybe he

had ideas of his daughter marrying and having children and not having to think about a long term career outside of the home environment. I often thank Sheila for spending time and encouraging me in the area of nursing as I value her contribution in helping me to find a career that I have found truly satisfying and challenging and which has led me into areas of nursing which I never dreamed were possible.

I commenced part-time university studies in 1984 and received encouragement from a very special friend and mentor, Pat, who I had worked for in his general practice. During my studies at university I was employed in the areas of practice nursing, public health nursing and occupational health nursing. I completed my undergraduate degree with above average grades which I had never thought possible for me.

Upon completing my degree I moved into the area of nursing education where I have been able to share many of my skills and knowledge in a caring environment. The Whitirieia Community Polytechnic's Nursing School's philosophy is based on Te Tiriti o Waitangi (Appendix 1) and is reflected in students learning through partnership, governorship, autonomy and empowerment. This philosophy has profoundly affected the development of my professional philosophy in education as well as my clinical practice.

The overriding principles of assessment in the curriculum are to encourage critical self-evaluation and for students and tutors in partnership to gain personal and professional insight into their practice (Whitireia Curriculum, 1993, Appendix 2). Another principle of the Institution is that of equity which supports "second opportunity" education for those who have previously failed or under-achieved in the education system. I believe that because of my own personal experience as discussed, I can empathise with these students and have a strong commitment to support them in their quest for higher learning and achievement.

Nursing is a profession that I have always felt proud to be working in and it has always been important for me to give 100% of myself in all areas of my practice, especially with my clients. From an early age I have always enjoyed caring for others and nursing has given me the opportunity to focus upon developing the art and craft of caring, which I believe is a skill unique to nursing. Most of my post-registration years have been spent working primarily in the community where the 1986 Ottawa Charter for health promotion and Alma Ata codes were forerunners to the organisational mission statements of the late 1980s. Since 1993 I have worked in nursing education, where my philosophy of practice has evolved.

1.4 PHILSOPHY OF PRACTICE.

My philosophical beliefs centre around being in partnership with my clients, the community and the students in the teaching/learning process. I value and respect others' values, culture, gender, age, spiritual beliefs and experiences.

I realised at an early stage of working in the area of primary health care that it was vital to work in partnership with my clients in order to practice effectively. I viewed myself as being a guest in their environment initially, and when a trusting relationship had been established I worked with them as partners in their journey to health and wellness, whatever health and wellness meant for that particular individual, family, community or group. I am in a unique position to enact those beliefs in my day to day work and to shape my sense of quality in practice.

In my present practice in nursing education I see partnership as caring not controlling. I value both myself and the student being cared for on their journey of discovery (Watson, 1988). I acknowledge the students unique past experiences as being part of the caring relationship. I view both partners, that is students and myself, as being on a journey and an important link in the chain, where the students are prepared to become

responsible and accountable for their own practice. Knowles (1987) discusses the importance of providing an environment which enables the adult student to feel accepted, respected and supported, where the spirit of mutuality between both the educator and the student exists as joint enquirers.

Personally, I need to share of myself in a teaching/learning environment, to establish trustworthy relationships with the students. This relates to Peplau's theory that gives support to the nurse/client relationship. Peplau identifies four phases in the nurse/client relationship as being orientation, identification, exploitation and resolution, which although separate, overlap and occur over the time of the relationship (Marrimer-Toomey, 1989). I see myself as coming together with the students as strangers where we build up a relationship of trust, teaching each other, utilising each other as resource persons and leading each other on a journey of discovery with the ultimate aim of assisting the students to gain the necessary knowledge in terms of theory and practice. Benner (1984) refers to this as the 'beginner practitioner'.

I want the students to enjoy their journey, to give them a thirst, a passion and a commitment to nursing and to feel proud to say they are "a nurse" in a powerful voice, not "just a nurse" in a passive voice. I have a professional obligation to care for the students. I have evolved this sense of care so that I care for firefighters.

I am in a unique and privileged position to assist them on their journey of finding their house, travelling through their garden by cultivating and toiling their roots and by being there for them in times of wandering through the wilderness. Kelley (1995) discusses the house-garden wilderness metaphor where Parse's theory of Human Becoming (1992)

> *"fosters journeying and sojourning with persons in a house-garden wilderness " (p.61).*

I used Parse's practice methodology to guide me in living the ideal of a 'true presence' with my clients and students, travelling with them on their journey and seeing how it is for them. True presence for me means real and genuine human to human relating and being open to what is happening to the person in the moment. Parse's Human Becoming theory (1992)

> *"is grounded in the belief that humans co-author their becoming in mutual process with the universe, co-creating distinguishable patterns which specify the uniqueness of both humans and the universe" (p.5).*

Another key concept in my personal philosophy is that of viewing the clients and students holistically, understanding them as a non-reducible totality, being more than the sum of parts. Chin and Kramer (1991) claim

> *"the most consistent philosophic component of the idea of the person is the dimension of wholeness or holism" (p.42).*

It is important for me to view the students as totally unique, irreducible, unpredictable and forever changing. I believe communication skills, knowledge of self and others, and personal growth are all important areas to be developed with the nursing students so that the students will be able to provide humanistic care and are also able to view their clients as totally unique, unpredictable and forever changing.

Wholeness enacted in my daily practice means that I have to "walk it like I talk it" and to enable this to happen I need to create an environment which is full of possibilities, a garden which has rich soil with potential for much growth and future development. In 1859 Nightingale (1969) ascribed a great deal of importance to knowledge of environmental factors. My goal is to create an environment that puts the students in the best condition for learning to occur. By presencing myself with the students, to truly care, I create authentic care, not a power-based care which creates dependence,

but care which enables the students to travel through their own house-garden wilderness.

It is important for me to establish an open authentic relationship genuinely allowing the students freedom and choice, providing a loving, nurturing environment which recognises the potential for human growth, even in times of wandering through the wilderness. It is necessary to be consciously in partnership, with space to learn from one another and acknowledge this learning. The chance of promoting self-actualisation, self-acceptance and self-fulfilment with the ultimate aim of the students becoming everything they are capable of becoming can be realised. As nurse educators we take the transformative potential from the Te Tiriti o Waitangi document embedded in the Whitireia Nursing Department's curriculum philosophy and illuminate the teaching/learning partnership, and the nurse/client relationship in nursing practice (Southwick, 1994).

The curriculum also illuminates Parse's (1981) Man-Living-Health (now known as Human Becoming) theory where she elaborates on Roger's description of human beings by expounding about the person's nature being able to transcend the actual and move toward the possible. Students can come into the undergraduate and post-registration nursing program, who may have failed in other educational programs and by assisting the students in their journey, in providing a nurturing, supportive environment, the students learn and discover they are able to do what previously they considered impossible. I have the skills and empathy to assist as a person who experienced the feeling of underachievement in my secondary schooling and was then able to move into a university program within the Nursing Department at Victoria University of Wellington which provided a very affirming, nurturing and caring environment. I assist students in their own journey of discovery by sharing my own story and walk with the students, encouraging them to believe in their own possibilities and to believe in the process.

Hughes (1995) discusses how Madeleine Leininger explored major factors that aided or hindered the practice of caring. Leininger teaches care-giving strategies to nursing students through role-modelling experiences from day one in their clinical experience. She considers it is important to teach and model to nursing students how to spend time talking, listening, touching and comforting, with less time focussing on the technological interaction. This is consistent with the emphasis on the need to focus on the client as a human being. I believe care is the essence of nursing and the desire to care is one of the main motivating factors in people who choose nursing as a career. Benner and Wrubel (1989) used the word "caring" to mean *"being connected and having things matter" (p.1).* It is a term that fuses thought, feeling and action and can be used to describe a wide range of nursing involvement.

The capacity to care is not an automatic way of relating to people. As a nurse educator the challenge for me is to develop and professionalise the capacity to care for students. Caring must be affirmed and actualised. However, it is only through experience that students learn the practice of care. I must not just be content to work with students to only develop their thinking skills but it is only through the many times of applying the content in actual situations which include reflecting on mistakes that students can begin to practice skilfully the art and craft of care.

I believe that to help foster nursing students capacity to care, the students need to have a sense of being cared for, to nurture their abilities to care for others. The students need to feel valued and respected and the precious gift of time is an essence of care. By being made to feel special and valued, that is cared for, this assists them to use caring behaviours with their clients in the clinical settings.

As a Nurse Consultant working as a Clinical Director with the New Zealand Fire Service, I have been able to integrate the roles of clinician, educator, researcher and policy developer in the organisation. Like Kelley's (1995)

house-garden-wilderness metaphor which is linked to Parse's Human Becoming theory (1992), I have travelled a journey through many houses in my various roles in nursing. It has been in travelling through gardens, being cultivated and having my roots shaped by others with indepth knowledge and experience (who have being there for me in my times of wandering through the wilderness) that I have succeeded. These role models have journeyed with me in times of doubt and confusion and have helped me shape my practice to what it is today.

My philosophy of practice fits well with my present and previous workplaces. It is one of the main motivating factors why I have chosen to work in these areas. I recognise organisational influences such as frequent health policy changes and political influences that constrain the full expression of my philosophy of practice. In the present time of the increasing need for fiscal restraint, cost is a factor which definitely hinders my philosophy of practice. Nurses are forever reminded about the costs of care in terms of time, energy and money. However, it is important for me to teach/learn the ethic of care knowing that nurses do make a "difference" and that extra time, energy and even money is very likely going to enhance recovery or aid in a peaceful death. As a nurse I can be active in educating those who hold the power and the money, of the importance of care in terms of quality care and the ultimate cost savings. Watson (1990) discusses how the

> *"health care system has traditionally operated within a patriarchal structure that treats normal life processes as illness and has no place for the basic health human caring concerns. It is an approach that has persisted despite caring, courageous and skilful contributions made by nurses" (p.62).*

To positively change this structure, I need to work collectively with my colleagues to influence changes in health policies and to overcome our invisibility as we are a major contributor to effective health care. We have

proven that hierarchal and patriarchal structures no longer create high achievers or competent nurses, but if we become co-participants on an equal level as colleagues, we can offer a high quality of care.

Roberts (1990) discusses the invisibility of caring nursing practice. These caring characteristics need to be uncovered so they can be taught, rewarded and recognised with the ultimate aim of successful patient/client outcomes so that collaboration and co-operation between nurses and physicians can truly enhance patient/client outcomes. When I worked collaboratively with the Regional Medical Officer in the Fire Service in Occupational Health, our ultimate aim was working together to achieve what was best for the occupational group. I engendered in my clients a feeling of power and control over their own health and/or illness. By educating and assisting my clients on their journey, be they student nurses or Fire Service personnel, I knew I was sowing the seeds and assisting them to cultivate their own garden, that is one of self-responsibility, self determination, a feeling of being in control and not being controlled or oppressed by the nurses and doctors who held the knowledge and power. As the Brazilian educationalist Paulo Freire (1972) contends, the great humanistic and historical task of the oppressed, is to liberate themselves and their oppressors as well.

I remain ever mindful of my commitment to human caring and remain vigilant in raising caring consciousness in the nursing educational curriculum without devaluing technological advances. Many believe that technology is the panacea for treatment and cure but high technological environments can prevent me from truly caring. Hawthorne and Yurkovich (1994) discuss that the results of technology are no longer being balanced with a consciousness of the spiritual nature of man and his need to care and for caring.

In the past and even in the present, nurses tend to hid behind professional masks which prevents true caring taking place. This can be related to

culture, values, lack of trust and a lack of knowledge of own self. These need to be addressed with individual nurses and help must be made available to work through their own issues that impede their ability to care.

My philosophy of practice encompasses various nursing theorists (Parse, 1981; Benner, 1984; Watson, 1988; Christiansen, 1990) that have influenced and reflect my practice focus which relates closely to the curriculum philosophy of my workplace. I have used the Te Tiriti o Waitangi as my philosophical base to illuminate meaning in the teaching/learning and nurse/client partnership of my practice. There are other outside influences that impede full expression of my philosophy of practice such as oppression, costs and the hiding behind professional masks, but I believe these can be overcome by a critical analysis, performance, reviews and strategies with career planning in order to provide quality care. As nursing is moving in an era of rapid health care reform, it is even more imperative that nurses become more vocal by advocating for their clients, families and communities for quality health care. Nurses must remain committed to the centrality of caring to nursing practice.

As I continue my lifelong journey in nursing, I am continually challenged and passionately interested in enhancing my practice of caring with the ultimate aim of engendering excellence in the art and craft of caring, be it in nursing education or nursing in the community. Caring to me is the true essence of nursing.

I have discussed my philosophy of practice at length as I feel it is vital for me to explicate my day to day interactions of being in the world as a person and as a nurse. For me there is daily evidence that these insights and the ability to converse in the moment about who I am and how I work professionally, provides an important mature role model in the New Zealand Fire Service. I have introduced the journey metaphor and will develop it through this research as I plan to further disclose my practice by discovering and revealing the art and craft of my practice in relation to Critical Incident Stress Debriefing.

In the following chapters I will present a journey metaphor to enable the reader to consider my personal and professional story, the history of the New Zealand Fire Service Occupational Health Service and a discussion on the Fire Service culture and occupational stress related to firefighting. An extensive review of the literature in relation to Critical Incident Stress Debriefing of emergency service personnel will be discussed. My choice of methodology and the difficulty around this choice and the research design followed throughout the research will be discussed in two distinctive chapters. The four participants' narratives will be unveiled with an analysis of their stories and the research findings in three chapters. The first of these chapters will focus on one particular firefighters unique experience, the second chapter will focus on the three other participants unique experience and the third chapter will highlight the pattern and themes that were uncovered in the analysis of the narratives. Following these chapters a discussion on the implications for future practice will be discussed presenting a model based on the pattern and themes that were highlighted in the research. In conclusion I will make recommendations to Management of the New Zealand Fire Service based on the findings with a discussion on the limitations of this study and recommendations for further research.

1.5 CONCLUSION

In this introduction I have positioned the Thesis within a context of my nursing experience both in the educational setting and the New Zealand Fire Service. I have discussed at length my personal philosophy as I believe it is vital to understand my being in the world as a Nurse Consultant, particularly in relation to my practice in caring and supporting firefighters following their exposure to critical incidents. In the next chapter I intend to discuss my professional story in relation to the introduction of the CISD concept into the New Zealand Fire Service.

2. A PROFESSIONAL'S STORY

2.1 INTRODUCTION

As previously stated I have a passionate interest in understanding firefighters experience in relation to their exposure to a critical incident. My intention is to use this research to actively reduce the traumatic effects following a critical incident through understanding the value of Critical Incident Stress Debriefing. Having worked in the area of Critical Incident Stress Debriefing (now broadly referred to as Critical Incident Stress Management) for 10 years, I am resolute to increase my personal knowledge in this area and committed to the wide sharing of this knowledge within and beyond the New Zealand Fire Service. The way I have chosen to do this is through sharing my journey of my "house-garden-wilderness" in relation to the establishment of a Critical Incident Stress Debriefing Peer Support programme. Subsequently this programme was redeveloped and renamed a Critical Incident Stress Management Peer Support programme. I share my journey so that others may benefit from my story.

2.2 THE BEGINNINGS

I was attracted to the position of Occupational Health Nurse for the New Zealand Fire Service as I wanted to focus my practice on one particular occupational group. Working for an emergency service organisation appeared to offer me the challenge that I was searching for. I had previously worked in the field of Occupational Health and enjoyed the diversity. I found it challenged my own values and belief systems. I believed that I could make a difference through empowering people who I was working with to take control of their own lives in terms of their own personal safety and health. It had a reflexive action on myself as their partner. I felt I could truly work in partnership with my clients journeying with them in the their lives, not only in relation to their physical health, but also the emotional, mental, spiritual and social aspects.

In 1988 I was employed as a Regional Occupational Health Nurse together with a Regional Medical Officer of Health in one of the six Regions of the New Zealand Fire Service. Our employment arose out of an inquiry into the ICI fire, which occurred in Auckland in 1984 (Report on the Fire at ICI New Zealand Limited's Riverview Store, Mount Wellington, 1984). As a consequence of attending the ICI fire many firefighters suffered long-term physical, emotional and psychological effects. It is my belief that if a credible Occupational Health Service had been in operation many of these harmful effects could have been minimised or even prevented. Dr Bill Treadwell, the Principal Medical Officer for the New Zealand Fire Service for 13 years, said on his retirement with regards to the Occupational Health Service and subsequent development of CISD

> *"I believe if we'd had these in place at the time of the ICI fire there wouldn't have been the perceived problems that subsequently arose" (Treadwell, 1993, p.3.).*

It was with this history, that I embarked on my new position as an Occupational Health Nurse. The wide ranging impact of the ICI fire, was to have a significant impact on my practice. My brief was to cover a geographical area that was reasonably well contained. However, my occupational group consisted of both permanent and volunteer firefighters and a large number of administrative staff. I felt like a pioneer treading new ground. As this was a new service, there was a certain amount of suspicion and fear regarding the role and aims of the Occupational Health Service from both the Management and from those firefighters who worked at the grassroots level. In order to provide an effective service, I realised at the outset that it was vital to establish a trusting relationship with the firefighters. I decided that the most practical way to establish this relationship was to begin with Standard 1: Assessment of the Standards for Occupational Health Nursing in New Zealand (1988). Within my first year of employment I carried out a health and audiometry assessment on all permanent firefighters within the Region. It was during this time that I began to recognise what I believed

were the effects of work-related stress. I recognised a high incidence of alcohol and suspected drug abuse, a higher incidence of smoking than in the general population (when smoking was beginning to reduce in the general population) and a particularly high incidence of marriage breakdown.

An increasing number of firefighters were being medically "boarded out" of the service and I believed that there were some firefighters who may have been suffering from PTSD as a consequence of attending a critical incident. They had received little or no crisis management interventions following their exposure to the critical incident. It may have felt more comfortable for those individuals to be medically boarded on the grounds of a physical injury, which was viewed as more acceptable and genuine, as opposed to being medically boarded for a stress related disorder. It must be remembered within the context of that era that the stress of the job was seen as an inherent part of the job of firefighting and 'if you couldn't take it you shouldn't be there'. You had to tough it out, and that meant toughing it out in silence.

Unfortunately I was unable to do any health or audiometry assessments with the volunteers due to their large numbers and geographical spread but I often asked myself the question. If permanents suffered work-related stress then what impact did this stress have on the volunteer firefighters who often were involved in critical incidents where the victims were known to them in their small communities? Did they have the same opportunity to discuss the incident on their return to the station or were they required to return to work or home to sleep in order to be available for their permanent job? What effect did these critical incidents have on them, their families, friends and work colleagues? I was to discover the answer to these questions when I introduced the concept of Critical Incident Stress Debriefing to the volunteers sometime later. Many shared in great depth and detail their personal pain and suffering from incidents they had attended years before. In telling their stories there was often a certain amount of anger attached to the lack of recognition and help available to them. For some volunteers this was the first time they had had an opportunity to vent their anger and tell their

personal stories related to horrific incidents. Often, after these presentations I pondered on how they had released the stresses of attending critical incidents over the years. How had it affected them personally in terms of their physical, mental, emotional, social and spiritual wellbeing? From their stories, I was beginning to have some understanding that for many the stress of attending critical incidents and the lack of opportunity to ventilate the painful thoughts and feelings associated with these incidents, had had a huge negative impact on their lives. I felt really sad and distressed that there had been very little acknowledgement of critical incident stress within the Service or any formalised support structures, where those who required assistance, were able to access appropriate services. With this knowledge of their personal stories I decided that it was vital that some form of crisis intervention be introduced into the New Zealand Fire Service.

It is important to discuss the context of the male culture at the time when I first joined the Service. I was one of the first females to have free access to visit fire stations and only two female firefighters were employed in the Service at the time. There existed a strong macho image or what I refer to as the "John Waynes" or the "Cowboys" of the Service who still "sucked" the hazardous smoke at fires and failed to use the breathing apparatus sets that were provided. It just wasn't manly!!! This image was particularly prevalent in the older aged firefighters. Fortunately over time, with the support and encouragement of the Occupational Health Service education programmes in relation to personal health and safety, firefighters began to become more self-responsible for their safety and health. It also became more acceptable to talk about personal thoughts, feelings and reactions in relation to attending critical incidents, particularly those that involved children and young adults. There was a gradual shift in attitude and an increased ability to talk about the stresses of the job which was beginning to be seen as acceptable and not a sign of weakness. I believe this shift in attitude may have been made easier as a result of the pre-education sessions that I carried out in the Region on Critical Incident Stress and the Critical Incident Stress Debriefing (CISD) concept, prior to forming a CISD Peer Support Team. A strong emphasis

was placed on the fact that Critical Incident Stress (CIS) was a normal reaction to an abnormal situation in normal individuals following their exposure to a critical incident. I found I developed a style of presenting the material over time that was informative and also produced a change in attitudes and behaviour. This was possible because as firefighters shared their stories it enabled me to build up an accurate general picture of how stress had affected their lives.

In 1989 I attended a seminar on Critical Incident Stress Debriefing which was facilitated by Dr Robyn Robinson, a psychologist from Melbourne, Australia. In 1986 Dr Robinson had established a CISD Peer Support Team for the Metropolitan Ambulance Service in Melbourne. The following year she established and trained the first Combined Emergency Services Debriefing Team in Australia. Robinson (1984) undertook the largest known empirical study into emergency services stress for the Ambulance Services of Victoria, Australia. The results of this study confirmed my thoughts in relation to how stressful firefighters found dealing with the death of children. Robinson, together with Mitchell (1993) evaluated 31 psychological debriefings conducted by the Combined Emergency Services CISD team from December 1987 to August 1989. I found Robinson a very credible and committed mental health professional who had a genuine concern for providing the most appropriate and effective stress management strategies to meet the specific needs of emergency service personnel.

As a consequence of attending Robinson's seminar, the Assistant Commander of Personnel and I decided to look at providing a similar service within our Region. In order to provide a service that was acceptable to the consumer's I believed that firstly it was important to establish whether such a concept would be acceptable to firefighters and whether they would access it. I began questioning firefighters about work related stress and discussed the idea of establishing a stress management strategy such as a CISD programme. I questioned both the novice firefighters with limited firefighting experience and those who were known to be able to tough it out under all

circumstances. The response, particularly from the "John Waynes" was extremely positive, though the language was somewhat "strong" in terms of the need for Management to acknowledge the stress associated with attending critical incidents and the obligation to provide appropriate stress management assistance.

After much research and considering what was available in terms of psycho-social support, the Assistant Commander of Personnel and I approached Management with a proposal to establish a CISD Peer Support Team. After marketing the concept to Management we were given approval to establish a pilot program within our particular Region. We approached firefighting personnel who we believed were well respected and had a genuine interest in supporting their colleagues in managing work related stress and were able to work co-operatively and collegially as part of a Peer Support Team.

Carkhuff & Truax cited in Mitchell & Everly (1995) demonstrated the value of lay support models. By being a firefighter and having an understanding of the stresses of the job, peers are in a unique position to assist their fellow firefighters in adapting to the stress response as 'they have been there, done that'. They have walked in the shoes of those to whom they were offering assistance. They are familiar with both the nature and the culture of the Fire Service. Taylor (1990a) views the peer group team members as trained volunteers from within the emergency service who assist their peers to discard the accumulation of negative feelings following attendance at a critical incident. Keywords are used by the team members to stimulate emotions, that if left unreleased could be both debilitating and stressful long-term.

Those firefighters who accepted the invitation to join the CISD Peer Support Team received extensive training on the CISD process. This involved training in the seven phases of debriefing following what is commonly referred to as the Mitchell's model (1983). These seven phases include the introduction; fact; thought; reaction; symptom; teaching and re-entry

phases. They also include training in listening and communication skills; stress management; how to recognise when a distressed firefighter fails to respond to the assistance being provided and requires more expert help; and training in the other types of Critical Incident Stress Management (CISM) such as one-on-one support, demobilisations and defusings.

The aim of debriefing was discussed with the trainees. They were there to assist their colleagues deal with the inevitable stresses of their work and thus prevent more serious consequences of unresolved stresses resulting in serious physical, mental, emotional, social, financial and occupational distress and pain. It was continually stressed throughout the training that the Peer Support Team was not there to provide counselling or psychotherapy to the firefighters or infer that they had failed to cope, but to provide an opportunity for those who attended a critical incident to review the incident, not from an operational perspective, but from a psychological perspective. The team was there to assist the firefighters deal with the incident, give them an opportunity to discuss the incident in relation to their roles, their feelings, thoughts, reactions, frustrations, satisfactions and to assist them to deal with any negative effects and to look at the positive aspects of the incident. Finally, towards the end of the debriefing firefighters were educated on how to care for themselves holistically over the subsequent weeks until hopefully the negative effects would decrease. At all times it was stressed that the team members were not there in the role of 'mini counsellors' but should consider themselves as a peer supporter, 'a 12 stone listening ear'.

The training was highly successful and continued with mental health professionals presenting seminars on their own research findings into Critical Incident Stress and stress management strategies. Practical exercises such as role plays were recorded on video in order to analyse and critique the performance of the perspective team members. This was carried out in a safe and caring environment where we were all learning together in partnership with the ultimate aim of providing a very credible and safe service. At the end of the training, team members were given the opportunity

to withdraw if they felt that they were not suited or comfortable with the role. Fortunately those who were identified as being unsuitable withdrew of their own accord before it was deemed necessary to ask them to withdraw. These were personnel who had personal issues that they needed to address, or who had difficulty with being a good listener.

Having attended many seminars, national and international conferences and received extensive training in CISD, I believed that it was necessary to adapt the concept to meet the specific cultural needs of the New Zealand Fire Service. As previously mentioned, as an appointee to a newly created position, I had initially been viewed with some suspicion. I realised that before I could be of any benefit to the Service I had to build up a relationship of trust in order to convince the firefighters that I was employed to keep them in their job by addressing their health and safety needs in partnership with them. My philosophy of partnership of practice was based on Christiansen's model (1990) in which I work collaboratively with firefighters. Rather than working in a controlling manner and dictating what their occupational health and safety needs were, I viewed my practice like Hinder (1997) as "accompanying" firefighters through their health care episodes by assisting, supporting and providing health education and knowledge. As discussed by Dunning & Silva (1980), I saw the need to establish a program that ameliorated the stressful effects following a firefighter attending a critical incident, where they would be accompanied through their rocky journey of Critical Incident Stress and their subsequent recovery.

In developing any new service it is important to determine how it is to be staffed professionally, which is crucial to the outcome. Discussions were held with the Regional Medical Officer of Health and the Peer Support Team regarding the appropriateness of having a mental health professional such as a psychologist or psychiatrist as the Clinical Director of our team. All the literature indicated the need to employ a mental health professional in this role. I believed it was imperative that we provide a service that was culturally appropriate, acceptable, accessible and would be valued and utilised by the

firefighters. Was a psychologist or psychiatrist the most appropriate person to act as the Clinical Director? Would he/she be viewed with even more suspicion than I had been initially? While we all agreed that there was a place for a mental health professional within our structure in terms of providing assistance with training, in a professional supportive role and as a referral for personnel who required more professional assistance, it was decided that the role of Clinical Director would be carried out by the Occupational Health Nurse with the support of the Regional Medical Officer. Initially I felt somewhat apprehensive about taking on this role, but as I had a commitment to providing a holistic approach to health and had many years of broad nursing experience with an interest in mental health, I did have the expertise and the enthusiasm for providing and overseeing mental health services, as distinct from mental illness services. Also, I had built up an excellent rapport with the firefighters and believed that I had gained their respect and trust and was more able to provide the most appropriate care as I had developed a broad and contextual understanding of the culture of the Fire Service and the different roles and stresses associated with firefighting.

2.3 POLICY

As a consequence of the success of the pilot program of the CISD Peer Support Team, in 1994 the National Headquarters of the New Zealand Fire Service (Health & Safety Division) developed a National Policy on Critical Incident Stress Debriefing under the umbrella of Occupational Safety and Health. The five other Regions were to establish and provide CISD Peer Support Teams which would service the particular needs of their Region. Overall the established teams followed Mitchell's model (1983). One Region subsequently employed a psychologist as their Clinical Director. However he was an ex-firefighter with a degree in psychology, who understood the culture and was well respected and trusted by the firefighters.

2.4 MODEL OF PRACTICE

I continued to lead the CISD Peer Support Team until 1993 and the team continued to be led by the successive Occupational Health Nurses up until 1996. It was the nurse's role to oversee the intervention activities of the team and ensure that the most appropriate services were being provided at the right time and that the Peer Support Team members were working within the boundaries of their training and expertise. The nurse's role was pivotal to the ongoing success of the team in that he/she "drove" the team by their commitment and enthusiasm, recognising the need to organise and assist in the on-going training and education of the Peer Support Team and acknowledging the importance of keeping statistics in relation to the Team's activities. The nurse was the link between Management and the team, and provided the clinical support and expertise to the Team members.

It was a role that I found challenging, deeply satisfying and also exciting. My real commitment to the benefits of the programme was established following a particularly stressful incident that required a formal debriefing which I facilitated and was involved in the follow-up care of the participants. I would like to share my story which was a real journey for me in appreciating the impact of Critical Incident Stress on firefighters and why it is vital to provide the most appropriate follow-up support.

This incident occurred early on in my experience with debriefing. At this stage I could envisage the benefits but was still a little sceptical when reading the literature as to its real benefits. I thought that mental health professionals, that is. psychologists and psychiatrists were the best first point of call when dealing with work-related stress and that the Peer Support Team that was being advocated as the back-bone of the concept were not really the most appropriate persons to be involved in stress management strategies for firefighters. However, my doubts about the credibility of peer support were to be turned around.

The particular incident in question involved a group of firefighters from a

small community who had been called out to a housefire in the early hours of a cold winter's night. No further details were forthcoming at the time. The firefighters responded to find a house dwelling fully engulfed in flames. It appeared that all persons in the house were not accounted for and a search of the house was required. However, the house was deemed too unsafe for the firefighters to enter. Sometime later the firefighters searched the gutted house and were unsure of whether they had found animal or human remains. While they were searching several occupants of the house began acting rather strangely and had to be restrained by other emergency service personnel.

Following a police surgeon's identification it was found to be human remains in the gutted house. On further investigation it was found the person had been murdered. Because of the suspicious nature of the incident, the firefighters spent many hours at the scene and returned to the station cold, hungry and extremely fatigued. Due to the unusual and uncertain circumstances of the incident, the emotional impact on the firefighters was felt immediately at the scene and continued after the call was completed, not unlike Lightfoot's (1991) example. The firefighters were mystified about the circumstances of the incident. They had expected to attend a housefire and initially felt anger and frustration at not being able to rescue what they thought was a 'person trapped'. They felt fear and anger at the behaviour of the other occupants who were acting strangely and their attempts to hinder the operation.

The Fire Chief recognised that this situation was a critical incident that required the support and assistance of the CISD Team and a call for assistance was received. A CISD was scheduled for the following day, approximately 48 hours following the incident, which is considered an ideal time post-incident. I facilitated the debriefing and was assisted by a Peer Support Team member. Naturally we had some initial fear and anxiety attached to what we believed to be a debriefing around an unusual incident. We set up the environment so that the participants felt safe and comfortable,

established our credentials, introduced the CISD programme and the aims of the debriefing. It was immediately evident to both myself as the facilitator and the Peer Support Team member that this incident had had a significant emotional impact on all members of the firefighting crew. Some firefighters had over-indulged in alcohol the night following the incident to dull their pain. Some had had difficulty sleeping and eating, and one particular firefighter was severely affected by the unusual behaviour of the occupants of the house and suffered from recurrent and distressing flashbacks to the incident. Some felt anger and guilt that they had not been able to save the deceased person. However, prior to the debriefing we had been briefed by the Fire Chief on the facts of the incidents and he had informed us that the deceased person had died sometime before the fire which had been deliberately lit. I was able to share this information with the participants.

The seven stages of debriefing were followed and I found the process to be an amazing experience. To begin with we were feeling anxious and unsure about our abilities as debriefers but soon realised that with careful guidance through the seven stages of debriefing, the participants began sharing their feelings, thoughts and symptoms with ease. It felt as though they were controlling the debriefing and we were there to guide them through the process, to normalise their reactions and provide the support and reassurance in order that they recovered without any long term effects.

Following this debriefing, I began to reflect on my initial question regarding whether a psychologist or psychiatrist would have been the most appropriate person to debrief these firefighters. Would they have accepted them in their fire station with as much trust and respect? Would the mental health professional really have understood their unique culture, their frustrations, fears and anger related to their firefighting tasks? I began to understand and acknowledge the literature with regards to the powerful role of the Peer Support Team members in terms of understanding the firefighters culture. They were able to validate their fellow firefighters' feelings, thoughts and reactions, and were the most appropriate persons to discuss and support

firefighting decisions that were made during the critical incident. Also it was imperative that the facilitator, in this case myself, had a genuine understanding of the firefighters culture and unique personalities.

It was a very emotional experience for all concerned, both those debriefed and the debriefing team. This was the first time a CISD had been utilised in this particular area. The firefighters expressed their gratitude and satisfaction with the process and the team's quick response and availability. Due to the nature and severity of the incident all participants were followed up individually by telephone contact over the next few days, and those that required more ongoing assistance were supported individually. Because of the severity of the incident, a brief follow-up meeting was held one week later to ensure that any new issues or problems were discussed and that those who had participated in the debriefing, had responded to the support and assistance offered. All appeared to have responded extremely well to the support offered and all the firefighters felt that they had no major distressing symptoms that were causing them difficulties in their daily lives. The debriefing team left their contact telephone numbers so that the lines of communication were left open for any of the participants who might require further assistance.

This particular debriefing presented several interesting points for me personally. Following the debriefing, I was more convinced of the effectiveness of the programme and became even more committed to marketing the programme in order to meet the holistic needs of firefighters. I had personally witnessed the powerful role of the Peer Debriefers in assisting the firefighters to reduce the harmful effects of attending a critical incident. I now felt more able to question the literature with regards to a mental health professional being the Clinical Director for our particular occupational group. Also for both myself and the Peer Support Team members, this experience of debriefing gave us more confidence in the validity and usefulness of utilising such a programme within the Region. I have often discussed this particular debriefing with one particular participant who was severely traumatised and

he has spoken warmly and positively of the assistance he received from being personally involved in the debriefing. He has been one of the greatest advocates of the CISD programme in the Region.

A lesson that I learnt personally was the need for the debriefing team to be debriefed following a CISD. While the Peer Support Team member and I discussed the debriefing in terms of the process and the individual participants, we did not spend enough time discussing how we were feeling and whether we needed further support from other Team members. Several nights later I awoke in the early hours of the morning with flashbacks. A severely traumatised firefighter had visually and verbally acted out the strange behaviour of the occupants of the house during the debriefing. My flashbacks were related to his acting out and I was somewhat frightened, and also surprised at their occurrence. Fortunately I discussed this with a Occupational Health Nurse from another Region who was experienced in CISD and who provided me with the necessary clinical supervision. The lesson to be learnt from this experience is that following all debriefings, it is important to spend some time discussing the debriefing and to provide the necessary support to the Debriefing Team following this discussion.

In 1993 I left the Fire Service to pursue full-time academic study. I continued to work in a voluntary capacity as a member of the Peer Support Team. As I had worked in the Service, and was well respected and trusted, and had a good understanding of the role of firefighters, their culture and their occupational stresses, I was often asked to facilitate debriefings. This may have been related to the fact that the Region no longer employed a full-time Occupational Health Nurse.

2.5 FUTURE

Due to the continuing restructuring of the New Zealand Fire Service, in 1998 the Occupational Health Services in the Region were contracted out to private providers. In some Regions their brief does not include providing

Critical Incident Stress Management services. While many of them are experienced and credible Occupational Health practitioners, they do not have the necessary training and expertise that is required to meet the needs of a Clinical Director of the CISM team. Due to their relatively recent employment and, in some cases their lack of experience and their location (which is often located outside the Fire Station), they have been unable to establish a credible and trusting relationship with the firefighters. As previously discussed, I strongly believe that the nurse has a pivotal role in "driving" the team. The Occupational Health Nurses who were employed following my resignation received the necessary training, expertise, commitment, enthusiasm, respect and trust necessary to continue the programme and report they observed the true value and benefits to the firefighters in their everyday practice.

In July 1997 the National Office (previously known as National Headquarters) of the New Zealand Fire Service circulated a draft policy document on Occupational Safety and Health with recommendations for Best Practice Guidelines for Stress Management. There was much criticism of the document from around the Regions with regard to the role of the Mental Health Professional and while attempting to meet all the ideals of stress management, in the current economic climate, it was seen as being unrealistic, not achievable and in many instances unacceptable to firefighting personnel.

In the mid to late 1990s, the CISD Peer Support Team continued to respond to requests for assistance but they received little funding or support from Management. No formal training was carried out and there were grave concerns about the credibility of the team. As a volunteer Peer Support Team member, I expressed my concerns to Senior Management regarding the lack of support, clinical supervision and training. Upon formulating a new Health and Safety Policy, there was a commitment to provide support for the continuation and restructuring of the Team in the Region. As a consequence of my approach to Management, the Regional Commander/Manager

contracted me as a Clinical Director on a part-time basis, to restructure the Team in the Region and to establish a new Team in part of the new Region that had previously received little or no CISM services in its previous Region. As a consequence of the restructuring of the Team, it is now known as the CISM Peer Support Team in order to keep up-to-date with current global trends.

2.6 CONCLUSON

In this chapter, I have discussed the concept of Critical Incident Stress Debriefing by relating it to my own professional journey. I have discussed how the programme began, how it was established in my particular Region and its subsequent introduction into the other five Regions of the New Zealand Fire Service. I have purposefully shared a personal story of professional development (with some parts of the story fictionalised so as to protect confidentiality) in order to highlight how powerful and convincing a particular debriefing was for me personally. I have discussed how the team is operating in 1999 after its recent restructuring. In the following chapter, I will discuss the history of the New Zealand Fire Service Occupational Health Service, as it has had a significant impact on the introduction of the CISD programme. Recognition of the context of the service has been a significant factor in being able to position myself as a Nurse Consultant working in the area of Critical Incident Stress Management and the impact the service has had on the New Zealand Fire Service firefighters health and safety over the years since its introduction in 1990. It has had a significant impact in reducing some of the stress attached to the ongoing restructuring of the New Zealand Fire Service which will be discussed in a later chapter.

3. HISTORY OF THE NEW ZEALAND FIRE SERVICE OCCUPATIONAL HEALTH SERVICE

3.1 INTRODUCTION

In this chapter I plan to describe the health services that existed prior to the infamous ICI Fire in 1984, the health services that were utilised following the ICI Fire and the health effects which appeared following firefighters attendance at the fire. I have identified the relevant reports that influenced the introduction of an Occupational Health Service within the New Zealand Fire Service. As a result of the fire, a pilot program and subsequent establishment of the six Occupational Health Units occurred. I will conclude this chapter with an analysis of what is currently happening in relation to Occupational Health in the New Zealand Fire Service.

Since 1990 significant changes have taken place within the Fire Service that represent a massive restructuring of the Service. In order to understand how the Critical Incident Stress Debriefing concept was shaped within the context of the Occupational Health Service, it is necessary to have some understanding of the history of the New Zealand Fire Service. It is important to identify the health services that existed prior to the introduction of the Occupational Health Service in 1988. Finally, I will discuss the socio-political impact on the Occupational Health Services from 1988 until the present day.

It is my intention to provide historical evidence of the changes that have taken place in the New Zealand Fire Service by referring to important documents that detail these changes and also providing information that was provided by the Fire Service's first Principal Medical Officer of Health in a personal interview. I will also include my own personal reflections on these changes as I have not only worked within the Service during the early significant changes of the Occupational Health Service but left the Service

as a full paid employee and was able to look back on the effect of some of these changes in a more reflective manner. Since beginning this research project, I have been employed on a part-time contract basis as the Clinical Director of a Critical Incident Stress Management Peer Support Team within a Region of the New Zealand Fire Service.

3.2 HEALTH SERVICES – PRE ICI FIRE

I found it difficult to establish what medical services that existed prior to 1976. Dr William J. Treadwell was appointed as the first Principal Medical Officer for the New Zealand Fire Service in 1976. I interviewed Dr Treadwell who provided me with the following information in relation to the Service that existed prior to his appointment.

Dr Treadwell related how in 1975 as the Principal Medical Officer for the New Zealand Police, he was invited to a meeting with the Fire Service and the Firefighters Union in Wellington. He was asked to discuss his present role within the New Zealand Police and how the health services for the Fire Service could be improved. Following further discussions he was invited to take up a part-time position with the New Zealand Fire Service as their first Principal Medical Officer based in Wellington (W.J.Treadwell, personal interview 15 April, 1998).

From 1976 to 1979 Dr Treadwell established a medical profile for all firefighters. This new initiative was viewed by some within the Service with suspicion as it was feared that the results of a medical examination could put firefighters' jobs at risk. In 1976 Regional Medical Officers were appointed in each of the six Regions throughout New Zealand. They performed a practical role which was largely confined to pre-employment medical examinations and the medical boarding procedure for retirement from the Service on medical grounds. The Principal Medical Officer's brief was to advise the Fire Service on matters of health, not safety, and no formal procedures were established in matters relating to incidents requiring medical

assistance and intervention.

> *"There were no plans in place for managing treatment, testing or monitoring health problems in firefighters exposed to occupational health risk"* (Elias, Bandaranayake, Edwards & Glass, 1990, p.39).

Prior to 1976 there were 277 local Fire Services which were controlled by individual urban Fire Authorities. On 1 April 1976 the Fire Service Act (1975) came into effect and the 277 local Fire Services were taken over by the newly established New Zealand Fire Service. All existing Fire Authorities were dissolved and their assets were transferred to the New Zealand Fire Service Commission which became the controlling body for the New Zealand Fire Service. The 277 existing Fire Brigades, 26 permanent and 251 volunteers were grouped into 22 Areas. These Areas, in turn, were grouped into 6 Regions for administrative control. This structure, with some minor changes, existed until the 1995 restructure (Information Centre, 1998).

Prior to the establishment of a Commission, each Fire Authority employed their own Medical Officer who was usually a local general Medical Practitioner with little or no occupational health experience, or knowledge of the health risks associated with firefighting. They were mainly employed to examine firefighters for pre-employment medical examinations. It was done on an ad hoc basis and the Medical Officers generally established their own criteria for passing a firefighter as fit. Often this was done in consultation with the local Fire Chiefs. At this stage no set health policies had been established in terms of addressing the health suitability of potential firefighters, and the health and safety needs of those already employed.

According to today's' standards this assessment would be seen as a very crude way of addressing the health and safety needs of this particular occupational group. However it must be considered within the context of that time. Occupational Health, though not new to the health services, was still

relatively invisible in many occupational disciplines within New Zealand. However, an event occurred that was to have far reaching consequences for the health and safety of firefighters.

3.3 ICI FIRE

On 21st December 1984 the Riverview, Mount Wellington store of ICI (N.Z.) was seriously damaged by fire. The warehouse stored significant quantities of hazardous chemicals for distribution throughout New Zealand and the Pacific. Eighty six firefighers extinguished the fire. A further 141 firefighters attended the incident on the same day. In total, approximately 340 firefighting personnel were involved in either fighting the fire, dampening down the hot spots, remaining on stand-by in case of further fire or chemical spill, or involved in the subsequent clean-up of the site and fire equipment used in the incident (Elias et al, 1990).

This fire was to have long term consequences for both firefighters exposed to the known hazardous chemicals and the New Zealand Fire Service generally in terms of the lack of a co-ordinated health response or an established Occupational Health Service with protocols prior to the ICI fire.

Much controversy surrounded this large scale incident in relation to both firefighters and public safety concerns. The anxiety experienced by firefighters and the public may have been exacerbated by misinformation about the chemicals involved, the risk associated with exposure and the uncertainty regarding the toxic effects on those directly and indirectly exposed to the chemicals (Elias et al, 1990).

First aid treatment was provided by the St.John's Ambulance at the site of the fire over the 3 days following the incident and approximately 30 firefighters attended three local Accident and Emergency Departments. Their attendance at their local hospitals was on the advice of their supervisors and did not follow any formal process within the medical structure or within the

Fire Service at the time. There was a great deal of misinformation, which may have been related to a lack of a co-ordinated emergency response and the inadequate and ineffective communication systems. This created unnecessary anxiety. I believe it was related to no one person being responsible for disseminating information regarding the chemicals involved and for advising on the appropriate tests and treatment. This is supported by (Elias et al, 1990)

> *"Neither the hospitals nor the Fire Service made contact with the National Poisons Centre for information about the effects of the chemicals known to be involved, the symptoms of the firefighters or general management and investigation of cases of suspected exposure to toxic substances"* (p.39).

Thirty firefighters reported symptoms of skin rashes within a few days of the incident. These symptoms were consistent with those exposed to a toxic substance. While for many the skin rashes resolved, many firefighters continued to complain of recurring skin problems, memory loss, fatigue, irritability and other symptoms. Several months following the incident 200 firefighters were diagnosed as suffering from chemical poisoning. This diagnosis was made by a Medical Practitioner utilising a diagnostic method not usually accepted by conventional Medical Practitioners. The Principal Medical Officer at the time preferred not to have direct contact with the firefighters as he felt it risked his objectivity with his other functions if he was directly involved. He and the Regional Medical Officers at the time, did not see their role as providing direct treatment. At the time of the ICI fire there were no formal procedures in place for managing, testing or monitoring for health problems.

Due to the unsatisfactory treatment received by firefighters, particularly in relation to the skin rashes, the Fire Service involved the local Medical Officer of Health who was employed by the Department of Health. A dermatologist

was arranged for treatment and advice on the management of the skin rashes. The Medical Officer of Health was not officially responsible for the firefighters health. However, he was willing to assist as he was already involved with the public health management of the incident and because the Fire Service had no formalised Occupation Health Service at the time. A dermatologist provided an initial consultation which included both tests and treatment. Follow-up treatment was arranged through the Regional Medical Officer with the Fire Service in Auckland. All other firefighters complaining of symptoms were advised to see the Regional Medical Officer who arranged the appropriate treatment, including blood and urine tests which all proved negative.

Over the ensuing months the Regional Medical Officer was to play a vital and active role in consulting with approximately 75 firefighters with continuing skin problems, complaints of memory loss, clumsiness and psychological symptoms. It must be remembered that the Fire Service did not have an Occupational Health Service at this time. The Regional Medical Officers did not directly treat firefighters who were advised to consult with their own general practitioners.

> *"The involvement of the Regional Medical Officer in Auckland in a strategy for the general management of the health of those firefighters who attended the ICI fire was therefore unusual and a specific response by the Fire Service to the concerns of the firefighters. The strategy for management (testing and treatment) was not one that was in place at the time of the fire but was worked out by the Medical Officer of Health and the Regional Medical Officer in response to increasing anxiety and criticism both within the Service and among members of the public days after the event."* (Elias et al, 1990, p.59).

Fortunately with time there have been lessons learnt from this particular incident and the New Zealand Fire Service have made significant changes

that have had a positive effect on the health, safety and welfare of their firefighting personnel.

It has become well recognised that symptoms suffered by firefighters who attended the ICI incident were not confined to physical symptoms. Not only were they exposed to toxic substances but also to significant psychological and social stresses over a lengthy period of time following the incident. There were multiple stressors which included a belief that they had been exposed to toxic and hazardous substances; uncertainty with regards to the harmful effects; misinformation by the press in relation to the long term effects of their exposure; lack of a co-ordinated and credible health response; continuing health problems with conflicting medical opinions and treatments; significant strain on their family relationships; and anger and suspicion directed towards the Fire Service management, to name a few. It is important to note that no formal stress management strategies in the form of psychological debriefings following major incidents were available to Fire Service personnel at the time. After working as an Occupational Health Nurse in the Fire Service from 1988 - 1993, being immersed in the culture and following many, many discussions with firefighters in relation to the ICI fire, I believe that those firefighters who sought alternative health methods did so due to a lack of a co-ordinated and credible health response.

Six firefighters were medically retired from the Fire Service following the ICI fire and the medical grounds for their retirement was attributed to their attendance at the fire. Public and firefighter concerns about the long-term effects of their exposure to the known toxic chemicals still exist to this day. Four years following the fire, a firefighter died of leukaemia and the cause of his death has been linked by the press to his attendance at the ICI fire (Elias et al, 1990)

Due to firefighter concerns, the Minister of Health set up a Ministerial Advisory Committee on 21 March 1989, to investigate the health effects of firefighters who had attended the ICI fire which will be discussed in the following section.

3.4 PRESENT DAY

Following the success of the one year pilot project of an Occupational Health Service where an Occupational Health Nurse and Medical Officer were employed in the No.1 Region of the New Zealand Fire Service, an Occupational Health Service was established nationally in December 1988. Six Regional Occupational Health Nurses were appointed to support the six existing Regional Medical Officers. The nurses were administratively responsible to the Regional Commander and professionally responsible to the Regional Medical Officers for medical matters. As Registered Nurses with a current Practising Certificate, they were responsible for their own nursing ethics and standards of practice.

As a nurse appointed to a Region, the biggest challenge I faced was to get the message across to both Management and operational staff regarding the value and role of Occupational Health. I believed that my role was not to be seen as the traditional one, that of a 'bandaid nurse'. My standards of practice focussed on maintaining and promoting health and safety, and the prevention of illness through encouraging safe and healthy workplace practices and environments.

During the early years of the Occupational Health Service, the nurse's role in the area of health and safety was fraught with difficulties. Initially Management were fearful that the Occupational Health Service would be used to support industrial complaints and the staff within the Occupational Health Service felt constrained by Management in their daily practice. However, with the passage of time the nurses gradually proved their worth and were able to take on a more proactive role particularly in regard to health monitoring, hazard identification and their availability to attend and consult following major incidents. Initially some Regional Commanders looked unfavourably on the nurse's presence at a major incident. While expertise existed in the Service it was being ignored to the detriment of the health and safety of firefighting personnel.

In the early days, the Occupational Health Service was viewed with much suspicion and issues around confidentiality of health information was of real concern to the firefighters. With the passage of time, ongoing reassurance and the building up of a trusting relationship, there has been a gradual acceptance of the Service amongst the firefighters.

I believe my role as Occupational Health Nurse within the New Zealand Fire Service was able to be realised more effectively, not only with the passage of time, but with the publication of the Report to the Minister of Health on the Health of Firefighters in the Fire at the ICI Review Store, Mount Wellington, Auckland, 21 December 1984 (Elias et al, 1990). The Report acknowledged that the establishment of an Occupational Health Service had corrected some of the deficiencies evident at, and following the ICI fire. However, the report highlighted that the Service had a crucial role to play in three of the areas where the fire had revealed weaknesses in the safety system

- *Co-ordination of health hazard information on the fireground.*
- *Co-ordination of medical responses to firefighters affected including testing as well as treatment.*
- *Provision of after care to those affected, including the provision of stress debriefing, health monitoring and follow-up of appropriate treatment* (p.107).

The report highlighted for me problems that I was encountering in terms of being able to exercise my role both on the fireground and following incidents, from some Senior Management personnel. While I believed the Occupational Health staff had the required expertise and knowledge in co-ordinating an effective medical and nursing response, we were being hampered in providing the most appropriate response. It also identified that the Service did not provide debriefings or stress counselling after major incidents.

A Critical Incident Stress Debriefing (CISD) Peer Support Programme had

been established early 1990 as a pilot programme in the Region where I was employed, which provided stress debriefing following highly stressful incidents. As an Occupational Health Nurse new to the Fire Service, I had begun to recognise in my practice a significant amount of stress amongst firefighters. Upon talking with firefighters and attending major incidents, and having attended a 2 day workshop on CISD, facilitated by Dr Robyn Robinson, from Melbourne, Australia, I began to recognise that much of their stress could be related to Critical Incident Stress. As a consequence of talking with firefighters and Management, a CISD Peer Support Team was established under the umbrella of the Occupational Health Service.

The ICI Report (1990) addressed the need to ensure the safety and health management of volunteer firefighters to match the standards applied to professional firefighters. At this time the Occupational Health Nurses brief covered professional firefighters health and safety in depth but was only able to respond to acute calls for professional assistance to volunteers. An increase in Occupational Health Nurses was required in order to meet the needs of the large numbers of volunteers and their geographical spread. At this time I was beginning to recognise the need to provide psychological debriefings for volunteers as I believed they could be more vulnerable to Critical Incident Stress due to their community involvement where often they knew the victims of fire, accidents or medical emergencies. They were also less able to debrief themselves informally due to the need to return to work if the incident occurred during the day, or if the incident occurred at night they tended to return home for some much needed sleep. The professional firefighters were more likely to return to the station following a critical incident and discuss the incident amongst themselves on an informal basis over a cup of tea sitting around the "smoko" table. This had the potential to assist in mitigating the effects of stress related to the incident.

The ICI Report (1990) also recommended the appointment of a Director of Safety and Health who should report directly to the Chief Fire Commander with the function of reviewing procedures and practices in each Region and

with the function of reviewing procedures and practices in each Region and to oversee the operation of the Occupational Health Service. This recommendation was actioned in 1991 when a Director of Safety and Health was appointed by the Chief Executive.

The ICI Report (1990) highlighted that if health problems were not identified, monitored and treated, individual health could be put at risk. Occupational risks may not be properly appreciated and firefighters in dangerous situations may be put at risk by a colleague who was not functioning adequately either physically or psychologically.

The Occupational Health Service in the Fire Service has also been affected by the multiple changes in the Management structure since the Fire Service Amendment Act (1990). The law change took away the day to day running of the Fire Service from the Fire Service Commissioner and placed it in the hands of a Chief Executive. The role of National Commander responsible for operational activities of the Fire Service was separated from that of the Chief Executive and required senior operational firefighting experience. The first Chief Executive was the former senior Fire Commissioner. However, in April 1993, a new Chief Executive was appointed following a confidential review of the New Zealand Fire Service by the Minister of Internal Affairs. The new Chief Executive did not have a New Zealand Fire Service background.

In September of the same year, the Chief Executive announced that a major review of the Fire Service was to take place. In March 1994 the review results were released and the Chief Executive announced major restructuring with significant job losses. Following this announcement firefighters fought the changes both on the streets, through a national referendum which opposed the cuts in professional firefighters and in the Courts.

> *"Firefighters believed that cuts would reduce their ability to do their jobs and put the public at greater risk" (Hawkins, 1998, p.5).*

In 1995 the Fire Service, despite the Professional Firefighters Union disapproval, introduced another level of firefighter called Community Safety Teams who later became known as CSTs. The Fire Service now had a three tiered level of firefighters. The three tiers included the professional firefighters; the volunteer firefighters (who traditionally had served their communities admirably but had often been poorly treated by professional firefighters who understandably viewed their employment as threatening to their own); and now the Community Service Teams.

In April 1996 training of the first Community Service Teams began at Wigram Air Base. The recruits were trained by a large team of trainers which consisted of New Zealand Fire Service personnel and consultants. Many of the trainers were former Fire Service executive officers who had left during the restructuring. The 13 week training course saw the recruits trained in firefighting but undertook a wider range of training to include fire safety, community education and other emergency duties. The CSTs role was to be dramatically wider than that of existing firefighters. The change was to move from a reactive force that fought fires, to a proactive one that prevented them from occurring in the first instance. The CSTs were to work a completely different shift system to the existing professional firefighters which included longer hours with a significant increase in hours per week of productivity. The Professional Firefighters Union attacked the CSTs role and referred to their employment as "cut price workers" (Information Centre, 1998).

The amount of anger and distress following the implementation of a significantly different contract resulted in the sabotage of two fire engines used in training and "Judas" letters being sent to some former Union members who were involved as trainers. The ongoing stress related to this change in personnel and their duties continues to impact on the health and safety of all levels of personnel today (Information Centre, 1998).

In 1997 a New Fire Service restructuring proposal was announced. A new Commission was appointed and the restructuring plan stated that further

management jobs would go. Roger Estall, the new Chairman of the Fire Service Commission stated:

> *"The Fire Service currently selects and deploys its resources in our urban fire districts in much the same way and based on the same assumptions as existed mid-century" (1997, p.1).*

He continued to discuss the fundamental changes that had occurred in the nature of fire risk which had invalidated this historical assumption. The environment had changed, the ethnic make-up of the communities had changed and there was a need for the Fire Service to make changes to meet the ever changing needs of people and the environment

In May 1998 the Fire Commission Chairman unveiled "The Way Forward", a restructuring package which would see all 1600 firefighters sacked and made to reapply for 300 fewer jobs, in competition with volunteers and others outside the Service. Included in the restructuring proposals was the dropping of one firefighter off a standard fire appliance, which in the past had been crewed by four firefighters. This restructure was referred to as the Modernisation of the New Zealand Fire Service. Estall (1998) described how resources for the future Fire Service would be re-balanced by a refocus on the type of work the Fire Service would carry out and a broader role for volunteers. He emphasised the need for greater skills and competencies that were required for future employees and volunteer staff to deliver a refocused Service. While the volunteers welcomed the Fire Service Commission's modernisation plans, there was some concern that the volunteers would become over-burdened once the Fire Service cut paid staff (Catherall, 1998, p.3).

In June 1998 Jean Martin was appointed as Chief Executive of the New Zealand Fire Service. The Professional Firefighters Union took legal action against the restructuring and won a permanent injunction in the Employment Court. A new National Commander, Ken Harper, was appointed in January

1999 and he expressed concerns about some of the Commission's restructuring plans. Jean Martin and the Professional Firefighters Union secretly reached an accord to end the industrial dispute, however this was rejected by the Commission. Roger Estall resigned just days prior to a Parliamentary Select Committee releasing a report damming his financial management of the Commission. He was replaced by the Director-General of Social Welfare, Margaret Bazeley. Within days of her appointment, Jean Martin resigned and was replaced by Alison Timms, who had worked previously with Margaret Bazeley in the Department of Social Welfare. Margaret Bazeley announced the Fire Service Commission Strategic Direction on 7 July 1999, stating that the reform process would continue. In her communication to personnel she made it clear that she hoped to work co-operatively and collaboratively with personnel to achieve the reform process, and viewed further Court proceedings with much disdain.

In October 1999 the controversial plans to reduce firefighter numbers and reduce crew numbers from four to three on some selected fire appliances, was laid to rest following the Court of Appeal decision. The Court rejected a bid by the Fire Service Commission to overturn the previous Employment Court's decision which prevented the dismissal of all firefighters as part of a radical restructuring move driven by the previous Fire Service Commissioner, Roger Estall. While many of the firefighters would view this decision as a victory, the radical restructuring proposals had caused significant stress and tension amongst all ranks of the Fire Service and had created much uncertainty amongst the Service. Following the Court of Appeal's decision, the Fire Service Acting Chief Executive, Alison Timms, and the Professional Firefighters Union, had plans to work towards settling a new contract for firefighters.

Through all these changes the Occupational Service has not been left untouched. During the lengthy ongoing restructure the nurses particularly have had to provide ongoing support in terms of counselling and stress management in order to attempt to maintain the health and safety of their

clients. Their working conditions have also changed dramatically. In 1993 a new Health Policy was implemented which included a method for the reporting of accidents, and volunteers suddenly appeared on the statistical reporting form. This was not discussed with the staff and in one particular Region it represented a 500% increase in personnel to be covered by the Service.

Up until 1997, the Health and Safety policy has not changed in line with the new structure and Health and Safety Committee meetings had almost ceased in some Regions. The National Health & Safety Committee previously had an Occupational Health Nurse representative but had not done so since the new Fire Service restructure. The compliance with the Health and Safety in Employment Act (1992) has at times been dubious. Investigation of accidents became the exception rather than the rule. Near misses, which has the potential for a major injury or even death, were not usually reported.

With the loss of the Director of Safety and Health during one of the many restructures, the Occupational Health Services was left out on a limb. Up to the current 1998 restructure, I would suggest that the Fire Service was not fully meeting its obligations in providing a healthy and safe work environment for its employees. In such turbulent times I would suggest that given the high level of anxiety and unrest, that it was even more imperative that the health and safety needs of personnel were paramount.

In 1997 the Commission called for submissions on the Occupational Health Service, but a general fear existed amongst the staff and firefighters that like many of the services previously carried out by Fire Service employees, the Occupational Health Services would be tendered out to private providers. This fear was to be subsequently realised in some Regions. The Occupational Health Units prepared submissions which highlighted its strengths in terms of value to the Service, the trusting relationship that had been established over the years, its cost effectiveness and efficient use of

time, its accessibility and availability to staff and the appropriateness of the services it provided. The Occupational Health Nurse co-ordinated the Peer Support Teams to ensure quality assurance and a consistent service and this role was seen by myself and other Occupational Health Nurses as a vital role in maintaining a credible and safe Critical Incident Stress Management programme. The subsequent loss of the Occupational Health Nurses in some Regions was to cause a significant effect on the co-ordination and quality of the existing CISM Peer Support Teams and they struggled to maintain their credibility.

Some of the weaknesses that could be highlighted were that Occupational Health were not seen as being fully integrated into the Health and Safety programmes but were seen as a separate entity. There was not a separate designated Occupational Health budget and equipment needed updating. The volunteer firefighters had limited access to the Service due to their large numbers and the geographical spread of their locations. The Occupational Health staff were generally not represented on Advisory Committees such as Uniform and Equipment, and as previously mentioned the Occupational Health Nurses were not represented on the National Health and Safety Committee.

3.5 SOCIO-POLITICAL CONTEXT

Despite strong opposition from the firefighters, the Professional Firefighters Union and the Occupational Health staff, tenders from private occupational health providers were called for early in 1998. Nightingale (1998) discussed the need for a more comprehensive and co-ordinated service. He acknowledged that the Occupational Health Nurse based service partly provided health monitoring and rehabilitation services but concerns existed due to inadequate time or resources not being available to meet the Safety and Health needs of volunteers and support staff. Further concerns included Safety and Health auditing and ACC cost control and reduction. A more comprehensive service was preferred by Management. However, when one

looks at the historical development of the Occupational Health Service it is evident that a fully comprehensive and integrated service was never truly actualised.

As an Occupational Health Nurse who was previously employed by the New Zealand Fire Service and having maintained my contacts with many of the nurses who had remained until their demise or disestablishment, I challenge this argument. The reasons why I challenge this argument has been previously identified in this chapter where I discussed both the strengths and weaknesses of the previous Occupational Health Service. While progress was slow in the initial conception of the Occupational Health Service, the Occupational Health Service was expanded over time due to experience, and the gradual acceptance by Management and firefighting personnel of the Service. This acceptance was also assisted by some of the recommendations made in the ICI Report. Two key legislative changes, the Health and Safety and Employment Act (1992) and the Accident, Rehabilitation and Compensation Act (1992), also assisted in increasing the role and effectiveness of the Occupational Health Service within the Fire Service.

To become a more comprehensive service, the last restructure has followed the ethos of the ever changing work environment, where services that were previously provided within the organisation have now been contracted out to private providers who often have little or no knowledge of the culture of the organisation they are serving. While I appreciate that with time they will develop and understand the culture, this has been just another change that firefighters have had to face. The cost of providing private providers in many instances far exceeds the cost of the previous Services. While currently several Occupational Health Nurses who practised in the old system have remained within the Fire Service, they have taken up a new role as the Health and Safety Manager for their particular Fire Regions. Each Region has their own individual Health & Safety Policy, not a National Policy, and the Regions working independently of each other without any major direction

from the National Office, previously known as National Headquarters. Many of the day-to-day nursing tasks have been passed over to part-time contracted nurses and firefighters on the whole view these Health and Safety Managers with some suspicion. They view these ex-Occupational Health Nurses as part of Management, where previously the nurses were never aligned with Management. While I believe that these part-time contracted nurses will in time be able to build up a trusting relationship with the firefighters, it is going to take a considerable amount of time, as the firefighters do not see them as belonging to the Service. The Occupational Health Nurses that practised in the old system were generally accepted by the firefighters as belonging to the Service.

It is my belief that the Occupational Health Service provided within the New Zealand Fire Service did generally meet the needs of its people, had become accepted by personnel and was able to provide an affordable, appropriate and culturally safe service. However I do not believe it was able to reach its maximum potential due to a lack of resources and the expertise that existed within the Service was not being utilised to its full potential as previously discussed in this chapter.

3.6 CONCLUSION

In this chapter I have documented the history of the health services within the New Zealand Fire Service prior to and following the ICI Fire in 1984. I have commented on the recommendations that were made following the Report on the ICI fire and identified the many significant changes in the restructuring of the Fire Service from 1990 to the present. I revealed how this has impacted on the operation of an effective Occupational Health Service, with a subsequent increase in the need to provide an effective stress management programme such as Critical Incident Stress Management. In the following chapter I will discuss the Fire Service culture particularly in relation to occupational stress and stress management strategies.

4. FIRE SERVICE CULTURE & OCCUPATIONAL STRESS

4.1 INTRODUCTION

In this section I will discuss the Fire Service culture particularly in relation to occupational stress and the stressors firefighters are exposed to in the Service. The effects of coping with the occupational stress of firefighting and firefighters personality traits will also be discussed.

It is well documented in the literature, which will be discussed in this chapter, that firefighters and other emergency service personnel such as ambulance, police, nursing and medical personnel use particular coping strategies for their stressful jobs (Hartsough,1985; Raphael, 1986; Pennebaker & Susman, 1988 & Janik, 1998). They utilise these particular coping strategies as a form of a psychological shield to protect them, and often their families, from their day to day encounter with human tragedy. I have personally witnessed firefighters coping strategies, particularly following attendance at a critical incident where immediately following the incident they attempt to maintain a sense of control. It is usually sometime later that they begin to experience the stressful effects of having experienced a traumatic event and may require some support to cope with the distressing effects. Because of this need to maintain a sense of control in the immediacy of the incident, as a Clinician I will quietly and sensitively let them know, without being intrusive, that help is available if and when they may require it

Different emergency workers may, because of their particular work tasks, use different coping mechanisms. However, I intend to focus in this chapter specifically on firefighters coping mechanisms. These coping mechanisms are seen as a form of personal stress management mobilised by firefighters to cope with the immediate crisis on hand, but may ultimately cause significant distress following the incident. Over time they can take over the

personality of the individual firefighter and effect their interpersonal relationships in the work, family and social setting. In this chapter I will communicate my argument for the need to provide appropriate stress management strategies such as Critical Incident Stress Management for firefighters.

4.2 THE PERSONALITY OF A FIREFIGHTER

The common profile of the personality traits of the professional firefighter, although not common to all, are that they tend to be action-orientated, obsessive-compulsive individuals who like to be the centre of attention and to be in control of the situation. They are described as being family orientated particularly in regard to their "firefighting family", that is their fellow firefighers. They tend to seek instant gratification, are loyal and highly-dedicated to their tasks and many firefighters are risk-takers, willing to risk their own lives for the safety of others.

> *"Being a firefighter is for many the central feature of their identity, as well as for their family members. Success on any job is largely a function of the "fit" between the personality of the individual and the demands of the job" (Harris, 1992, p.20).*

Kutner (1992) also discusses the personality profile of firefighters as being action-orientated, self-confident and self-assured in that they are able to cope with whatever confronts them in their daily occupational roles. Because of this profile they often have difficulty admitting that they are suffering emotional pain as a consequence of attending a critical incident. They tend to suffer in silence as opposed to seeking help as they are often embarrassed and perceive themselves as being weak.

These personality traits deserve further discussion. If taken to extreme lengths they can have the potential to increase a firefighter's vulnerability to

experience Critical Incident Stress. If the appropriate help is not provided it may cause them to suffer from Post Traumatic Stress Disorder.

A firefighter who has an obsessive-compulsive type personality may experience a sense of failure if an incident does not have a positive outcome. They tend to ruminate over how they could have done better and get into a cycle of self-blame. This can be further exacerbated by feelings of lowered self-worth and self-esteem. Often the firefighter may establish unachievable or unrealistic personal goals in relation to their work. When the firefighter expects everything to go well and all lives can be saved, they set themselves up to fail and may suffer disappointment if it is not actualised. Mitchell (1988c) discusses the dilemma that if a firefighter experiences too many failures from unfulfilled expectations this can dampen their enthusiasm and ultimately decrease their job satisfaction.

The histrionic trait of enjoying being the centre of attention, while a useful trait in order to perform their tasks competently, can also have a negative impact. Their personalities are often seen as controlling, overbearing and annoying and leave little room for others to speak or be heard. This can affect their relationships with other firefighters, their families and social interactions.

While action-orientated they are easily bored and if their thrill seeking needs are not being met, they often partake and enjoy dangerous sports such as mountain climbing, sky-diving etc. Mitchell (1988c) discussed how not only overstimulation is a frequent stressor by repeated exposure to emergency situations, but the opposite can cause as much stress due to inactivity leading to boredom in the emergency worker.

As firefighters are seen as wanting to remain in control of the situation and as a consequence they are very often experienced at suppressing their emotions. The old movie image of "John Wayne" holding it altogether is important, though I believe this is decreasing. Seeing the need to seek emotional support following the experience of a critical incident or a traumatic

event, is often viewed as a sign of weakness.

The Fire Service is seen as a culture, as a family. The very nature of their work in which they face life and death situations, are not normally faced on a regular basis like other occupational groups. This produces a strong camaraderie and family culture rarely experienced by other occupational groups. Because of the duration of their shifts, the need to sleep over and share meals and routine chores, firefighters get to know and care about one another. Stuhlmiller (1996) discusses the developed interdependent family system being due to the shift system and the intensity of the work shared and absorbed. As an Occupational Health Nurse who worked within the culture of the Fire Service, my observation is that it is necessary to establish a bonded trusting relationship, a connectedness between firefighters so they are able to successfully perform their work. This relationship, once established, allows the firefighter to have a sense of confidence in their firefighting crew, particularly when they are placed in life and death situations. This research may highlight this relationship.

> *"Firefighters have a strong team affiliation with built-in socialisation practices that encourage and support that team identity" (Stuhlmiller, 1996, p.348).*

Bowker's (1988) study of firefighters in Wellington, New Zealand, discussed team work as a focal point of their social mechanisms. Each team member is allocated a specific task or position and they are all dependent on each other. This is particularly relevant when working together team in an emergency situation. They rely on each other in terms of their own personal safety.

Some firefighers need instant gratification and become impatient and frustrated, but also are recognised as working harder and longer to achieve a positive result. As risk-takers they are known to remain on the job longer than is advisable thereby compromising their own health and safety. Berg, Clifford & Wheeler (1997) discuss the dilemmas faced with regard to standing

down firefighting personnel at major incidents such as the Thredbo Landslide, New South Wales, Australia, which occurred on 30 July 1997.

> *"Some personnel wanted to be relieved with no shame. Some personnel wanted to be relieved but felt they would be "letting the side down". Some personnel were adamant that they would find it more stressful to be relieved before all the bodies were recovered" (p.5).*

The above example from Thredbo indicates that those who choose the profession of firefighting are highly dedicated and have a greater sense of obligation for the saving of lives than the average person. Firefighters appear to be motivated by a humanitarian urge and assume risky behaviour in order to achieve a positive outcome in the saving of life and property (Frago, 1999). While these qualities show a great sense of dedication and commitment to saving lives, it is not without its negative affects on firefighting personnel when support and assistance are not provided and when the demands of the job far exceed their personal coping strategies. On occasions even the toughest "John Wayne" experiences the harmful effects of being exposed to repeated critical incidents. This is another area of interest that I hope will be highlighted in this research.

4.3 OCCUPATIONAL STRESS

Like most theories, the theory of stress has developed and changed over time since Hans Selye, an Austrian endocrinologist, wrote on stress between the 1930s and 1950s (Selye, 1976a). In 1926 Selye identified what he believed was a consistent pattern of mind-body reactions which he called *"non-specific response of the body to any demand"* (Selye, 1974, p.14). He later referred to this pattern as *"the rate of wear and tear on the body"* (Selye, 1976b)

Many different and useful theories of stress have advanced with time and research. However, in this research it is not possible to discuss these indepth. I will focus on developing the background and management of Critical Incident Stress. It is important to discuss occupational stress in emergency service personnel, particularly firefighters, in some depth before discussing Critical Incident Stress in the next chapter.

In reviewing the literature there is no single universally accepted conceptual model of occupational stress. There continues to be a growing interest in the literature in relation to Critical Incident Stress in emergency service personnel. Occupational stress has been described as the interaction (or transaction) between an employee and their work environment. The presence of stress can be inferred from the existence of problems in the employee/environment interaction (Ellis, 1995), or it can be measured in terms of health problems, cognitive processes and emotional reactions (Cox, 1992). It can also be measured in the organisational outcomes such as absenteeism or presenteeism where employees may be viewed as being physically present at work but "mentally absent", and measured in terms of staff turnover and injuries (Ellis, 1995).

Therefore occupational stress is dependent on the interaction of the individual and the environment or the circumstances they are in. It is not solely dependent on either the individual or the circumstances.

Cox (1992) stated

> "*The experience of stress at work is therefore associated with exposure to particular conditions of work, both physical and psychosocial, and workers' realisations that they are having difficulty in coping with important aspects of their work situation. The experience of stress is usually accompanied by attempts to deal with the underlying problem (coping) and by changes in cognition, behaviour and physiological function. Although*

adaptive in the short term, in the long term such changes may threaten health" (p.18).

Over the past 15 years, researchers have explored some of the occupational stressors of firefighters and other emergency service professionals. These studies (Kalimo, Lehtonen & Daleva, 1980; Hammer, Matthews, Lynons & Johnson, 1986; Mitchell & Bray, 1990) have suggested that firefighters and other emergency service personnel are exposed to extraordinary demands in relation to their emergency work and as a consequence, are at risk of "burn out" and/or suffer from a variety of physical and mental stress-related disorders.

While many of these research studies have focused primarily on traumatic events or critical incidents following catastrophic disasters with multiple casualties, it must be remembered that there are a multitude of other significant sources of occupational stress that affect firefighters.

Mitchell & Bray (1990) highlighted stressors that were task-orientated, specific and unique to firefighting such as driving an emergency vehicle at high speeds and using the ever changing and technologically sophisticated equipment at the scene of accidents or disasters. I facilitated a debriefing where the main stressor was malfunctioning and poorly maintained equipment. While it was a significant traumatic event, the firefighters were more stressed by the failure of the equipment to perform vital tasks in order to rescue the injured. Other potential stressors included fears of personal injury and the emotional strain of relaying the news of a tragedy to family and friends of the victims.

Firefighters are exposed to other occupational stressors such as organisational stress. This can include disagreements over operating procedures and power struggles with immediate superiors and/or with peers (Steinmetz, Kaplan & Miller, 1982). Alexander and Wells (1991) study of reactions of police officers to body handling from the Sioux City plane crash,

suggested that it was the organisational and the operational characteristics, rather than the exposure to the macabre sights, that was the primary cause of perceived stress.

Organisational stress can take several forms. Hartsough (1985) cited conflict between organisations, low rewards, role ambiguity and the discomfort with new roles, as causing distress. Communication problems, role conflicts, role ambiguity, and associated role strain have also been identified by Steinmetz et al (1982) and Paton & Finn, 1999. Berah, Jones, & Valent (1984) noted the effect of interorganisational stress as one of the most stressful aspects of the Australian bushfires when dealing with other relief agencies. Bartone, Ursano, Wright and Ingraham (1989) and Paton & Finn (1999) also cited interagency conflict as a major stress, as well as role conflict and a lack of clear role definition. Bushfire workers who did not have a high social support suffered significant stress from role conflict (Innes & Clark, 1985). Raphael, Singh, Bradbury & Lambert (1984) found that off-site workers suffered greater ambiguity of role than do on-site workers.

Personality conflicts with peers and/or a lack of camaraderie can further lead to significant stress within a crew who work long hours in close proximity to each other with very often little personal space. A heavy reliance on team work and upon one another in "life and death situations" can lead firefighters to feel unsafe when working with particular peers who are not "team players" or who have caused significant stress.

Sleep disturbance can be a problem for firefighters and with the impending change in shift structure to a 24 hour shift system for all paid firefighting personnel, this is a potential occupational stressor for New Zealand firefighters. Members of the New Zealand Fire Service who are known as Community Service Team (CST) members already work a 24 hour shift system. Many firefighters complain about the disruption to their sleep, sleep deprivation and/or the poor quality of sleep. Furthermore they are on the alert for an impending emergency call and as discussed previously they

complain of boredom and inactivity (Mitchell & Bray, 1990).

Certainly not unique to firefighters, but particularly pertinent due to the ongoing major restructuring of the New Zealand Fire Service, is the concern of job security. In June 1998 the Chief Executive, in essence, sacked all professional firefighters in New Zealand and requested them to reapply for new positions. The number of positions was to be greatly reduced and their role significantly changed as discussed in Chapter 3. The Professional Firefighters Union fought this decision in the Employment Court and were successful in having the decision overturned. This has caused a high level of stress in firefighters with reported complaints of low morale, an increase in sick leave, particularly stress leave, and lowered productivity. This has had a spill-over stress effect into their family and social environments. While the Court of Appeal rejected a bid by the Fire Service Commission to overturn the Employment Court decision in October 1999, many firefighters still continue to suffer stress in relation to their uncertain industrial relations.

A further occupational stress is that many firefighters, due in part to their shift work schedules and partly due to their level of income, work in secondary jobs. This has the potential to cause further stress related to their secondary employment which may affect their primary employment.

Karasek, Theorell, Schwartz, Schnall, Pieper & Michela (1988) highlighted the effects of psychological demands and job latitude and control. As discussed there are studies which have researched the effects of organisational and leadership such as communication, poor information management systems, and inadequately prepared leaders, are all contributors to stress (Hammer, Hammer, Lyons & Johnson, 1986; Paton, 1997). There is an ever increasing body of knowledge on the importance of Critical Incident Stress in the emergency services personnel.

Tools to measure occupational stress have been developed such as the Occupational Stress Inventory. However it fails to consider the variety and

unique job-related stressors as discussed in this chapter in relation to firefighters (Murdock,1981).

A review of the literature on emergency service personnel revealed a number of outcome measures for occupational stress (Kuorinka & Korhonen, 1981; Hammer, Matthews, Lynons & Johnson, 1986; Markowitz, Gutterman & Link, 1987). No single instrument was used to address task demands, role responsibilities and job-related stressors. The Sources of Occupational Stress Instrument (SOOS) (Beaton & Murphy, 1993) was developed and has been modified over time. The SOOS identified 57 occupational stressors inherent or related to being employed as a professional firefighter/paramedic. While developed in the United States of America I consider that it is can be applied in the New Zealand context to measure occupational stress in firefighters.

Beaton & Murphy's (1993) study of firefighter and paramedic emergency service personnel to measure job-related stress, revealed that conflict with management was the job stressor that most strongly correlated with the report of low job satisfaction and low work morale in both groups. Other commonly reported sources of occupational stress included disturbed sleep, and tedium related to boredom and dislike of day-to-day duties which correlated with job dissatisfaction and lowered morale in the firefighter group. However, these findings may not be a valid representation of this group as there was only a 50% response rate to the survey.

Research by Taylor (1983, 1991) reported more than a decade ago that exposure to occupational stressors does not necessarily cause adversity in individuals but can have the positive effect of providing a challenge from which emergency service workers character and resilience are built. From my own observation working with firefighters, they are trained to respond to emergency situations. However some firefighters may never experience a "good fire". When they do, they experience a real high in terms of the challenge and a feeling of a job well done particularly if life and property has

been saved. In firefighters terminology it is referred to as a "good save". A further study by Motowidlo, Packard and Manning (1986) discussed how other factors influence the perception of occupational stress. Job conditions, personal characteristics, especially job experience, type A personality characteristics, the fear of negative evaluation, all strongly influence how events in one's life will be experienced and interpreted.

In order to preserve the careers of emergency service personnel and to prevent the crippling effects of stress-related disorders which are not only emotional but also physical stress-related disorders, it is important to gain a better understanding of occupational stress in firefighters. While firefighters enter their careers as physically fit and well able to perform their duties to a high standard, recent data indicates that job-related mortality in relation to stress-related disorders such as cardiovascular and coronary artery diseases are prevalent (Brooks, Parsons-Nicota & Richardson, 1998). The most recent reports (cited in Brooks et al 1998) of fireground death from the United States Fire Administration and the Federal Emergency Management Agency for the years 1995 and 1996, show that almost half of deaths occurring at incidents resulted from myocardial infarctions and half of the fireground deaths were a result of stress and/or exertion.

4.4 COPING MECHANISMS

Since the beginning of time people have been exposed to unusually stressful events. Natural or man-made disasters are shown in records such as the Book of Genesis which discusses the experiences of Noah and his family during the Great Flood. The history books recount endless stories of death and destruction from war.

However, it is only in very recent times that the impact of disaster on individuals has been studied. For instance Mitchell and Bray (1990) described the stress theory. Earlier Walter Cannon (cited in Selye, 1956, p.196) formed the basic foundation of this theory when he described the

"fight or flight" response, emergency reaction, in humans. He postulated that when a person was stressed beyond his/her capacity, an expected physical reaction such as freezing occurred, to enable the individual to prepare to fight, or challenge the stressor, or flee in order to escape the stressor. Hans Selye (1976a) added to Canon's work with his introduction of the General Adaptation Syndrome (GAS). During the first phase, an alarm reaction occurs and the person recognises a stressful stimulus. The mind and body respond with an increase in heart and respiration rate, and blood pressure. Muscles tense and the pupils dilate to take in more light. Biochemical responses occur in order to prepare to deal with the perceived stressor. Concentration improves and behaviour becomes extremely controlled. In the second phase the body attempts to resist the impact of the stressor by adjusting. Tensions increase due to the stressor until the body accommodates or exhaustion occurs. With enforced rest, the body recovers and achieves a steady state of relaxation until the next unusual stressor activates the syndrome once more.

More recently Horowitz (1976) posited that when people are exposed to prolonged stress, particularly during an emergency or disaster, a mode of coping called "denial/numbing" is initiated. By using this method the person is able to tolerate the constant threat of harm by either denying its existence or by assuming a numbed fatalistic stance. The findings of Lazarus (1975) adds credence to the role of cognition that the level of perceived threat during the stress experience determines the seriousness of a person's emotional response. Stanley (1990) produced further specific acute emotional reactions to extraordinary stress or trauma such as minimisation, disbelief and cold-like symptoms, to name a few. While cognitive defences are used by emergency service personnel to cope with the immediate and ongoing stress, overall little is known about its prevalence, effectiveness or ability to be learned by the less experienced emergency services personnel (Janik, 1992).

Taylor & Frazer's (1982) incidental finding in their study of rescue workers, embalmers, mortuary staff and pathologists, found that those who were involved in body recovery and transportation, and victim identification, were able to cope more satisfactorily with their unaccustomed tasks if they regarded the grisly sights of broken bits and pieces of humans as broken dolls, frozen meat, tailors' dummies or waxworks' models. At a later stage it was necessary to readjust their cognitive defences of coping to equate with the reality of death (Taylor, 1990b).

Emergency workers historically have been known to use specific coping mechanisms when faced with the tragedy and suffering of others. There appears to be a paucity of empirical literature on coping strategies used specifically by firefighters. Most studies have subsumed firefighters as a subsection of emergency service personnel or health care workers. Coping mechanisms such as avoidance and distancing oneself, that is withdrawal from the reality of the incident, denial and a strong desire to achieve a successful outcome, all assist the firefighter to focus on the immediacy of the incident. While these coping mechanisms are essential strategies for use in the immediate situation, they have the potential to cause significant distress if the firefighter fails to cognitively process the incident sometime later.

Stress reactions can and do occur in firefighters during critical incidents which has the potential to interfere with effective operational performance. Ersland, Weisaeth & Sund's (1989) study investigated 134 rescue workers who participated in the rescue operation during the A.Kielland oil rig disaster in 1980 in which there was a large loss of life (58%). Approximately 20% of the participants reported one or more strong emotional reactions of significant strength and intensity of an overwhelming degree while working. Of interest, was that those who were less qualified for the task experienced more frequent and more severe stress reactions.

In the past the Critical Incident Stress Management Peer Support Team in which I am actively involved, has received significantly more referrals for

assistance from the less qualified and experienced volunteer firefighter as opposed to professional firefighter referrals. However, this does appear to be changing with an increased number of referrals from professional firefighters being received in relation to the stress attached to the ongoing protracted restructuring of the New Zealand Fire Service. However, Hytten and Hasle's (1989) study of professional and non-professional firefighters stress and coping following a hotel fire in which 11% of hotel guests died, found that despite the extreme stress associated with the incident, the frequencies of disturbing stress reaction during the incident were found to be low unlike McFarlane's study (1988b). These findings need to be placed in the unique context of the specific incident when comparing results from different incident studies. Every incident has its own special characteristics and problems. Emergency service personnel's competence and experience varies with different incident operations, the number of lost or saved lives and whether the rescue was positive in regards to the saving of lives and property.

On occasions firefighters may suffer excessive stress following exposure to a critical incident. They may resort to self-destructive and risky coping tactics. Some firefighters may not want to acknowledge the stress and deflect the excessive stress by using such maladaptive coping strategies as the abuse of alcohol and misuse of drugs. They may exhibit extreme use of anger and violent behaviour and socially withdraw, both in their occupational setting and/or family/social environment. By using these maladaptive coping strategies there is the potential to cause significant physical, mental, emotional and social disruption to their lives and the lives of significant others. This can cause greater problems than the original stress of the incident (Mitchell & Everly, 1995). Firefighters should be encouraged to use positive coping strategies such as cognitive reinterpretation and reframing of the critical incident in order to find some meaning or "silver lining" in the incident. This could be to reinterpret the "failure" into a "success" or relook at the stressor and view it as learning an valuable lesson for the future and seeing it as being part of personal growth. Other positive strategies for coping could be the use of relaxation such as meditation, massage,

biofeedback and deep breathing exercises.

I will expand on how maladaptive coping mechanisms can be avoided or lessened, particularly in relation to firefighters when I discuss the Critical Incident Stress Debriefing component of Critical Incident Stress Management in a further chapter.

4.5 CONCLUSION

Having worked in the area of Critical Incident Stress Management for the last 10 years, I have gained a greater understanding of the culture of the New Zealand Fire Service whereby firefighters are part of a large family who support each other through the good times and the bad. A special camaraderie exists which is related to the closeness of the work environment where they eat, sleep and work together for lengthy periods of time often under times of great stress. The need to care for each other through times of acute danger and stress all adds to the need to care for and understand the complexities of being a member of the Fire Service. I have personally witnessed some of the common personality traits, especially the need to remain in control, to stay on the job no matter what the cost is in terms of fatigue and safety, and the great sense of failure when property or life has been lost. Because of the culture that has been developed over time, it is my belief that one needs to understand the culture of the Fire Service with all its complexities in order to be able to work effectively with firefighters in the area of Critical Incident Stress Management. Members of the Peer Support Team who assist a trained facilitator in a debriefing are a vital link in the success of the debriefing. I believe they are the most important person in the debriefing in terms of being able to provide the most appropriate support and assistance. The Peer Support Team members understand the culture, the inherent occupational stressors, organisational stressors, the operational procedures and the different personalities, and are therefore able to provide the most effective support in order to assist firefighters through and following

a Critical Incident Stress Debriefing.

In this chapter I have discussed the culture of the Fire Service and in particular have discussed in some depth common personality traits that I and the literature recognise in firefighters. Ways in which these personality characteristics can help or hinder during their operational duties have been highlighted. I have also highlighted some of the known occupational stressors firefighters face and have also discussed some of the common coping strategies that firefighters utilise, particularly in the acute incident situation in order for them to remain effective operationally. Some of the less effective ways of coping following the incident such as maladaptive coping, have also been discussed and the impact this has on their lives and others.

In the following chapter, discussion will focus on a selection of the literature that defines and explores the phenomenon of Critical Incident Stress particularly in relation to firefighters, and the stress management strategy of coping with the critical incident called Critical Incident Stress Debriefing.

5. A REVIEW OF THE LITERATURE

5.1 INTRODUCTION

The need for preventative psychological care was identified following the recognition that some emergency service personnel suffered psychological distress following their exposure to critical incidents where there was the potential for either direct or indirect personal physical or psychological harm (Mitchell, 1983; Dyregrov, 1989; Parkes, 1991). A technique called debriefing for use after emergency service personnel were exposed to a critical incident was developed by Mitchell (1983) and Dyregrov (1989) and more informally by Raphael (1986).

In this chapter, I will define what a critical incident is and explore more closely the literature on critical incident stress. The formalised technique used to lessen the effects of Critical Incident Stress which is Critical Incident Stress Debriefing (CISD) will be discussed, together with the history of debriefing and the various models of debriefing. Due to limited space and my professional congruence with Mitchell's model (1983), the main focus in a review of the literature will be on this model of debriefing.

Critical Incident Stress Management (CISM) will also be discussed briefly as CISD is a component of CISM and it is a subset of an even broader field, crisis intervention.

I will discuss the contemporary debates on the efficacy of CISD and will conclude with a discussion on my position within the literature in relation to my own practice within the field of CISM, specifically CISD. I will explore a range of literature on CISD in order to identify the detailed steps in the process and its benefits to emergency service personnel when the model is applied appropriately and effectively.

5.2 CRITICAL INCIDENT/STRESS

The emotional response of emergency service personnel, that is ambulance, paramedics, firefighters and police, in relation to their exposure to critical incidents, has received considerable attention in the literature over the last two decades. In 1983 Jeffrey Mitchell, an American psychologist and paramedic defined a critical incident as:-

> *"any situation faced by emergency service personnel that causes them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function at the scene or sometime later (p.36).*

Very often critical incidents are sudden, unexpected and powerful events which are outside the range of usual human experiences. The potential fallout from exposure to a critical incident is Critical Incident Stress (CIS) which usually results from exposure to a traumatic or sudden situation or event which triggers a strong reaction in an individual. The sequence is well documented as being experienced even in well trained and experienced emergency service personnel. The incident has the potential to place an overwhelming demand on the individual's coping ability short-term, or even long-term. Because of the extreme nature of the critical incident, it may serve as the beginning point for the psychiatric disorder known as Post Traumatic Stress Disorder.

Critical Incident Stress is:-

> *"the reaction a person or group has to a critical incident. It is characterised by a wide range of cognitive, physical, emotional and behavioural signs and symptoms" (Mitchell & Everly, 1995).*

Critical Incident Stress occurs when normal individuals experience a normal

stress reaction which overwhelms their usual coping mechanisms following exposure to an abnormal event. They often feel overwhelmed by their sense of vulnerability and/or lack of control over the situation. Critical Incident Stress (CIS) begins as a normal response in a normal individual who has been exposed to an abnormal event. It is not a sign of weakness, poor training or leadership, in the individual suffering from CIS (Mitchell, 1992). Professionals historically have ignored the needs of emergency service personnel during crisis situations despite the occurrence of medical, emotional and mental disorders following these events (Raphael, 1975). In the past there has been the prevailing attitude that emergency service personnel are professionals who have "seen it all before" and "it is part of their job which they are trained to do". If they require professional help in coping with the negative effects of attending a critical incident, that is Critical Incident Stress, then it is considered that "the person is not suitable for the job". It is now well documented and understood that emergency service personnel are vulnerable human beings who have the potential to suffer from physical and psychological effects when exposed to the horror of human suffering (Mitchell, 1983), and that their job and training does not train or adequately prepare them for the negative effects of their exposure to critical incidents.

5.3 CRITICAL INCIDENT STRESS DEBRIEFING

Since the 1980s debriefing of personnel who have been exposed to the pain and suffering of individuals, groups and communities following natural disasters and accidents has been studied. (Mitchell, 1983; Bergmann & Queen, 1986; Raphael, 1986; Solomon & Benbenishty, 1986; Dunning, 1988; Manton & Talbot, 1990; Armstrong, O'Callaghan & Marmar, 1991). Providing debriefing services has been described as beneficial to emergency service personnel emotional wellbeing (Armstrong, O'Callaghan & Marmar, 1991; Mitchell, 1983).

Before discussing debriefing, it is vital to understand that debriefing is not

psychotherapy or counselling (Mitchell & Everly, 1997). It does however apply some of the basic communication skills utilised in counselling such as non-verbal rapport, asking open-ended questions, paraphrasing and summarising. There are several models of debriefing that require discussion before focussing on Mitchell's model (1983) which is the main focus of this research. It must be recognised that other forms of debriefing were carried out, somewhat informally and crudely well before the 1970s and 1980s when debriefing became organised more formally for the emergency services in the United States.

Although debriefing emergency service personnel is a relatively recent practice, encouraging limited ventilation or expression of the trauma experience has been used with soldiers in combat for at least 80 years (Mitchell, 1988a). Samuel Marshall, a military historian described a method similar to debriefing (Shalev, 1994). Marshall's diaries during the Second World War, and the Korean and Vietnam wars, discuss the benefits of debriefing. During this period small groups of soldiers were encouraged to discuss their experiences related to the traumas of war in some detail in a structured format soon after exposure. The debriefings were noted to have positive effects on the psychosocial functioning of the soldiers.

The most rudimentary of debriefings was held on the beaches of Normandy during the D-Day operations on 6 June 1944. Though not named debriefing or structured in any formalised process, the psychiatrist who facilitated the process generally sat with groups of soldiers and allowed them to talk of their traumatic experiences during the invasion (Mitchell & Everly, 1995). The effect on those who participated in the debriefings and were encouraged to ventilate their feelings was that they were found to be more alert and ready for battle the following day. Due to this intervention, combat stress-related casualties in the Army produced a significant decrease from 20% in mid-1944 to 8% one year later (Harkins, 1997). The success of this intervention quickly spread and during the remainder of the war other psychiatrists carried out these informal debriefings.

A Norwegian psychologist, Dr Atle Dyregrov developed a model (1989, 1997) and referred to his method as psychological debriefing. It is based on that of Mitchell's model although there are some significant differences. Dyregrov begins the debrief with a question that focuses on how the participant came to hear about the incident. During the thought stage, Dyregrov's model focuses on the participants decision-making process of the to reduce their tendency to self-blame. To increase the understanding and processing of the experience, a stage of sensory impressions of the incident is included. Though similar to Mitchell's model (1983), Drygrov's (1989) model places greater emphasis on normalisation of reactions and responses and suggests that this may be safer for those participating in the debriefing.

The Australian psychiatrist, Dr Beverley Raphael's (1986) model focuses on the emotional experiences of the participants and there is no formal assessment of cognitive processes. Interpersonal relationships are discussed in relation to identifying with the victims, concern for fellow workers and the impact of the incident on family and friends. Raphael's model is broader in focus than either Dyrgrov's or Mitchell's models. It does not follow the cognitive-emotional-cognitive pattern of both Mitchell's (1983) and Drygrov's (1989) models and is more involved with individual participants and their emotional experiences. She also deals with the participants' feelings for the victims of the critical incident which is not found in either of the two previously mentioned models.

The whole movement of CISM grew out of Professor Jeffrey Mitchell's nine and a half years as a firefighter/paramedic. In the 1970s Mitchell personally experienced the painful emotional effects following his exposure to a particularly unpleasant critical incident. He realised he was suffering the psychological effects of stress associated with his occupation and that others could also be similarly affected. His interest in mitigating, even preventing the stress attached to working in the emergency services field, began out of his own personal experience. He attained advanced degrees in psychology and human development and so began the birth of the CISM field (Bell, 1991).

The core of CISM is Mitchell's model (1983) of Critical Incident Stress Debriefing (CISD). Critical Incident Stress Debriefing is

> *"a psychological and educational group process designed specifically for emergency workers with two purposes in mind. First to mitigate the impact of a critical incident on the personnel, and second, to assist in the healing process of the members who are experiencing the normal symptoms and reactions to a stressful event" (Pierce, 1993, p.19).*

In essence it normalises the physical, emotional and cognitive effects on personnel from an exposure to an abnormal event.

> *"Most reactions to trauma are normal and do not indicate pathology or collapse" (Buckle & Hill, 1995, p.34).*

It represents a group meeting of those exposed to a common traumatic event/critical incident. It is led by a credible facilitator who is usually a mental health professional or other health professional, who is dedicated and has received the necessary training and who understands the culture and the unique personalities of emergency service personnel and the tasks they perform. The facilitator is supported by Peer Support Team members, often referred to as Peer Supporters, from within the particular occupational group. It was designed to mitigate the acute symptoms of distress associated with the exposure to a critical incident. It is supportive and encourages participants to discuss their experience, their personal feelings and reactions in a safe, caring and controlled environment. As the group members are all individuals who have been exposed to the same event, it enables them to share feelings and information on the incident. As a consequence of this group sharing the individuals feel less isolated and this reduces the likelihood of blaming or scapegoating and encourages participants to accept their reactions to the incident as normal (Hodgkinson & Stewart, 1991). By allowing the participants the opportunity for catharsis through discussing the

critical incident, there is a reduction in arousal and improved immune functioning (Pennebaker & Beall, 1986).

My experience with debriefing is that it involves a "piecing together" of the event, getting the whole picture, not dissimilar to the piecing together of a jigsaw puzzle where participants have some part of the puzzle/picture, but each has their own story, but not the full story. By the piecing together of the incident the participants are able to have a better understanding of the incident and to make some sense of the incident. Raphael (1986) refers to this piecing together as gaining mastery of the incident which ultimately allows the participants to eventually distance themselves from the incident and bring it to some conclusion. An important dimension of Mitchell's model (1983) of debriefing is that personal experiences are normalised and participants are assisted in looking to the future. Participants are encouraged to find something positive in the incident in which to make some sense of their experience. Participants are given health information and are assessed to identify those requiring more ongoing assistance.

As discussed in a previous chapter, emergency service personnel have a strong sense of wanting to be in control. Dyregrov (1989) has shown that adverse reactions from exposure to critical incidents can be prevented by debriefing as it gives the participants back that perception of being in control of their lives which is particularly important to emergency service personnel. Pennebaker & Susman's (1988) discussion suggests that the intense personal experiences brought about by the incident is able to be controlled by encouraging the participants to integrate the experience at both a cognitive and an emotional level.

The main aim of debriefing is to assist or accelerate recovery in normal individuals who are experiencing a normal reaction to an abnormal event before harmful stress reactions have the potential to damage their work performance, their careers, health, social and family life (Mitchell, 1983, 1988b; Dyregrov, 1989; Robinson & Mitchell, 1993).

Group psychological debriefing following critical incidents was originally designed to assist emergency service personnel deal with significant stressful situations they faced in their daily occupation, such as line of duty death, serious injury, deaths of children and multiple casualties (Robinson & Mitchell, 1993; Wollman, 1993). Debriefings are based along the lines of the military principle of immediacy, proximity and expectancy (Solomon & Benbenishty, 1986).

The functions of debriefing are essentially preventative although sometimes reactions and disorders may arise that require more specific psychological assistance or referral (Raphael, 1986). It must be acknowledged that CISD is not psychotherapy or a substitute for any such process.

5.4 CRITICAL INCIDENT STRESS MANAGEMENT

CISD was never designed to stand alone in the field of crisis intervention. It has always been considered one of the components of the comprehensive and mutlicomponent crisis intervention programme, Critical Incident Stress Management (CISM) (Everly & Mitchell, 1997).

CISM defined: As stated it is considered a comprehensive, integrative, multicrisis intervention programme. It is considered comprehensive because it has multiple crisis intervention components which range from the pre-crisis phase through to the acute crisis phase and into the post-crisis phase. The seven core components of CISM include pre-crisis preparation in the form of stress management education and crisis mitigation training; one-on-one crisis intervention throughout the full range of the crisis spectrum; family crisis intervention; disaster or large scale incident support which include demobilisation's; briefings and staff advisement; defusing, which is a small group process provided within hours of the crisis for purposes of assessment; triaging and acute symptom mitigation; CISD as already discussed; and finally follow-up and referral for assessment and treatment for those who require more on-going assistance. CISM provides a comprehensive system

in which multiple interventions are available to provide the maximum benefit to individuals, groups and communities during times of crisis. CISM services have been provided for emergency service personnel for the last two decades. However, it is now becoming a "standard of care" in many communities and organisations not associated with the field of emergency services (Everly & Mitchell, 1997).

5.5 SCIENTIFIC EVIDENCE

It is important that I define Mitchell's model (1983) since I base my practice on this model and this is the basis of the literature review. There have been multiple reviews of psychological debriefings but the conclusions with regard to the effectiveness have been varied. Some studies have failed to clearly define and identify the specific model of psychological debriefing that was used. These studies will be discussed under the non-supportive literature section later in this chapter.

Mitchell's model (1983) has seven stages (Mitchell, 1983; Mitchell & Everly, 1995) and is facilitated by a trained mental health professional or someone who has extensive training and experience in CISD. The facilitator is assisted by trained debriefing personnel, often referred to as Peer Support Team members or Peer Supporters. The debriefing is preferably held within two to seven days following the critical incident and can last from one to three hours. Attendance may be voluntary or mandatory. Generally participants are encouraged to participate voluntarily in the group process.

Mitchell's model (1983) places emphasis on the participants of the group processing the experience within a cognitive, emotional and cognitive framework. The **first stage** called the **introductory phase** establishes the ground rules, the goals of the debriefing, the various roles of the facilitator and Peer Support personnel, and the facts related to the particular critical incident are discussed. The **second stage** is the **fact phase** in which the critical incident is described on a cognitive level from each participant's

perspective from the time they arrived at the scene. The **third stage,** the **thought phase**, encourages the participants to describe their cognitive reactions and is a transition into their emotional reactions. In the **fourth stage**, the **reaction phase**, participants are asked to discuss what was the most traumatic aspect of the incident for them personally. The **fifth stage**, the **symptom phase**, participants are encouraged to discuss their symptoms of distress. This phase begins the transition back to the cognitive level. The goal of the teaching phase, the **sixth stage**, **normalises** their reactions and provides information on adaptive coping mechanisms. The **seventh** stage, the **re-entry phase**, addresses any outstanding issues, summarises the participants' experiences and assists the participants to find something positive from the experience. The process goal of CISD is psychological closure following the crisis. Since the goal of CISD is completion or closure, the CISD is not usually repeated (Mitchell & Everly, 1995).

Some critics of debriefing postulate that there is little empirical evidence which demonstrates the efficacy of debriefing and its subsequent prevention of Post-Traumatic Stress Disorder (Raphael, Meldrum & McFarlane, 1995; Gist, 1996; Gist, Lohr, Kenardy, Bergmann, Meldrum, Redburn, Paton, Bissen, Woodall & Rosen,1997). Research methods designed to measure simple cause-effect relationships of individuals who have participated in a debriefing, reveal little about the complex interactions between various factors which can affect an individual's response to the intervention. Variables such as the debriefing process utilised, the training and experience of the debriefing team, the timing of the debriefing, the type of critical incident the individual has been exposed to, repeated exposure to horrific critical incidents, cumulative stress, individual coping styles, support systems, and history of previous mental illness, can all influence the outcome of the intervention.

Mitchell & Everly (1997) discuss that those who oppose the use of CISD claim that there is no scientific evidence to support that CISD is effective; that CISD lacks a legitimate theory base; that CISD has not been scrutinised

and that those working in the area of debriefing require no specific training.

Researchers who have reviewed the literature on debriefing have highlighted several methodological limitations in various studies. (Raphael, Meldrum & McFarlane, 1995; Gist, Lohr, Kenardy, Bergmann, Meldrum, Redburn, Paton, Bissen, Woodall & Rosen, 1997; Avery, King, Bretherton & Orner, 1999). Because of the sensitive nature of the research related to critical incidents involving loss of life, multiple casualties and disruptions to communities, controlled studies are inherently difficult to carry out. Critical incidents are sudden, unexpected and can involve large numbers of people. Immediate support and assistance is required and research is very often inappropriate or difficult to carry out.

Critical incidents vary in nature and in their impact on individuals, groups and communities, affect the methodology employed. The loss of a colleague in the line of duty or multiple deaths and casualties such as the Port Arthur incident in Tasmania, Australia, or a natural disaster such as a major earthquake, raises the question whether the effect on emergency service personnel would be the same as that of volunteers assisting in the disaster cleanup.

A further important methodological issue relates to the use of control groups. Control groups cannot be easily formed as this involves withholding assistance. Randomly selecting experimental and control groups in the traditional research design poses ethical issues and can also be difficult to perform due to the chaos and nature of many critical incidents. Withholding crisis intervention services when it is seen as an important aspect of support raises serious ethical issues. Seligman (1995) also argues that assessing the outcome of psychological interventions in controlled laboratory conditions as opposed to those in the natural environment, can adversely affect validity.

Outcome measures in assessing the effectiveness of debriefing are problematic when carrying out studies. Individuals who have received the

intervention following a critical incident do not often see research questionnaires as being a priority and may fail to respond or give the questionnaire the time and attention it requires. Furthermore, emergency personnel often close ranks after major traumatic incidents and resist research efforts (Robinson & Mitchell, 1993). Due to the sensitive needs of those who have been exposed to critical incidents, research efforts often have to take a lower profile as the needs of those traumatised must take priority.

Studies need to evaluate behaviour outcomes such as return to work, and evaluating possible psychological outcome indicators such as the presence of intrusive thoughts, numbing and avoidance in relation to the incident. Because of the nature of their jobs, emergency service personnel, in particular, may fear the loss of their job if they reveal changes in their behaviour and psychological wellbeing. Management may view personnel who seek psychological assistance as no longer being suitable for the job in terms of their ongoing ability to cope with critical incidents in the future. Even if their job security is not able to be threatened by Management, their ability for job promotion may be compromised in the future. A further factor is that of time delay between the incident, the intervention and the assessment of the outcome tool. This is very relevant to emergency service personnel who, because of the very nature of their jobs, are regularly exposed to critical incidents, and the longer the delay in assessing the outcome the more likely they are to be exposed to further critical incidents which could sway the assessment of the original incident.

Further methodological issues which are not always specified in the literature relate to the exact nature of the intervention, what model or method was used, by whom and whether they have the necessary experience and training in the intervention being assessed. As discussed earlier, there are several models besides Mitchell's model (1983) which can be utilised in the field of debriefing such as Raphael's (1986) model and Dyregrov's (1989) model.

As can be appreciated, the above discussed methodological issues can all significantly affect the validity when assessing the efficacy of debriefing. However, it must be considered that research into debriefing is in its formative development and should be considered within this context.

5.6 THE LITERATURE

Due to the enormity of the literature in relationship to debriefing individuals, groups and communities, it is my intention to confine the review of the literature in relation to debriefing emergency service personnel which includes fire, police, paramedics, nurses and doctors. My main focus is on firefighters who are classified as emergency service personnel and are very often exposed to similar critical incidents or multiple critical incidents, and have similar characteristics, training, and coping abilities as other emergency service personnel. Also emergency and recovery personnel are classified as third-level victims of disaster (Taylor, 1990a).

5.7 SUPPORTIVE LITERATURE

Several Masters' Theses and Doctoral Dissertations highlight the positive benefits of CISD. The earliest study was carried out by Lanning in 1987 (cited in (Mitchell,1997), on emergency service personnel who were debriefed following their exposure to the Delta 191 air crash. She identified six positive perceptions of debriefings for the debriefed.

1. *Participants found the debriefing prepared them for future stress symptoms.*
2. *The debriefing enabled participants to accept symptoms and not feel crazy.*
3. *Participants received support from other participants.*
4. *Some problems were resolved.*
5. *The participants felt safe in talking about their feelings and not having to hide them or be "macho".*

6. *The mandatory debriefings did not make the participants feel singled out (Lanning, 1987, cited in Mitchell, 1997, p.89).*

The lack of a randomised control group is problematic in Lanning's study. Bohl (1988) studied Mitchell's model (1983) of debriefing in police andfirefighters. Using a naturalistic randomised control group, some personnel were debriefed by trained debriefers within 24 hours following an incident that involved a threat to or loss of life. Other personnel in a neighbouring department were not debriefed. All those involved in the study had been exposed to the same incident and their exposure to the incident was similar. Three months following the debriefing those who received debriefing from both the Police and Fire Services reported significant less depression, anxiety, anger and fewer stress related symptoms than those who were not debriefed.

> "*The results showed that even a single session, one and a half hours in length can be effective in reducing the symptoms seen 3 months after a critical incident" (Bohl, 1988, p.180).*

Roger's (1993) Doctoral Dissertation (cited in Seligman, 1995) evaluated Mitchell's model (1983) of debriefing on emergency service personnel. The findings suggests that CISD was helpful in reducing the participants psychosocial stress by providing a moderate increase in a feeling of being in control of one's reactions to the critical incident. As discussed previously emergency service personnel have a strong drive to be in control, particularly during critical incidents and in their lives generally. Another positive effect was that the participants reported lowered symptoms post-debriefing and were better able to resolve their stress reactions than non-debriefed personnel. Though a control group was utilised, participants in the study experienced different traumatic events with variations on the intensity of the distress.

Following the Los Angeles riots in 1992, researchers studied both the impact

of stress reactions on emergency medical service personnel and the effectiveness of CISD using a randomised control group. Wee, Mills and Koehler (1993) assessed 65 emergency service personnel who had either been attacked or threatened during the riots. Forty-two participants chose debriefing over 24 who declined. Utilising the Mitchell (1983) model and trained debriefers, it was found that participants who received debriefings had less symptomatology than the non-debriefed personnel, and were less stressed.

A further study by Jenkins (1996) found that debriefed personnel had fewer symptoms of depression and anxiety one month following debriefing using the Mitchell (1983) model. Thirty emergency service providers, who were mostly male and who were exposed to a mass shooting in a cafeteria in Texas, were offered debriefing. Fifteen of the personnel volunteered for debriefing and 15 declined the debriefing intervention.

Hytten and Hasle's (1989) study looked at the effectiveness of group debriefing for 39 firefighters who were involved in the rescue operation of a fatal Norwegian hotel fire. While participants found the debriefings helpful, their scores of intrusive thoughts and avoidance behaviour measured by the Impact of Event Scale (Horowitz, Wilner & Alvarez, 1979) did not differ considerably from firefighters who were not involved in the debriefings, but who discussed the incident informally with colleagues, family and friends. It was difficult to measure the effectiveness of the intervention as self-report measures were not standardised in this study.

In Shapiro and Kunkler's (1990) study following the football stadium disaster in England, 35 debriefings were held in 2 separate hospitals. Thirty-two debriefings were held in the hospital that received most of the dead and 2 debriefings were held in a second hospital. Sixty-eight per cent of those who were debriefed found it to be helpful.

In Smith and de Chesnay's (1994) qualitative evaluation study of 10 police

officers involved in violent incidents, ranging from the murder of a young child to the death of a fellow-worker, ten cases were presented. All but one participant rated CISD helpful on qualitative evaluation measures. It was difficult to measure the outcome due to self-report measures that were not standardised.

A descriptive study of questionnaire responses of 682 emergency nurses' perceptions of critical incidents and debriefing in Illinois, Indiana and Louisiana was carried out by Burns and Harm (1993). Respondents viewed the death of a child and the death of a colleague as the most critical. Thirty two percent of the respondents had participated in debriefings and 88% had found them to be helpful in reducing Critical Incident Stress. However, the authors of this study did not clearly define the group debriefing model utilised, or the training or experience of the group leaders.

Robinson and Mitchell (1993) conducted a systematic study of group debriefings on 172 emergency service, welfare and hospital personnel in Australia. The study evaluated 31 debriefings using the Mitchell (1983) model conducted over a 21 month period. The incidents which led to the debriefings were fairly routine except for three exceptions which were significant critical incidents involving loss of life. Participants were asked to complete an evaluation questionnaire two weeks post-debriefing on the value of debriefing. Ninety-six per cent of the emergency services workers and 77% of the welfare and hospital personnel noted a reduction in stress symptoms which they attributed in part to the debriefing. However 41% of the group of chiefly female welfare workers and approximately 65 of the group of chiefly male emergency workers reported the traumatic incident as having a significant and/or great impact on them with a high frequency of cognitive and other symptoms. However, symptoms were not assessed systematically with standard measures.

A further study by Robinson (1994) researched the broad range of CISM services offered to ambulance personnel in Australia following the aftermath

of tragedies. Of the 823 ambulance personnel involved in the study, 82% believed that the CISD's were helpful. As in Robinson's and Mitchell's (1993) previous study, due to the absence of a control group and the variance of critical incidents, it is difficult to draw valid conclusions.

Hanneman's (1994) qualitative study for her Masters Thesis on CISD evaluated the Mitchell (1983) model of debriefings. The group studied included volunteer firefighters in Nova Scotia. Hanneman identified eight dominant themes associated with CISD services. They were

1. *The positive impact of the CISD on the department.*
2. *The positive impact of the CISD process on the individual.*
3. *The value of venting.*
4. *The value of being able to express emotions.*
5. *The importance of getting the whole perspective.*
6. *The CISD helped firefighters accept that they had done their best.*
7. *The CISD helped them feel that they were not alone in their feeling.*
8. *The CISD produced a sense of bonding or brotherhood.*

Hanneman concluded:-

> *"This research was able to support some of the basic assumptions and rationales which are the foundations of Mitchell's Model. Psychological debriefings were found to be effective in reducing the signs and symptoms of distress. The cathartic discussions helped to reduce stress, facilitate group cohesion and mutual support, reduce or eliminate any misunderstandings or mis-information, and peer support was identified as being very valuable" (Hanneman, 1994, p.48-49).*

In 1994 Scandanavia suffered its worst peacetime sea disaster in its history

with the sinking of the "Estonia", when over 900 people lost their lives. Nurmi's (1997) study contrasted three groups of emergency personnel who received CISD with a group of emergency nurses who received support from their supervisors but were not debriefed. The rescue personnel that included firefighters, police investigators and disaster victim investigators, scored lower on the Impact of Event Scale (IES) (Horowitz et al., 1979) than the nursing group who did not receive the CISD. It is important to note that this was the largest application of Mitchell's model (1983) of CISD in Finnish history.

A study by Chemtob, Tomas, Law and Cremniter (1997) provided three hours of debriefing and two hours of disaster coping information to 43 disaster rescue personnel following Hurricane Iniki in Hawaii. Disaster related psychological distress was measured using the Impact of Event Scale (IES) (Horowitz et al, 1979). Two groups of individuals were debriefed using the Mitchell's model (1983) six months and nine months respectively following the incident, which is significantly later than what Mitchell recommends. Despite the fact that the debriefing occurred six and nine months following the incident, the CISD process was found to be effective in reducing symptoms of distress in both groups. This study is significant as it is one of the first studies to introduce a partially controlled design for psychosocial intervention after natural disasters. Though the group studied were not strictly from the emergency services group, because of the methodological strength of this study, I believe it required inclusion in this review.

In an attempt to evaluate the effectiveness of debriefings, Everly and Boyle (1997) carried out a meta-analysis. A meta analysis is useful because it

> *"allows for the statistical integration of the results of independent investigations so as to summarise and statistically express the overall effectiveness of the intervention under investigation". (Everly & Boyle, 1997, p.2).*

The methodological strengths of studies by Bohl (1988), Chemtob et al (1997), Jenkins (1996); Nurmi (1997) and Wee et al, (1993) and their use of the Mitchell model (1983), blended themselves to a meta-analysis of their data. All studies identified a common critical incident, clearly defined the group intervention utilised and assessed the outcome before the passage of time that may have further exposed the research participants to another critical incident. The five empirical investigations yielded a sample size of 337 subjects. The outcome of the meta-analysis showed a significant effect size, Cohen's d=.86, which is indicative of a large positive effect size attributable to the debriefing intervention. Clearly the results are compelling and encouraging with regards to the power of CISD to mitigate symptoms of psychological distress. Despite the variance of subject groups, traumatic incidents and the diversity of outcome measures, the beneficial effects were revealed.

5.8 NON-SUPPORTIVE LITERATURE

A further body of data in the literature on CISD presents findings that this type of group psychological intervention has no appreciable positive effects.

One of the most commonly cited examples of a CISD comparative study is McFarlane's study (1988a & 1988b) which revealed negative outcomes. This longitudinal study over a 25 month period examined the post-traumatic morbidity of 469 firefighters who responded to a bushfire disaster in Australia. The bushfire disaster (McFarlane & Raphael, 1984) destroyed almost three thousand square kilometres of bush, grazing land, orchards and national parks. Several thousand trained volunteer firefighters who either lived within and outside the fire affected area were exposed to extreme levels of danger for lengthy periods without respite. A number of homes were lost, stock and farms were destroyed, three volunteer firefighters were killed and many were injured. The General Health Questionnaire (Goldberg, 1972) was used as an instrument for measuring Post-Traumatic Stress Disorder (PTSD) in the study. Using a four-stage longitudinal design, participants were assessed at

six monthly intervals over a two year period. McFarlane found that those who were debriefed had less acute traumatic stress but had a greater likelihood of developing delayed PTSD. However, it is important to note that several of the participants were primary victims due to personal bereavement (7%) or personal property damage (23%). A further methodological flaw identified in this research is that the author did not clearly identify the type of debriefing utilised.

A further commonly cited study is that of Kenardy, Webster, Lewin, Carr, Hazell & Carter (1996) which evaluated the effects of stress debriefing on 195 emergency service personnel and disaster workers following an earthquake in Newcastle, Australia. The researchers compared 62 debriefed personnel with 133 who were not debriefed. Utilising the General Health Questionnaire (GHQ) (Goldberg, 1972) to assess post-trauma stress reactions and the Impact of Event Scale (IES) (Horowitz et al,1979) to assess general morbidity, participants were assessed on four separate occasions over a two year period following their exposure to the earthquake. There was no evidence of an improved rate of recovery among the 62 helpers who were debriefed. This finding was consistent in two years of follow-up assessments. However, 80% rated the debriefing as helpful. Once again there was no standardisation of debriefing. Kenardy et al (1996) were not able to determine objectively the quality of the debriefing provided and whether it matched Mitchell's model (1983). These studies were not controlled trials and the groups may not have been comparable. Some participants may have experienced different stressors, loss rather than trauma, had uncertain roles, or had more welfare or counselling duties for which the debriefing model was inappropriate. Some participants may have been distressed prior to the incident.

A significant flaw in both the McFarlane (1988a) and Kenardy et al (1996) studies is that both were longitudinal studies following participants exposure to a critical incident. By its very nature CISD was intended to provide short-term, acute crisis intervention to stabilise a critical situation and to assess

those personnel who may require more professional assistance. The key objective of CISD is to focus on short-term effects and therefore it is inappropriate to carry out longitudinal studies on short-term interventions. Also worth noting is that research participants may be exposed to further critical incidents, both professionally and personally, during the course of the study which further flaws the findings.

Drygrov, Kristoffersen and Gjestad (1996) conducted a study of 43 rescue personnel who were debriefed following their exposure to a fatal bus crash in Norway. Findings concluded that rescue workers had lower total scores on the Impact of Event Scale (Horowitz et al., 1979) at both one and thirteen months. However, those personnel who handled the dead and injured had significantly higher intrusion and avoidance scores which is indicative of Post-Traumatic Stress Disorder. Different types of victims were presented in this research and the delay in assessing the effectiveness of debriefing limits the useful interpretation of the results of this study. A further limitation to this study was the response rate. It was not considered optimal as there was a decline in responders over time. The sparse information regarding the non-responders precluded the researchers in determining whether the non-responders were more traumatised than the responders.

Following the Kempsey and Grafton bus crashes in Australia, which resulted in multiple losses of lives and casualties, Griffiths & Watts (1992) reported negative findings amongst half the subjects surveyed one year after the incidents. Two hundred and eighty-eight subjects, which consisted of fire, police, ambulance and medical personnel, and ministers and telephone operators were also included in the study and were followed up one year later. The 182 secondary victims that had been debriefed had significantly higher scores on the Impact Event Scale (Horowitz et al., 1979) and poorer scores for general health. The group with the high distress may have been worse without the debriefing, but the study was unable to show this. Several significant flaws were evident. Different types of victims were used in this study. The debriefing model that was utilised was not stated, nor the training

or experience of those who provided the debriefing. Also the delay in assessing the effectiveness of debriefing, especially amongst the emergency service personnel group who may have been exposed to further critical incidents, could have confused the assessment of the original incident.

A further Australian study (Matthews ,1998) examined the efficacy of debriefing using Mitchell's model (1983) in ameliorating the impact of post-traumatic stress on psychiatric care workers after a critical incident at work such as assault by a psychiatric client. The study included sixty-three direct care workers from two areas in Sydney who worked in residences caring for people with both psychiatric and developmental disorders. The sixty-three participants were surveyed for symptoms of intrusive thoughts, avoidance and hyperarousal, one week following an assault by a patient or another type of work-related incident. The participants who responded to the survey included fourteen workers who requested and attended a debriefing during the week following the incident; eighteen workers who chose not to attend the same debriefing though they were offered the intervention; and thirty-one workers who worked in a different area of Sydney where debriefing was not available. The study found there was no significant reduction in the stress reaction between the 14 workers who received the debriefing and the 18 workers who did not. While the debriefing was evaluated positively by the majority of the participants, there were some aspects of the debriefing, such as its timing and the work environment in which it was offered, which could affect the degree to which participants benefit from it. It is worth noting that Matthew's did not randomly select his sample group which limits valid interpretation of the intervention and subsequent study results.

A comparative study of debriefing in police officers following their involvement in rescue work where a Boeing cargo plane cashed into two high-rise apartment blocks in Amsterdam, claiming the lives of forty-three people, was carried out by Carlier, Lamberts, Van Uchelen amd Gersons (1998) Two hundred police officers were involved in the rescue, 45% were debriefed and 55% were not debriefed due to operational circumstances in

relation to the lengthy duration of rescue work or their unavailability due to the need to rest after the exhausting rescue work. Non-debriefed police officers were used as the control group in the study. Two assessments were carried out on the participants at 8 months and 18 months post-disaster. One hundred and five officers were recruited, forty-six had been debriefed and fifty-nine had not received debriefing. Results indicated that a total of 7% of the participants developed Post Traumatic Stress Disorder following the disaster rescue work. At the first assessment no significant differences between the debriefed and the non-debriefed were found which is consistent with the results of Hytten and Hasle's (1989) study and Kenardy et al's (1996) study. However at the second assessment, eighteen months post-disaster, the debriefed police officers exhibited significantly more hyperarousal symptoms in relation to the rescue work than non-debriefed police officers, which resembled McFarlane's (1988a) study with firefighters and Griffiths and Watts (1992) study with rescue workers. While the study indicated that the participants were recruited to reflect the entire population of rescue workers, the participants did not differ significantly in pre-event or post-event distress; in activities performed at the rescue site; or in their motivation to undergo debriefing. However, there were some limitations to the study in that data in relation to exposure to the trauma, motivation for debriefing and early symptom levels were collected retrospectively at 8 months following the trauma which has implications in relation to recall bias. While the two groups did not appear to differ significantly, it is possible that subtle or unmeasured differences such as their commitment to the task of rescue work, could have influenced the possibility in their participation in the debriefing in the first instance.

There are other significant comparative studies (Lee, Slade & Lygo, 1996; Hobbs, Mayour, Harrison & Worlock, 1996; Bisson, Jenkins, Alexander & Bannister, 1997) that showed similar negative results. However, all these studies focussed on primary victims of critical incidents, such as women who were debriefed at home following a miscarriage (Lee et al., 1996); victims of motor vehicle accidents who had been admitted to hospital (Hobbs, Mayour,

Harrison & Worlock, 1996); and burns victims (Bisson et al, 1997).

Other uncontrolled studies (Creamer, Burgeess, Buckingham & Pattison, 1989; Weissaeth, 1989; Searle & Bisson, 1992) suggest negative results. Once again these studies focussed on primary victims of critical incidents, such as individuals involved in a street shooting (Creamer, et al, 1984), victims of a factory fire and explosion (Weisaeth, 1989) and soldiers involved in traumatic combat duties during the Gulf War (Searle & Bisson, 1992).

While those studies that I have discussed resulted in negative outcomes, they still should be considered within the context of debriefing. However, as mentioned throughout the discussion of the various studies, there were significant methodological flaws which limits the validity of the studies.

Raphael, Meldrum & McFarlane (1995) and Gist (1996) discuss the rapid expansion of debriefing programmes reflecting a powerful social movement that is said to address the needs of emergency service personnel and victims of disasters and violence. All authors claim that there is little solid evidence on which to judge the increasingly sweeping claims that debriefing is effective, and there is some evidence to suggest that it is not effective and may even exaggerate the traumatic process (Kennardy et al., 1996; Watts,1994). While debriefing meets some real and symbolic needs and many of the participants who have participated in the many studies mentioned report it as being useful, it is expensive and not effective for many people. It may negate the need for more individualised and longer term programmes focussing on recovery and rehabilitation for those who have been traumatised. Also suggested by Raphael et al (1995) and Gist (1995, 1996) is the comment that debriefing may focus on the trauma to the exclusion of other important issues such as organisational and personal stressors. Raphael et al (1995) and Gist (1995, 1996) recommend that the existing programmes can no longer operate without randomised controlled trials of debriefing, using multiple outcome measures and assessments over time. They also recommend evaluating more individualised counselling.

5.9 CONCLUSION

The purpose of this chapter has been to discuss critical incidents, Critical Incident Stress and more extensively Mitchell's model (1983) of Critical Incident Stress Debriefing. I have referred to the literature utilising Mitchell's (1998a) CISM Review of the Literature which he presented at the Australasian Critical Incident Stress Association Conference, Auckland, New Zealand, April, 1998, and other sources which I have discovered through my research or everyday practice.

The CISD crisis intervention is but one component of the comprehensive Critical Incident Stress Management crisis intervention programme. CISD was never intended to be a stand alone intervention. However, I see it is a very important and effective group strategy in preventing serious and long term psychological distress. Everly & Boyle's (1997) study of CISD is extremely significant. A significant positive effect was revealed attesting to the power of the intervention in mitigating the symptoms of psychological distress. This positive effect was highlighted despite the wide variety of subject groups, traumatic events, and the diversity of outcome measures. As is usual, a larger pool of subjects would have added more credence. However, the results of this study are encouraging and hard to refute even by the strongest critics of Mitchell's model (1983).

As a Nurse Consultant with extensive training and experience in the use of Mitchell's model (1983), I have witnessed the positive effects and evaluated the debriefings which have on the whole revealed very positive results. For too long organisations and professionals in the field of emergency disaster have ignored the needs of rescue personnel exposed to crisis despite the occurrence of medical and mental illness following their exposure (Raphael, 1975). I believe that is because of the sensitive nature of a firefighters occupation. There is a continuing need to provide debriefing, where appropriate, to forestall even mild debilitation affecting their work, family and social environments.

While I have outlined the relevant research to date to assist the reader to gain some background understanding of CISD, I consider that many of these studies have lacked the ability to truly portray the benefits of debriefing. Many of these studies fail to gain a deeper meaning of the experience of debriefing from the individual perspective of the emergency service personnel. As a Clinician, I have a passion to gain a greater depth and breadth of understanding in relation to CISD from the individual's perspective in order to assist me to advise and offer the most appropriate CISD strategy in the New Zealand Fire Service. It is for this reason that I carried out a qualitative research project utilising individual narratives portrayed as case studies to gain a rich understanding of the experience of CISD. The research studies appear rather bland and do not reveal the individual's experience of debriefing. Many focussed on facts and figures to prove or disprove the value of debriefing. I asked myself when reflecting on the studies, whose benefit was being served by these studies, the researcher or the researched? How therapeutic was it for the participants to be involved in these studies? I hope that by carrying out this research project, that the participants in this research will experience a therapeutic process and that the readers of this research gain a greater understanding of CISD. As a researcher and as a Clinician working in the area of CISM, I anticipate that I will gain a deeper understanding of the process with the potential to benefit the research in this area and of course my practice in which I know I can ultimately improve the debriefing process for future participants.

As previously discussed, emergency service personnel have the potential to suffer from Critical Incident Stress following exposure to critical incidents. Reactions to highly stressful events can cause immediate and/or delayed physical, emotional, intellectual and behavioural dysfunction. With the emphasis in the 1990s on the need for preservation and conservation of the world's rich resources, so too should our human resources receive the same attention they deserve. However, many organisations fail to take the appropriate steps to value and protect their personnel from not only physical harm but also from mental and emotional harm. In the present era in New

Zealand of downsizing and people being disposed of due to increased technology and continuing financial restraints, it is important for organisations not to loose sight of their most valuable commodity, their workforce.

In this chapter I have explored in depth the development of Critical Incident Stress Debriefing and discussed the extensive literature in regard to those who espouse the positive effects of debriefings and those who negate its effectiveness. I have concluded with my initial thoughts on debriefing prior to the research. In the following chapter I will outline the methodology I used to conduct this research.

6. THE PROJECT

6.1 INTRODUCTION

This chapter presents the ontological and methodological principles that guided the process of my research in relation to choosing the narrative case study approach. The study is located within postpositivist interpretive research, to further explore Critical Incident Stress Debriefing. I will discuss in depth my personal philosophy of practice as a nurse researcher and will focus on the process of discovering a methodology and the method that was utilised. I will focus my debate on the difficulties I experienced and resolutions I made around finding a methodology and method that was fitting for the project in order to meet the needs of the participants and the readers of this research. I will discuss how I discovered a methodology that would illuminate the rich descriptions that I anticipated would be revealed. I required a research approach that enabled the mutuality of my working role to be ongoing with the research.

As a Nurse Clinician working in the area of Critical Incident Stress Management and research, I believed that I was in a unique and privileged position in which to explore with the firefighters the experience of debriefing, as the essence of my practice involves responding to firefighters in their particular context. While collectively I view them as a group, within a particular culture, I also view them as individuals each with unique experiences, though commonalities do exist, in relation to attending critical incidents and the subsequent stress attached to attending these incidents. I questioned some of the traditional forms of research exploring human experiences. Like several Australian nurses (Moss, 1991, Lumby, 1992, Taylor, 1994a), I wanted to explore using a different style of research in order to understand and explain the individual experiences of firefighters. I wanted to utilise a methodology that helped us all, the researcher, the research participants and significant others, to understand the personal experiences of

debriefing. The narrative seemed the most fitting, as I believed it had the potential to uncover both the uniqueness of the experience and the commonalities. It offered the potential to work with the research participants in a creative, artful and caring manner, that was congruent to the research and had the potential to influence my future and others practice.

My plan in utilising the narrative as a methodology was to examine the semi-structured interviews with firefighters who had participated in a debriefing, not as a series of set questions and answers, but as part of a large recurring narrative about the experience. I intended to interpret the interviews as an unfolding of a central narrative about a person who has experienced a debriefing, and how this person has come to be in the place that he/she is presently in. While reflecting on how the firefighters begin to share their story, I could see with greater clarity that the narrative methodology would best fit my research.

It was my intention to direct the findings of this research as a means of assisting the New Zealand Fire Service and other organisations in looking at their provision of Critical Incident Stress Management. With this in mind I believed it was imperative that the research was presented in a language that was accessible to both the participants, the New Zealand Fire Service and other organisations who were likely to access the findings. As a result of my indepth reflections, I believed I discovered the most fitting methodology and will describe my journey through this process of discovery.

6.1.1 THE LENGTHY JOURNEY

I have been on a long journey to discover and utilise a methodology and method which would provide the most appropriate, congruent, sensitive and effective research process, when journeying together with the debriefed firefighters as research participants. In order to illuminate their personal experiences in relation to the process of debriefing, like any journey we had to discover a way together. Like many long journeys there have been some

breakdowns along the way. I will share my personal experiences in order to assist the reader in understanding how I came to choose the narrative case study as my methodology.

Parse's Human Becoming theory (1992) is:

> *"grounded in the belief that humans coauthor their becoming in mutual process with the universe, cocreating distinguishable patterns which specify the uniqueness of both humans and the universe" (p.5).*

I believed that I would be on a journey with the participants where the journey had the potential for the participants to also have a mixture of house-garden and wandering in the wilderness effect which was akin to Kelley's (1995) house-garden wilderness metaphor. I had a professional obligation to care for the participants and was in a unique and privileged position to assist them on their journey through the research, finding their house, travelling through their garden by cultivating and toiling their roots in order to reveal their stories in a safe and caring environment. I did this by being present with them in times of wandering through the wilderness of uncertainty, in the uncovering of the painful effects of the critical incident.

I utilised Parse's practice methodology to guide me to live in true presence with the participants, travelling with them on their journey, and seeing how it is for them. True presence to me means real and genuine human to human relating, open to what is happening to the person in the moment. I believed that the qualitative research method best suited my study.

A further key concept in my personal philosophy is that of viewing the participants holistically, understanding them as a non-reducible totality, being more than the sum of parts. Chin & Kramer (1991) claim that

> *"the most consistent philosophic component of the idea of the person is the dimension of wholeness or holism" (p.42)*

This ontological position is compatible with my research methodology which views reality as being created by people through interacting with their environment. Each person creates their own reality from their own experiences they have within a particular moment and within the space of their social and cultural worlds. Lincoln & Guba (1985) support this idea of constructed reality as the most significant reality because it engenders the idea that multiple realities exist. There may be commonalties among realities, there is no one single reality. While there are many realities there is no one explanation of reality. The only meaning given to the reality is that which is identified by the person experiencing it and that knowledge is created . Thus knowledge is created by individuals and different actions will reveal different knowledge with knowledge being context bound. The above ontological beliefs underpin the methodology chosen for this research.

As my research was carried out on human subjects, my intention was to carry out ethically sound research where my focus of caring practice was able to be actualised. I wanted to move away from the traditional purist model with the dominant voice of the researcher and their interests being paramount over those of the researched. I wanted the participants to feel empowered so that they could be strong in voicing their world and to feel respected in their way of constructing and deconstructing their meanings within the context of their world and experiences. In the mainstream tradition of research there is a marked asymmetry of power between the interviewee-interviewer relationship (Mishler, 1986). Telling one's story and being fully heard can be empowering for research participants. Mishler (1986) proposes a mode of interviewing that empowers people and encourages them to speak in their own voice

> *"When the balance of power is shifted, respondents are likely to tell "stories"....interviewing practices that empower respondents also produce narrative accounts. Through their narratives people may be moved beyond the text to the possibilities for action. That is, to be empowered is not only to speak in one's*

own voice and to tell one's story, but to apply the understanding arrived at to action in accord with one's own interests" (p.119).

As my philosophy of practice centres on reducing the power differential, I view my clients, be they patients, firefighters, nursing students or research participants, as working collaboratively to achieve either an improved health outcome if possible, or a peaceful death; or in the development of the research study and in the analysis and interpretation of same. My philosophy also centres on the act of healing my clients and from my readings on the narrative methodology it did have the ability of healing by the participants telling their stories (Morse, 1988; Krysel, 1991; Sandelowski, 1991).

Storytelling has become a more acceptable method of research. It is culturally acceptable, adds both a richness and depth in the revealing and the understanding of the phenomenon being researched, and generates data which reveals genuine insights into the participants' experiences (Silverman, 1993). Storytelling also affords the researcher the opportunity to gain information that is contextually relevant and can thus assist providers of health care to develop services that are flexible and able to meet the realities of peoples' lives (Banks-Wallace, 1998). I believed that the use of the narrative would best suit my philosophy of practice and my chosen research.

6.2. PHILOSOPHY & QUALITATIVE RESEARCH

My particular philosophical and epistemological position in this study is based on Streubert & Carpenter's (1995) statement that qualitative research is not about prediction and control but is related to description and understanding.

I was attracted to qualitative research in that it is conducted within the real world of individuals' lives utilising methods that generate data in a more flexible and sensitive manner within the individual's own social world. I wanted to study a selected issue in greater depth and detail and believed that the qualitative method would enable me to meet my specific needs. I was

interested in obtaining a more complete representation of firefighters experience of debriefing and thus a more contextualized understanding of their needs.

Qualitative research is seen by some purists to be a new fad in the world of research and is deemed to be frivolous, without any real substance, value or able to be utilised in the real world of people and their problems. However, qualitative research is more concerned with the lived experience, unlike quantitative research which involves the positivist approach of finding the "truth" or facts and is purely objective.

Qualitative research is conducted with individuals who are influenced by the complexity of a social world which is often multi-layered (Mason, 1996). It offers a way to gain rich insights through the discovery of fresh meanings. I wanted to be able to truly understand the experience of debriefing from the firefighters experience in the complexity and context of their world, in order to discover fresh meaning which have the potential to influence my own and others practice in the area of CISD.

Qualitative research is grounded in a philosophical position which is broadly interpretivist, in that it utilises an holistic framework and it provides a mode to explore the depth, richness and complexity inherent in particular phenomena (Burns & Grove, 1993). My goal in utilising qualitative research was to transform my own and others understanding of debriefing. As Sandelowski (1997) states the goal of qualitative enquiry is not just the amassing of data but it offers the opportunity to transform understanding of the phenomena being studied.

6.3 DISCOVERING THE NARRATIVE

My journey in discovering the narrative was not without its wandering in the wilderness and along the highways where I felt at times incredibly confused and lost. The map that I planned to follow did not feel congruent with my own

philosophical beliefs. My own fear around following a different methodology tended to obstruct me in my ability to create a "fit" between myself as the researcher, the participants and those who were likely to access this study.

6.3.1. BREAKDOWN TO BREAKTHROUGH

Some years ago I was attracted to Parse's (in Kelley, 1995) house-garden-wilderness metaphor in discussing the journeying with clients through the health continuum. As a nurse researcher, relatively new to the world of qualitative research, I could relate to Parse's metaphor of being in the house-garden-wilderness during my journeying. However, I have used Parse's idea and taken the liberty of developing my own image in relation to the car metaphor that I will utilise as I tell my story.

As a novice in the world of nursing research, particularly qualitative research, my journey has not been without its "breakdowns". At times there have been major breakdowns where I have even considered dispensing with this "old car" as my research seemed beyond repair, particularly in relation to the dilemma of finding the most appropriate methodology that would "fit" the research. I even considered looking for a "new car" and starting afresh with a new research project. However, through the many breakdowns along my journey, with the assistance of my supervisor, nursing academics and nursing research peers, I began to see with more vision and clarity, that research is not a recipe and I did not have to follow a particular methodology step by step like a set of ingredients in a recipe book. I did have some freedom to design a methodology that suited my study and in order to describe and illuminate the experience of debriefing, I needed to enter into the research world fully. My dilemma centred on validating the firefighters experience of debriefing and checking out my model of debriefing in practice. I needed to discover a "fit" between the questions I was asking in relation to the debriefing the firefighters had experienced. As a Nurse Clinician involved in the debriefing, the best way to elicit this information from the participants was to co-create a text that would do justice to their experience. I had to

move away from questioning them to elicit this information in order to use the research process to both explore with them and to mutually discover what was occurring in the debriefing.

Initially, in considering this research, I was interested in gaining an understanding of the phenomenon of debriefing as it occurs "naturally" by listening to firefighters describe their experience of debriefing as it occurred. I knew I would ask them questions and that we would have conversations, but beyond this I did not know what the narratives might look like until I conducted a pilot interview. The purpose of the research was to understand the experience of firefighters following their participation in a CISD in which I had participated as a facilitator. I knew that knowledge of this experience is not possible without the firefighters describing their human experience as it is lived.

My initial intention was to use the interpretive approach grounded in Heideggerian hermeneutic phenomenology as a suitable methodology to study the experience of debriefing (van Manen, 1990). Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences. It does not claim to offer effective theory in order to explain and/or control our world, but rather offers us real insights into the everyday world of peoples' experiences (van Manen, 1990).

I viewed phenomenology as a method of research that appeared to offer an approach of accessing the "real life" experiences of firefighters in a way that retained the "aliveness" and context of their experiences. Rather than being focussed on the world of theory it is focussed on the world of experience (Reed, 1994).

As time passed I progressed with developing the research proposal and design. However, it became clear that phenomenology did not feel congruent with my own philosophy and did not "fit" well with me in terms of empowering the research participants and those who had the potential to

access the final research document. Congruency was important to my research. I felt uncomfortable with a methodology which the participants and the readers of this research would perhaps find somewhat foreign and difficult to understand its roots. Roberts & Taylor (1998) discuss the importance of choosing a methodology and method that has a degree of "fit" between the type of knowledge that can be obtained and the means available to achieve it.

After much soul searching I discovered narrative as a methodology. On reflection the periods of wandering on the motorway where I had a sense of being lost in the side roads during my journey of discovering the most congruent methodology was important. Because of the spiralling processing and reflection, I clarified and came to believe that the narrative would very likely reveal the liveliness of the experience of debriefing, the participants involvement and even illuminate the passion or depth of that experience for them. I realised I wanted to utilise a research process that had the potential to uncover the experience of the storyteller and that enabled this information to be shared with others in order to understand common human experiences.

Narrative is not dissimilar to reflective topical autobiography which focuses on a "snap shot" or a "part" of the participant's life story which is of some common interest and encourages comparison with others who have had a similar kind of experience (Berg, 1995). The aim of the participants' conversations was not to uncover a true account of the storyteller as required by some positivists' researchers subscribing to the philosophy of positivistic research. It was important to me that potential readers of this research were able to find some common meaning within the stories that were uncovered in order for the participants to gain new insights and a greater depth of understanding about their own and others lived experiences and the meanings they attach to these (Johnstone, 1999). In essence, the goal of the narrative was to facilitate the transformation of stories that sustained my own and others professional practice in the area of Critical Incident Stress Management, specifically Critical Incident Stress Debriefing.

I have used Sandelowski's (1991) discussion on the increasing use of narrative and story telling in qualitative research as a foundation to develop my position. Narrative and storytelling is a primary way individuals make sense of their experiences. By the telling of the story of the experience, it takes on new meaning for the person. Morse (1988) records that interviews encourage participants to tell the whole story, rather than just bits and pieces. She also discusses that participation is unquestionably a therapeutic process. I was later to discover that all the participants found the interview process to be a therapeutic experience as they were able to tell the story from their own perspective. At no stage during the interviews did any of the research participants find it difficult recalling their story of the particular critical incident and the follow-up CISD. Once a trusting relationship had been established at the beginning of the interviews, they tended to tell their story with much passion and in a great detail.

I have discovered in my practice that very often firefighters come into a debriefing feeling anxious and fearful about the process believing that they are going to go through a process of psychoanalysis. I have repeatedly witnessed the firefighters transformation from entering the debriefing in a tense and anxious state, to that of great relief and release following their own and others active participation in the debriefing process. In the introduction phase, the first stage of the seven stages of the debriefing, the ground rules for the participants, the facilitator and peer supporters are discussed in detail. The facilitator discusses that the participants are not undergoing a form of psychoanalysis, but are there to tell their story from their own position. I refer to this as each person having a piece of the jigsaw puzzle, and with each and everyone's support all the pieces will be put together into the full puzzle or picture. It is also established that the Peer Support Team members and facilitator are there to support and assist them through the processing of the trauma attached to attending the incident, and that the debriefing is not a critique of the operational side of the incident, but is a stress debriefing. If the introductory phase has been carried out in a caring and supportive manner, it is amazing to see the participants suddenly begin to relax and feel

less threatened by the process. I believe this sets the scene for the participants to begin to open up as they are being valued and feel empowered to share their own story in a more calm and relaxed manner.

Personally, I view nursing as focussing on experience, being engaged with people who are living in their personal worlds whereby together we negotiate a safe passage through the many uncertain journeys of health. My participation in their journeys is fraught with both vulnerability and strength as we negotiate this journey as partners in the process. These experiences can be conveyed as narratives of exploration (Gadow, 1995). The lived experience in narrative can afford an opportunity in which truth becomes visible. This will be discussed in a later chapter, where one of the major themes for one of the participants was that debriefing afforded him the opportunity to tell the truth. In telling his story he was able to engage with the researcher and offer others his experience of debriefing. Narrative is an excellent way of explicating knowing because by the sharing of the experience we can engage others in our explorations and join them in theirs (Gadow, 1995).

6.4 NARRATIVES AS STORYTELLING

In-depth interviews uncover personal stories (Hutchinson, Wilson & Wilson, 1994). My attraction to the narrative as a methodology rests on seeing the experience to be uncovered as having multiple meanings and open to differing interpretations, so that no one experience is reduced or objectified. Narrative is a way of highlighting aspects of the person's experience that cannot be fully realised within the positivistic model of research (Wiltshire, 1995). There are many ways of expressing and illuminating the lived experience and the narrative appeared to "fit" my research, especially in relation to the research participants and consumers of this research. It uses ordinary everyday language that has the potential to reveal and uncover the richness of the experience, without using new terminology that has little meaning or relevance to the experience or peoples real world. Instead of

uncovering the richness of the experience, new terminology has the potential to disempower and disengage both the participants and the readers of the research as they begin to view the subjects' experiences as being objectified by foreign terminology and jargon.

The earliest and most widely cited model of personal narrative is the Labovian model, which is still current today (Mishler, 1991). Narrative as a methodology has a long history of being invisible, inaudible and has been relatively ignored as an object of research. However, there has been a renewed academic interest in personal narrative (Langellier, 1989). It does not appear to fit neatly within the boundaries of any one particular scholarly field (Riessman, 1993).

Narratives located in research interviews require narrators and listeners. Participants in research studies together weave their stories with the interviewer and in many ways it is jointly woven. By utilising narrative in the research, a co-operative inquiry process and a culture is established that honours expression as well as explanation, and assists participants in making sense of the experience. I believe that narrative was a powerful method of communicating the findings of the inquiry to other people in a way that was congruent with their level of understanding of the methodology utilised. The narrative has the ability to seize the richness and the truth of an experience as it is told and retold over time. Not only does it assist those involved in the primary experience but meaning is shared with others. Not only is it a truly meaningful collaborative experience between the researcher and the research participants, but also meaning is able to be shared with others who may relate to the telling of the experience (Lumby, 1994).

In research we are taught that the goal of conducting research is to get the truth, the whole truth and nothing but the truth (Sandelowski, cited in Kikuchi, Simmons & Romyn, 1996). However, is our goal of research to get the whole truth or the whole story and whose interests are we serving in getting the former? Riessman (1990) relates stories as being the "strategic" way by

which individuals develop, sustain and present an interpretation of themselves and reality. Individuals use stories to describe and explain events and to justify themselves in their thoughts, actions and feelings. Good stories are a way of making our world more transparent and predictable. The descriptions elucidated in narratives have the potential to prescribe ways to act in the future.

It is important to acknowledge and appreciate that in the construction of stories the ultimate goal of storying is not so much to discover the real truth, rather to create it and to make sense, meaning and order. To acknowledge the truth in stories and the storied nature of truth requires that researchers maintain the completeness of the data gathered in the typical qualitative research interview (Sandelowski, cited in Kikuchi, Simmons & Romyn, 1996).

Stories have been used in the social sciences to view how we preserve a sense of connectedness in our identity over time. They reconstruct the experience in an ordered fashion to be understood in the past, experienced in the present and anticipated as the future. Humans are active constructors of their lives. People in their everyday life do not use abstract concepts to make sense of what happens to them, instead they tell each other stories. Stories reveal how people experience in a particular way the situations that effect their lives. Stories refer to lived experiences (Abma, 1998). Thus narratives have both a reconstructive and coherence function which Mishler (1991) refers to as the "narrativization of identity formation". Stories do not present a detached perspective but are told from a specific point of view. Stories are not completely static. They contain many meanings and are open to multiple interpretations and in the interpretation stories can change (Abma, 1998).

The act of constructing a narrative in response to an experience affords the storyteller the opportunity to examine their life that has been transformed by the experience. The details of individual stories may vary because the stories draw on the particular individual's position in their social world.

However the putting the story back together in all its totality, which is a function of the narrative, is seen as central to interpreting the experience (Mathieson & Barrie, 1998).

6.4.1 NARRATIVE AS INQUIRY

As I journeyed in the early stages of planning the study I had decided that the methodology that I chose would need to meet several critical criteria that I had highlighted as being paramount to the success and safety of the study. It was necessary to find a methodology that enabled the participants to describe, explain and justify their thoughts, feelings and reactions in relation to the critical incident and subsequent CISD. A methodology that had the potential to be healing in terms of making further meaning of the experience and also enabled the mutuality of my working role to be ongoing with the research. Once I had discovered the narrative I questioned myself as to why I had not been attracted to this methodology sooner. Had I been entrenched in the idea that I had to follow a particular recipe, which in hindsight would have been somewhat confining for both the participants and myself.

I had a great sense of relief once I was empowered with the freedom to develop my own methodology based on the narrative form of inquiry, using the case study method of data collection. I recognised that I could truly represent the generated data as narratives of the participants' experiences in a way that both the participants and the consumers of this research would appreciate and value. Using narrative enabled me to explore the experience of debriefing for firefighters and how they interact during and following the debriefing. It would have the potential to be both a credible and valuable piece of research that would have meaning to the wider community. Whatever methodology I chose would serve as a road map for the journey in order to reach the expected research outcome.

Mishler (1986) states that efforts to empower participants and the study of their responses are intimately connected. A significant way through which

participants make sense of and give meaning to their personal experiences is to construct them into a narrative form (Mishler, 1986; Polkinghorne, 1988). Human beings make sense of their experience by creating it in a narrative form (Gee, 1985). This appears to be particularly pertinent during difficult life transitions and traumas (Riessman, 1993). Therefore, I wanted to design a methodology in which there was a more equal partnership where the participants were empowered and felt more able to find and speak in their own voice. I believe that participants are more likely to tell their stories where there is a more open relationship and where the balance of power has shifted.

A further reason for choosing the narrative as a methodology was that storytelling is a time-honoured tradition in nursing. The narrative approach utilised in nursing research is seen as justifiable and practical because of the strength of the oral tradition in nursing. Nurses listen to their clients' stories and those of their families and friends. Clinical storytelling is a powerful tool in assisting the listener and the storyteller to develop shared knowledge and a greater understanding of the culture of nursing practice (Moss, 1991). Nursing is recalling the narrative to the world of nursing and storytelling is emerging as an important understanding within nursing practice (Baker & Diekelmann, 1994). Once I had discovered and decided to use this methodology I began to feel a sense of relief and congruency with the research.

My intention was that the research process would be of benefit to myself, both academically and professionally, for my continuing practice, but ultimately would be of benefit to the participants, their fellow firefighters and to the wider emergency services community. As will be discussed in a later chapter, it became evident during my interviews and follow-up discussions with the participants that the research process was of benefit to all the participants who found the process a very healing experience.

6.5 BENEFITS, CREDIBILITY AND TRUSTWORTHINESS

A further benefit from utilising narratives is that it has the potential to not only empower the participants by the telling of their stories, but the participants are also able to understand the possibilities for future action for themselves and for others. This became evident with my first case study, where the participant discussed how he had gained greater understanding of his situation and in future would be more aware of the need to carry out a defusing, an informal method of debriefing, with his crew following attending critical incidents. By telling his story, by reading the transcripts and by probing from the researcher, he was able to understand in greater depth the need for some form of CISM when the circumstances demanded it. Another participant, whose marriage had recently ended in unpleasant circumstances prior to the debriefing, was empowered by the process of debriefing in that he shared with the group more than what he was usually comfortable with. As a consequence of his increased confidence in the area of the telling of his story, he was considering seeking professional counselling to resolve some of his anger and pain attached to the breakup of his marriage.

It was my intention that this research, rather than be used to develop any major theory, has the potential to influence the New Zealand Fire Service and other emergency service organisations, of the need to provide Critical Incident Stress Debriefing where appropriate, or other forms of Critical Incident Stress Management, if debriefing was found to be of little or no benefit to the participants. My goal was to gain knowledge of the experience of debriefing practice. I explained to each participant prior to the interview process what my main intention was for carrying out the research. The participants had the role of acting as advocates within their community and culture, and the research was intended to serve their interests, the New Zealand Fire Service and other emergency service organisations' interests. The aim of the research was to collect information on the experience of debriefing in order to reveal its benefits in reducing the effects of Critical

Incident Stress and the subsequent potential development of Post Traumatic Stress Disorder.

It was always my intention that the voices of the four participants be "heard" in the final document. Primary quotations illuminating the pattern and themes that were uncovered are used to allow their voices to be "heard" in the text. I discussed with the participants at the beginning of the study that a copy of the analysis chapters would be made available to them for their comment on the truthfulness of the text, in that it accurately represented their personal experiences.

6.6 CASE STUDY AS METHOD

In this chapter I have identified and discussed the methodology that I have chosen that best "fits" the research. The philosophical and methodological premises of this research have created the methods that I have pursued to study the phenomenon of Critical Incident Stress Debriefing. As a researcher I needed to consider what method would best suit the research. I had a genuine interest in understanding the experience of debriefing and wanted to focus intensively on the experience of debriefing and all its complexities. With this in mind the logical road to follow was the case study method. The case study method was chosen because of the exploratory nature of the research (Yin, 1994). Case study is a method that is likely to seize the complexity of a single case or cases.

Case study investigates an individual, a group, institution or social unit indepth (Polit & Hungler, 1993). It is especially applicable when the researcher is concerned with client-centred clinical problems (Meier & Pugh, 1986). Case studies are considered an excellent method of carrying out research in nursing contexts (Sharp, 1998). It is widely postulated that case studies are beneficial in researching human experiences because they are practical and hold the reader's attention. However, case studies are not a

suitable basis for generalisation. They are often the chosen method of research as they may be epistemologically compatible with the reader's experiences and consequently to that person, a natural foundation for generalisation (Stake, 1978).

While it can be argued that the value of case studies is determined by the extent to which their findings can be generalised, the generalisability of such research is often underestimated. This relates to the confusion over two quite discrete logical bases upon which generalisations can be made; empirical and theoretical generalisations. Empirical generalisations relate to the claim that what is discovered is typical of the population from which the sample has been selected. Whereas theoretical generalisations are made on the basis of having highlighted or discovered some general principle concerning the phenomenon under investigation (Sharp, 1998). While only a few cases will be studied, they will be studied in depth. Certain issues, activities or problems will appear time and time again. Therefore, certain generalisations will be drawn (Stake 1994, 1995). There is another way for readers to learn from cases, Stake (1978, 1995) refers to this as "naturalistic generalisations". Naturalistic generalisations are the particular meanings the reader may associate to the text from the totality of who they are. It involves getting a feel for how things are, sensing what happens and generally extending one's experience whereby they are empowered and are given the sensitivity to act (Wilson, 1979).

The real pursuit of case study is not generalisation but particularisation. Case studies are particularistic in that they depict events or experiences in one particular situation as it exists in reality for the individual (Wilson, 1979). By taking particular cases the researcher comes to know the cases well, not just how it differs from each case, but what it is and what it does. The researcher looks for the uniqueness, understanding the particular case itself, seeing the difference between cases, but also looking for commonalities when interpreting the data (Stake, 1995).

The ultimate goal of nursing research, like other practice based professions, is to provide information that will lead to improvement in the provision of services to clients ((Meier & Pugh, 1986; Ray, 1991; Sharp, 1998). As a Nurse Consultant working in the area of Critical Incident Stress Management I am concerned with firefighters response to Critical Incident Stress and the resultant crisis intervention of debriefing. I have a commitment to understand the whole person and the complex issues that affect their response to a critical incident and the subsequent experience of debriefing. The case study approach I believe is well suited to focussing on the individual's experience. The case study approach focuses upon understanding the particular in addition to the general (Stake, 1994).

As it was my intention to use language that could be understood and presented to the wider community using narratives to describe the experience of debriefing, the case study method was the most appropriate method to pursue. It seemed reasonable to assume that the chosen methodology, narrative, and the chosen method, case study, are congruent with the type of research being undertaken for this study. Taylor (1994a) discusses the need for a degree of fit between the type of knowledge uncovered and the approach that is available to accomplish it. I wanted to portray the cases comprehensively using extensive but non-technical descriptions and narratives. I envisaged that the relationship between the researcher, the participants, and myself would be unique. I hoped that what was uncovered from the data would be of value to the New Zealand Fire Service, particularly in relation to providing the most appropriate CISM programme and may have some relevance to particular readers of this research, principally those working within the emergency services field.

6.7 CONCLUSION

In this chapter I have outlined my personal philosophy of practice and how it related to my choice of methodology and method for collecting the data. I have discussed in some depth the breakdowns related to my initial choice of

methodology and the discovery of, and subsequent choice of narrative as a methodology. I have discussed how narrative is a means by which individuals construct personal experiences to find further meaning. They touch others' lives by their familiarity which is akin to a mirror effect. Narratives are powerful tools for change as we learn from stories and are influenced by stories. Knowledge gained from narratives has the potential to be transferred to others working in the emergency services field. The case study method of social inquiry has also been discussed as a preferred method of research because it may be epistemologically in harmony with potential reader's experience and thus a natural basis for generalisation. There are potential benefits to both the participants and the readers of this research. The case study method has been utilised in the world of research and has been found to be a direct and satisfying method of adding to experience and improving understanding. The following chapter will discuss the research design utilised to conduct the research.

7. RESEARCH DESIGN

7.1 INTRODUCTION

The research design is akin to a map outlining the journey to be utilised by the researcher in order to provide an overall framework for the collection and analysis of data. In this chapter I will describe the study design focussing on the overall strategy that was utilised to access the research participants, the development of the research and the relationship that was established between myself and the research participants, the debriefed firefighters. I will also describe the decisions I made to shape the interview process; data collection and transcribing; ethical considerations and the process I used to gain rapport, verify and develop deeper interpretation of the data. I will conclude the chapter with a discussion on the trustworthiness of the data.

7.2 NEGOTIATING ACCESS

This research was carried out within the New Zealand Fire Service and the research participants were firefighters from within the Service. I had previously been employed as an Occupational Health Nurse in a Region within the Fire Service. At the time of the proposed research, I was a volunteer on the CISD Peer Support Team, and I was aware that there were a number of governing bodies within the Service from whom I was required to gain consent in order to carry out this study. Through my familiarity with the Service I realised that in order to gain the support of the firefighters, it was vital to have the permission and support not only of Management, but also of both the New Zealand Professional Firefighters Union and the United Fire Brigades Association. Without their support, especially the New Zealand Professional Firefighters Union, I knew that it would not be possible to carry out this study effectively. The journey of gaining consent from the five groups within the Service is a narrative in itself and is important in positioning the participants' narratives and the eventual reflections and practical value of the research to develop policy.

The research proposal and a covering letter requesting permission to gain access to the firefighters was sent to the Management of the relevant Region of the New Zealand Fire Service and the CISM Peer Support Team, where it was planned to carry out the study. The proposal was sent to the National Office of the New Zealand Fire Service; the New Zealand Professional Firefighters' Union; and the United Fire Brigades' Association of New Zealand. All parties approved and supported my request to access potential participants for the study without question. I felt affirmed in their approval and considered their unquestioning approval of my research proposal significant and an indication of their support.

The National Office required me to sign an agreement on four criteria relating to the research project. These included that no individual was able to be identified in any published reports; that the published report would only address the stated objectives; that the Region be advised of any change in the project that would significantly impact on the methodology, research or findings; and that the Fire Service reserved the right to withdraw approval (if warranted) as a result of any changes in the previous criteria. I have complied with these requests and conducted the research as requested. The New Zealand Professional Firefighters Union distributed a circular to its members in the relevant Region, outlining their approval and support by encouraging their members to participate in the study. This was another indication of their support for the study.

7.3 RECRUITMENT

As discussed, my study was approved and supported by the New Zealand Professional Firefighters Union, which assisted me in recruiting potential participants. Following receipt of ethical approval from the Central Health Wellington Ethics Committee and Victoria University of Wellington Human Ethics Committee to carry out the study, I then had to wait patiently for sometime for critical incidents to occur in rapid succession that required debriefings. Then several significant and powerful critical incidents occurred which required debriefing.

Following the debriefings which I had facilitated, I discussed with the debriefed participants my research study, its support from the five Service groups, and the purpose of the study. I discussed the full implications of what was involved if they consented to be participants. From previous experience of working with firefighters I was aware that confidentiality issues were of paramount importance to this particular occupational group, therefore this issue was discussed in detail. Questions about the project were answered. It was necessary to keep the discussions brief due to the usual fatigue experienced by the debriefed participants. To avoid any undue pressure to participate, the participants were provided with an information sheet (Appendix 111) to take home and read at their own leisure. With their approval, participants were informed that they would receive a follow-up telephone call from me within the next 24 - 48 hours, enquiring into their willingness to participate in the study. Several firefighters declined the information sheet and stated that while they supported the study they were unable to meet the time commitments required of the study. I thanked them for their honesty and also for their support.

Approximately 24 – 48 hours following the debriefings, the debriefed firefighters were telephoned to discuss their participation in the study. The first participant, who was to become my first case study (and became known as Fit) was originally recruited to assist me in a pilot interview. However, when reflecting on the data and following discussions with my supervisor, I believed that his experience was powerful and so his narratives became central to the study. I explored with him his willingness to be involved in the study. I discussed with him that the data gathered in the pilot interview was invaluable and that I would like to utilise it as one of my case studies. He was really happy to be involved in the study and stated vehemently that because of his experience with the debriefing process he wanted his story recorded and acknowledged.

Prior to seeking out potential participants for the research, I received a call from a debriefed firefighter who stated he was willing to participate in the

study. I telephoned the participants who had taken an information sheet and the first two participants who agreed to be involved in the study were recruited. The group now consisted of four male firefighters who had all participated in a debriefing prior to the interview process which began approximately 7 – 10 days post debriefing.

As the researcher I felt somewhat uncomfortable asking the firefighters to participate in the study. This was related to several issues, such as the time-commitment involved; the need to review the critical incident with the potential participants and the likelihood of resurfacing painful thoughts and feelings associated with the incident, and the uncertain and unhappy industrial climate within the New Zealand Fire Service. When I was considering undertaking the study 12 to 18 months previously, the Fire Service was going through significant change. However, it had been considerably more stable than it was at this particular time. There was a lot of pain, anger and distrust being experienced amongst firefighting personnel. I considered it was an enormous request of their time and energy to participate in the study at this particular time. For some individuals, they were barely able to cope with the day to day task of coming to work and attempting to stay motivated with the tasks ahead of them. However, I was really surprised and encouraged at their generosity when I somewhat hesitantly asked whether they would be willing to participate in the study. I felt really affirmed, particularly in my relationship with them, when they all replied that they were happy to be involved and support me in the study.

To ensure that they understood what was required of them, I discussed what was necessary in terms of personal time commitment and also that by participating in the interviews it had the potential to resurface some of the pain and suffering attached to attending the critical incident. I believed it was imperative to be open and honest in my dealings with the firefighters in relation to their participation in the study. By being honest in what the study entailed, it assisted me to build up a trusting relationship with the participants. At no stage did I attempt to coerce them to participate in the study. In fact, I

may have been overprotective of the firefighters in that I was more likely to discourage participation.

I agonised over whether the small number of participants would provide sufficient information to meet the aims of the study and whether I should approach more debriefed firefighters to gain a broader perspective and add further credibility to the study. The "logic" and "power" of the various kinds of purposeful sampling used in qualitative research rests principally on the quality of the information gathered from the sample group as opposed to their numbers (Patton, 1990, p.169). Sandelowski (1995) suggests that the way to determine the adequacy of sample size in qualitative research is essentially a matter of judgement and experience. That is the experience in discerning the quality of the data gathered against how it will be used, the particular research method employed and the sampling strategy utilised. Sandelowski's (1995) discussion on sample size has been very pertinent and has assisted me in my decision to remain with the four participants.

> *"An adequate sample size in qualitative research is one that permits – by virtue of not being too large – the deep, case-oriented analysis that is a hallmark of all qualitative inquiry, and that results in – by virtue of not being too small – a new and richly textured understanding of experience" (p.183).*

7.4 PARTICIPANTS

For inclusion in the study, the participants must have participated in a recent debriefing within the last 7 – 10 days prior to the first interview. There were no other restrictions apart from the participants being able to discuss their experiences in some depth and being open with the researcher.

The four participants who agreed to participate in the study were male, Pakeha, aged between 30 – 55 years, with between 10 – 30 years plus of firefighting experience. They were all paid employees within the Region, that

is they were permanent firefighters as opposed to volunteer firefighters. Their employment positions consisted of one Senior Station Officer, two senior firefighters and one firefighter. They all worked in four separate fire stations within the Region.

7.5 RELATIONSHIP BETWEEN THE RESEARCHER AND PARTICIPANTS

Ethical and moral principles guide my practice as both a Nurse Clinician and as a Nurse Researcher. They include a belief in social responsibility and a belief in democracy. Reason (1988) believes that researchers have a responsibility to think about the social, political, cultural, moral and financial implications of their research and also to consider the significance of their theory and subsequent action as a consequence of their research. With this in mind, I considered whether my study would be detrimental to the firefighters. Was it likely to cause harm, and if so was I morally responsible for redesigning my study or even abandoning it? Were potential participants likely to incur financial costs? Could my study have the potential to harm other cultures within the Service and did my study support the democratic ideal of the research participants being partners in the research process? I believed that if I failed to consider these issues, they could seriously affect my relationship with the research participants. I had considered these implications when preparing the research proposal and believed that I had addressed these issues responsibly.

The proposed research focussed on exploring the meaning of CISD for firefighters from their position using in-depth interviews between myself, the researcher, and the firefighters, the participants. Friere defines this dialogue as

> *"a two way inter-communication, a horizontal relationship between persons who are engaged in a joint critical search" (cited in Reason & Rowan, 1981, p.350).*

Following the assumptions of Habarmas 's (1971) critical theory, I was aware of the need to empower the research participants in the study by creating a trusting, mutually beneficial and collaborative relationship between myself and the participants. I have consistently used the term research participants as opposed to research subjects, to signify the collaborative relationship that was established. Heron (1981) and Reason (1988) believe that the collaborative research relationship could be the vehicle for empowering research participants.

One of the strengths of the qualitative research approach is the unique opportunity to get to know individuals. I felt that I was advantaged in having known all of the research participants prior to the study and had been in a privileged position of providing nursing services during my employment as an Occupational Health Nurse several years earlier. I had gained, over time, their trust and respect which was to be a great advantage to me during the research process.

Before commencing the interviews, I discussed with each participant that we were partners in a journey of discovery. They were co-researchers in the process of mutual discovery and that by their participation they were adding to the existing body of knowledge in relation to Critical Incident Stress Debriefing. Throughout the research process I repeatedly acknowledged their contribution to the study. I believed that by continually valuing their contribution and generosity it further enhanced the trusting, respectful relationship between the two partners. Throughout our journey together I continually asked them if they had any questions or concerns about their involvement in the study. I was concerned for their personal and professional safety, and that at no time during the study should it be compromised or threatened.

7.6 INTERVIEW PROCESS/DATA COLLECTION

At the beginning of my journey I decided that in order to gather the rich descriptions and personal interpretations of firefighters following their participation in a CISD, the most appropriate method of gathering this information was to use case studies. From my readings I understood that each case would not be the same, that each was unique in itself but also there were likely to be some similarities expressed by the participants. It was my intention to uncover and portray the multiple views of each case (Stake, 1995). I decided to utilise interviews as a method of gathering the rich descriptions and personal interpretations of the debriefed firefighters that I hoped would be revealed.

As I was new to the process of qualitative research and had certain anxieties around the interview process, I decided that it was important to design a map, an advanced plan in which to ponder my journey of interviewing. I had heard stories about the difficulties around asking the "right questions", the difficulties gathering relevant information from participants, and problems with recording and transcribing the information. The manner in which interviewers evoke respondents recall, information, expression and feelings has a direct impact on the quality of the data obtained (Drew, 1993). I decided that in order to minimise the likelihood of asking the wrong questions, and having problems steering the participants in the right direction, not to mention the potential problems with technology, that I would conduct a pilot interview. My ultimate aim was to get a "good" interview. Whereby the participant and researcher felt safe and comfortable with the process. I wanted to learn a few lessons along the way so that when I conducted the "real" interviews, I was less likely to have difficulties.

I had recently facilitated a debriefing in which one particular participant had been extremely distressed prior to the debriefing. I had spent some considerable time with he and his partner prior to the debriefing, assisting and supporting him through his fears and anxieties related to the incident. His life and the lives of several of his crew had been threatened and he had

considerable distress about his "near miss death" (which he referred to) and the potential loss of several of his crew. With this in mind I decided to contact him and ask him whether he would be willing to participate in a pilot interview. He answered positively and we set up a suitable time and venue.

In qualitative research, the researcher serves as an "instrument" through which data is collected (Boyd, 1993). With this in mind I saw myself as the driver where I was required to guide my co-driver, the research participant, in his responses, by probing in a caring and sensitive manner in order to gather further information required to gain depth and clarity. While it was important to have some structure to the interview process, I appreciated that it also required flexibility.

I had earlier decided to utilise the narrative as the research methodology of choice, and the purpose of the interview was not to explain, predict or generate theory. The purpose was to understand the shared meanings by drawing from the participant a vivid and "alive" picture that represented the experience, containing rich detail and within the context that shaped the experience. As "the driver" it was important for me to turn on the ignition to begin the interview, but once underway on our journey, I then believed that both myself and the co-driver, the research participant, would be participating in the interview process together. Once there was an element of comfort between both parties, I would be the co-driver, and when he began to tell his story with ease, then I would then take a backseat and allow him to tell his story with little interruption.

Prior to the pilot interview, I began to carefully frame an opening question which I hoped would gather the data necessary to reveal the rich detail of their experience, and which would not be too intrusive or intimidating in the early part of our journey. I decided to begin with a broad question which would be open to interpretation for the participant and once I felt the participant was at ease, I would then refine the question to probe for further meaning.

As I appreciated the intimacy of the situation and the likelihood that it could uncover a strong emotional reaction for Fit, I had spent time prior to the interview establishing a trusting relationship and building a rapport with him and his partner. Researchers focussing on very personal and private subjects do need to plan substantial time for building rapport (Kondora, 1993). Prior to beginning the interview, I discussed with Fit that the interview had the potential to resurface strong painful thoughts, feelings and reactions associated with the critical incident and subsequent debriefing. I assured Fit that we could stop at any time and terminate the interview if he wished. I also stated that if he had any long-term negative effects from participating in the interview that I had contracted the services of a psychologist to assist him to recover from these effects.

With all this in mind I began the pilot interview. The interview was conducted in the lounge of Fit's home. It was necessary to rearrange the furniture a little, send the dog outside and shut the windows in order to minimise the traffic noise. We sat face to face in comfortable lounge chairs, a comfortable distance apart so as not to invade personal space. Two audiotapes were set up on two low tables, one on either side of myself and Fit. The seating was arranged to create a safe and caring environment, and also to enable me to see and respond to Fit's verbal responses and body language. I explained that it was necessary to have two audiotapes recording. They were placed in a position that was not too intrusive and were visible to me to ensure that they were recording the interview.

I began the interview by thanking Fit for agreeing to participate and stating that this was a pilot interview and the reasons why I was conducting a pilot interview. I established the parameters of the interview such as if at any time he felt uncomfortable or wanted to end the interview, he only had to indicate this. I discussed the likelihood that some of the questions had the potential to uncover some painful thoughts, feelings and memories. Confidentiality was discussed and assured, and I informed Fit that the interview would take approximately one hour. After checking out with Fit that

he was comfortable and had no further questions or concerns around the interview I began the first leg of our journey, interview number one.

I had spent some time pondering over how to encourage Fit to describe his unique perspective of the experience of debriefing. I decided to structure the interview asking "inside-out" questions in order for Fit to describe his experience rather than his interpretation of the experience (Miller & Glassner, 1997). By steering the participant down this road, as the researcher I could gain a more holistic understanding of the experience that formed an important part of the participant's day to day existence. Silverman (1993) notes that interview participants construct social worlds, not just narratives.

> *"The primary issue is to generate data which give an authentic insight into people's experiences" (p.91).*

I was aware from my readings that certain kinds of open-ended questions are more likely to encourage the participant to tell their story. Asking questions that open up the phenomenon being studied, allows the participant to construct answers, in collaboration or consultation with the researcher, in ways they find meaningful (Mishler, 1986; Riessman, 1993; Streubert & Carpenter, 1995).

The open-ended questions that I subsequently framed which I hoped would generate discussion for further development included:-

> ***"Tell me about your experience related to participating in a recent Critical Incident Stress Debriefing?"***

> ***"What did you find most helpful in terms of assisting you to discuss the incident?"***

> ***"Tell me how being involved in a CISD has affected you?"***

These questions provided a beginning to the establishment of a relationship between myself as the researcher and the participants as co-researchers.

Data for qualitative research can be gathered easily and effectively through having people tell their stories that are relevant to the research (Roberts & Taylor, 1998). It is not uncommon for people to feel that they have little to offer research and they may feel intimidated by the thought of participating in the process. However, this is often made easier by inviting a person to tell their story of the experience or phenomena being studied. For this reason, my opening question centred on Fit telling his story of the experience of debriefing which asked for an extended account of his past experience of debriefing.

During the actual exchange I listened with much intent and took a few notes which I used to develop further probing questions. I began to feel relaxed within a short time of beginning the interview. The opening question had felt "right" as it elicited a story directly related to the experience of debriefing where Fit became intent on revealing his story, returning in vivid detail to the critical incident that had caused him so much pain and suffering. It was evident at an early stage of the interview that Fit was feeling relaxed and safe with the process as he appeared to reveal his narrative in great detail. I realised that I was required to say very little at this point. However, as Patton (1990) suggests, I used verbal and non-verbal probes in order to clarify or complete the participant's description of the experience.

Fit told his story and engaged me, as the researcher, in his story by making some sense of the incident and experience. Storytelling is a primary way people make sense of their experience. While the experience exists, it takes on meaning for the person in the telling of their story. Storytelling has the potential to heal both the storyteller and the listener. Interviews encourage participants to tell their whole story, rather than the bits and pieces (Morse, 1988). In the telling of their story there is a potential to cause significant distress, as was the case with Fit. He did become tearful and distressed when recalling the painful thoughts, feelings and reactions to the experience.

However, at no time did he express the desire to terminate the interview even though I gave him the opportunity to do so on several occasions. As a qualitative researcher I wanted to empower Fit in the telling of his story so I encouraged participant power by advocating process consenting (Munhall, 1988). I repeatedly assessed Fit's consent throughout the interview, particularly during periods of emotional distress.

At times I personally felt some discomfort when Fit became tearful and wondered whether he was safe. I kept checking with him whether he felt safe and was prepared to carry on with the interview process. While I felt some discomfort with his distress, Fit later revealed it was very cathartic and provided him with a sense of relief that appeared to come, in part, from having engaged me in active listening. When the storyteller is aware of the presence of a good listener, it defuses the power of the experience and thus provides some further emotional relief which was what Fit later reported. Catharsis was evident in each of the four participants during the telling of their story related to the experience of debriefing. At the conclusion of the three interviews, they all discussed that they had found it a very positive experience, not at all arduous but very freeing and healing.

Immediately following the first pilot interview, I made some notes on how the process had gone for me and how I thought it was for Fit. He assured me before I left, that he felt safe even though he had at times become distressed telling his story, but he appeared happy and almost relieved following the telling of his story. My notes centred around Fit and his personal safety. Had I threatened this? I made a decision that I would ring him several times over the next week to discuss how he was feeling following the interview process. My feeling was that while he was exhausted from the catharsis, that there was a sense of relief for him. I felt elation at the richness of Fit's story and considered that my questions "fitted" the research. I felt that the Critical Incident Stress Management strategy of debriefing had assisted Fit in processing the critical incident and its aftermath, both personally and professionally. With that processing came a healing for Fit. I felt encouraged that the interview process had gone very smoothly with no obvious technical

or interview flaws that might have hindered the successful gathering of data and subsequent analysis. On reflection I believed that I had been more anxious than Fit. I had a mindset that I had to do it "right" even though it was a pilot interview. During my follow-up telephone calls with Fit after each of the three interviews, I discussed with him how he felt about the interview. Could I have made the questions less intrusive for him and were these questions able to elicit the maximum amount of information regarding his experience? On each occasion Fit felt really happy with the interview process and questions and did not suggest any significant changes.

I subsequently decided, because of the rich data that was obtained in the pilot interview, that with Fit's permission I would use him as one of my case studies. Fit agreed to become a case study participant using the same pseudonym and he also agreed to participate in two further interviews. A second interview was held approximately 4 weeks later. The audiotapes from the first interview were transcribed and a copy sent to Fit to view, verify and suggest changes at the second interview. Fit had no problems with the transcribed text and made the comment that he had repeated himself often throughout the interview which he was surprised at. The second interview addressed issues arising from the first interview where I asked probing questions in order to seek clarification on certain issues related to his experience. The third and final interview was carried out approximately 2 weeks following the second interview, where as previously, Fit had been sent the transcribed text for his viewing, verification and modification if necessary. At no time did Fit request any of the text be removed or modified. His responses centred mainly around how he had found the interview a therapeutic process. The third interview was seen as a time for closure, to raise any concerns, queries or questions that Fit had, which was not dissimilar to a debriefing.

While the interview process concluded at the third and final interview with each of the four participants, I telephoned the participants on several occasions to check that they were not suffering any negative effects from being involved in the interviews. Each participant reported that they were

fine and once again appreciated the opportunity of being involved in the research as they felt it had assisted them in further processing the critical incident and the debriefing experience. I felt really humbled by their generosity and their ability to open up the experience by telling their stories.

A similar format was followed with the 3 other case studies. Three interviews took place. The first interview which was held approximately 7-10 days following a debriefing, lasted approximately one hour. The second interview took place 3 - 4 weeks following the first interview, and the third and final interview was held approximately 2 weeks following the second. The times did vary somewhat for one particular participant. This was due to his family commitments and the holiday period. Between each interview the participants were sent a copy of the transcribed text at least 7 days before the next interview to allow them adequate time to read and consider the text.

Few notes were taken during the interviews as I found it both distracting and somewhat intrusive and detrimental to the flow of conversation between myself and the participants. Following each interview I drove to a quiet and safe place to reflect on the interview process and content. I made notes which I reflected on before the next interview. These notes also assisted me in the ongoing development of the data analysis.

7.7 TRANSCRIBING

The pilot interview tapes were transcribed by myself. There were no problems with the audiotapes which were audible and easily able to be transcribed. While it was a lengthy process, I felt really engrossed in Fit's story which assisted me in becoming familiar with the data when analysing his narratives. I had planned to employ a professional typist to transcribe the subsequent interviews but technology failed me on the first interview of the following three cases. Because of the poor sound quality I was forced to transcribe these tapes myself. It was an incredibly difficult process taking hours and hours of rewinding, listening and then rewinding again to check

that what I had transcribed was correct. Due to the poor sound quality I felt that a lot of the emotion and feeling was unable to be heard so I had to trust on my memory when analysing these interviews. A professional typist who was required to sign a consent form regarding confidentiality issues (Appendix VI) transcribed the second and third interviews.

All the participants were allocated a pseudonym prior to their first interview so each transcript was headed by the allocated pseudonym. All tapes were kept in a locked cabinet that was accessible only to myself. Only the typist and myself had access to the raw data. Each participant was offered the raw data and audiotapes to be returned to them at the end of the study. However each participant stated that they were happy for me to destroy both the audiotapes and the transcriptions at the conclusion of the study.

7.8 PRESENTATION OF THE DATA

As discussed previously all four participants were given a copy of each interview transcript to read so they could verify their story and remove any data that they felt uncomfortable with. It was important that the participants felt safe in their participation in the study throughout the whole process of their involvement.

The process involved a partnership with me in the journey from their initial consent to participate in the study to the final document for presentation as a full thesis. All the relevant chapters, where data from their respective interviews had been utilised and interpreted, was sent to each participant for verification that they were satisfied with the data that was being presented. While this was a lengthy and time-consuming process I was mindful that it was important that they were comfortable with the final document and had no discomfort that their participation could be detrimental to them personally or professionally.

7.9 ETHICAL CONSIDERATIONS

The Central Health Wellington Ethics Committee and the Victoria University of Wellington Human Ethics Committee granted ethical approval. As previously mentioned, approval to access participants within the New Zealand Fire Service was gained from four management groups within the Service and the relevant CISD Peer Support Team.

Written consent was obtained from each participant (Appendix V). While the information sheet discussed issues around consent, I spent time explaining the aims and purpose of the study, the commitment that was required for participation in the study, that identifiability would remain confidential and how the information gathered from the study would be disseminated. As previously mentioned the person employed to transcribe the audiotapes signed a confidentiality agreement.

I was ever mindful that the recounting of their experiences of the critical incident and subsequent CISD could distress the participants. I had arranged for a psychologist, with experience in the area of Critical Incident Stress Management, to be available to accept referrals from participants who may have required support following the interviews.

Other details in regard to ethical issues will be discussed under participants' considerations in the next section.

7.10 PARTICIPANTS' CONSIDERATIONS

As a researcher I was aware of the importance of ethical considerations that needed to be observed for the wellbeing and safety of all the participants. At no time did I attempt to coerce participants into the study. As previously stated I tended to veer on the side of caution. The safety of the firefighters who had already been traumatised by their exposure to a critical incident, was paramount to my ethic of practice both as a nurse and as a researcher. I was also aware of the uncertain and tense industrial environment that the

participants were working in and did not want to add to their stress.

At the beginning of the first interview a comprehensive explanation of the aims, objectives, data collection process, methods of collecting the data and the intended outcome of the study was presented verbally. This reiterated what had already been stated in the information sheet that they had received following a debriefing. Following the explanation, the participants were asked to sign a consent form and were informed that they had the right to withdraw at any time (Appendix V).

In order to ensure that the participants felt safe during the interview process I empowered the participants to choose the place of interview and every attempt was made to ensure their personal safety and security at all times. Due to the time commitment involved by the participants, a time and place was arranged that was convenient to them. I continually valued their contribution to the research project and also frequently checked my interpretation of their data to avoid any misinterpretation from my own personal world view.

At the beginning of the first interview each participant was given a pseudonym to lessen identifiability. Confidentiality was maintained by using the pseudonym on all audiotapes and transcripts. All data, that is audiotapes, transcripts and computer discs were kept in a locked cabinet that was accessible only to myself. I assured the participants that I would retain confidential information from interviews and would not identify or discuss their identify or information with any other persons. I also assured them that every endeavour would be made to ensure that no participant could be identified by name or event from quotes or information included in the final report. The use of a pseudonym and the checking and approving of their data assisted in minimising this occurrence.

I informed the participants that when I had completed the final analysis of their narrative, I would send them a copy to ensure that they were satisfied with the contents. Each participant was informed that they would receive a copy of the final document.

Participants were followed up by telephone after each interview to ensure they had suffered no harmful effects from participating in the interview. I saw it as a mini-debriefing. I was conscious that the interview had the potential to raise strong emotional reactions by the resurfacing of the critical incident and debriefing. As previously discussed I had contracted the services of a psychologist to be available if the need arose for referral of a distressed participant. At no time was this necessary.

7.11 PROCESS USED FOR DATA ANALYSIS

Analysis involves reviewing the multiple sources of data methodically with the intention of organising and classifying them into representational groups and patterns (Roberts & Taylor, 1998). Data included audiotapes, the transcribed interviews, written notes that were recorded following telephone conversations with the participants and notes that I made during and following the interviews. The taped interviews were compared with the transcripts and special features such as long pauses, loud or lowered speech and emotional distress were identified and marked. This process was somewhat difficult with some audiotapes, due to the poor quality of the recording. At times I had to rely on my memory or the recorded notes I had made during and following the interview.

There is no particular moment during the research when data analysis begins (Stake, 1995). Analysis is seen as giving meaning to the first impressions as well as the final or completed document. Analysis is viewed as essentially taking something apart, piece by piece, the unravelling of the structure of the data that is essential to interpretation (Riessman, 1993). Reason (1988) refers to data analysis as the 'making sense' process. Data analysis was done contemporaneously with data collection so that the study could be shaped as it progressed. The aim was to focus on exploring the experience of CISD while collecting and analysing the data (Glesne & Pleshkin, 1992). With this in mind I studied and systematically examined all the data with multiple readings and listenings of the audiotapes, ever mindful of the aims

and objectives of the study. It was a time consuming process, not unlike warming the engine of the car on a frosty morning. I could not hurry the process. I had to wait and let the data "warm" and "surface" so as to be able to connect with the data in order to continue on my journey of analysis and interpretation.

I began dwelling with the tapes whereby I repeatedly listened for different cues that may not have been obvious in the transcriptions. I repeatedly read the transcriptions and often read them alongside the listening of the tapes. I also reflected on my field notes which I had recorded both during and following the interview. I had kept a journal on my personal reflections and thoughts throughout the whole process of the research project and these became a significant part of the data. The multiple pieces of text provided me with a fascinating reflection of Fit and the subsequent participants' stories. Each individual's story was unique, revealing differing meanings and yet there were also common meanings. Polkinghorne (1988) discusses this as plurastic epistemologies in which there is no one truth, rather there are multiple truths which correspond to our reality and are shaped by our contexts. This produces multiple ways of knowing.

The challenge for me in analysing the data was to seek out and understand the way in which the data is postulated as a unified whole while still being able to reveal the multiple truths, realities and meanings, without loosing the whole or the essence, while illuminating the parts. The process I followed in order to achieve this was repeated re-readings and relistenings of the transciptions, tapes and other data thereby recognising that

> "*.....the realm of meaning is best captured throughout the qualitative nuances of its expression in ordinary language (Polkinghorne, 1988, p.10).*

While I entered into each participants story in its entirety and its parts, I also intended to analyse the collective stories of those who had shared a common experience.

7.12 DWELLING WITH THE DATA

To locate the true essence of Fit's and the other participants' stories I began to analyse the data for key moments in the storytelling. I looked at how the narrative was organised, the differing ways each participant developed his story and the way in which they related their story. Each of their stories were situated in the interaction with myself, but was also influenced by cultural, social and institutional discourses which had the potential to affect the interpretation of their stories.

I was conscious that it was important that the participants' voices, not my voice, was situated in the final document. Because of my passionate interest in working in the field of Critical Incident Stress Management, there was the potential for my "voice" to override the participants' voices. I was ever conscious of this phenomenon. I discussed with each participant that when I had developed a draft of an interpretation of their story, that I would send them a copy for their verification and comment. I requested that they be open and honest with their critique in order to enable my interpretation of their story as a genuine and legitimate representation of their experience.

Lumby (1994) discusses

> *".....the equal relationship of the co-researchers meant that as the narrative took form, the primary researcher checked the authenticity of meaning with the co-researcher" (p.24).*

My next decision centred around how I would represent the stories in my thesis. It was imperative that I present their stories in a readable and interesting manner for potential readers. Authenticity and the potential for the material to be easily accessed and readable was a major issue for me.

My own philosophy of nursing influenced the process of analysing the data. I was ever mindful that the ontological position of each participant's singular view be established. By using the spoken words in the story, I needed to

carefully conduct an analysis and interpretation as it was important that their story remained as a whole text. Any attempt to put it into patterns or themes had the potential to distort or misinterpret the stories of the participants.

The data recalled the past experience of debriefing, but the way the storyteller recalled the experience gave meaning to both the language used and the emotion expressed during the storying. While my intention was to present the powerful stories in as meaningful a way as possible, I believe that it is impossible to truly present them with all their nuances, hidden meanings, feelings and emotions which they deserve.

With this in mind I began my journey of painstakingly analysing the multiple pieces of data. The transcripts were analysed manually by a process of line by line analysis in order to pick up the nuances in the text. I came to know the text intimately. Particular phrases, words and sections of the narrative began to emerge over time that made connections with other participants, but also that were unique to each participant.

Colour coding of the transcripts was used to identify emerging patterns, which represented different patterns and themes, which aided in the process of manual coding. These patterns were listed on individual pieces of paper and were subsequently reduced when similar patterns merged into respective groupings. When it was no longer possible to reduce the patterns without loosing some of their "specialness" in relation to the experience, these patterns then became the named themes. While initially I identified 3 main patterns, these were reduced to one main overriding pattern and eight major themes.

As a double check I used a giant mind map for each participant to enable me to visually contemplate the data and the emerging themes. As I am a visual learner it assisted me in making connections between the similarities and the uniqueness of the participants' experiences. I developed a gestalt approach of using the written word, both the transcribed text and my

own reflections; the oral voice with all its nuances; and the visual mind map, as valuable tools in which to analyse the data in all its totality. Unique themes appeared to travel down side-roads whereas some of the other themes consisted of similarities which tended to merge together on the main road.

While common themes were identified, I became engrossed in the individual themes that began to emerge with repeated readings. Over time and when I least expected, the participants individual stories would surface in my consciousness. The moments when this occurred were totally unexpected. What caused these times of what I refer to as "being hit in the face" with the uniqueness of their stories? I did not fully understand. As time passed I began to see that each individual's story, while having common patterns, had their own unique theme. However, all the themes yielded a greater understanding and interpretation of the experience and the importance of Critical Incident Stress Debriefing in my clinical practice of Critical Incident Stress Management. Not only were themes identified but with the telling of their stories it became evident that each participant found it a therapeutic and healing process in the telling of their story in relation to the experience of debriefing. Morse (1988) states

> *"Participation in a qualitative research project is undoubtedly a therapeutic process" (p.215).*

With this in mind I decided that while I would discuss the common themes that I had discovered in the literature and in the participants' stories, I had this passion to reveal the unique theme of each participant as I discovered that each and every participant had a theme that was "their's" alone. It belonged to them and was unique to them as an individual within their own personal context.

7.13 TRUSTWORTHINESS OF THE STUDY

There is no one method of guaranteeing absolute truth in qualitative research studies because truth can change due to context-dependent variables related to people, environment, time and conditions in which it is placed and emerges (Roberts & Taylor, 1998). However, there are various ways of demonstrating trustworthiness which qualitative researchers can utilise in their study. Qualitative research is trustworthy when it accurately represents the experience of the participants under study (Streubert & Carpenter, 1995). In order to ensure trustworthiness of the analysis of the data that I had spent many hours engaging in, I returned to each participant and enquired if the exhaustive descriptions and interpretative pattern and themes reflected their experiences. Lincoln & Guba (1985) call this activity "member checks" (p.314). I assured the participants that the content could be added to or deleted if they so desired.

Authenticity and trustworthiness can also be established by asking the participants if there were any negative aspects of the phenomenon under investigation. This affords the opportunity to compare and contrast the data and is another way of checking for trustworthiness. I questioned each participant towards the conclusion of the interview as to whether there were any negative aspects of participating in a debriefing for them personally. The only negative aspect of the debriefing was that one participant, Flick, stated that he would have liked the debriefing to be held earlier. This will be discussed in chapter 9.

Confirmability of the findings was achieved by an audit trail, not dissimilar to a fiscal audit (Lincoln & Guba, 1985) which records planning, ethical and procedural issues followed throughout the study. The audit trail illustrated the evidence and thought processes that led to the final conclusions of the study.

Exploratory and descriptive studies do not generate findings that have meaning to others in similar situations and are not directly transferable to the

wider community. They are unique to the person and the situation. However, the findings have the potential to provide an illumination of the experience within the context of the study for others in a similar setting and thus may offer significant insights into the experience under investigation.

7.14 CONCLUSION

In this chapter I have discussed the strategy that was utilised to access the research participants and a summary of the interview process. I have described in detail the semi-structured interview process utilised to collect data. Issues around transcribing, method employed to analyse the data, ethical considerations, and issues of trustworthiness were also discussed. The concern I had around the identifiability of potential participants and the possibility for participants to suffer negative effects from their participation and the methods that were utilised to minimise these effects, were highlighted.

In the following chapter I will present the narrative and relevant interview data from my first case study with Fit, which initially was gained from the pilot interview. This chapter will focus on the unique themes that were uncovered in the telling of Fit's story.

8. FIT'S STORY

8.1 INTRODUCTION

The review of the literature on Critical Incident Stress Debriefing highlighted many of the patterns that I discovered in the stories of the four firefighters I interviewed. There was a dearth in the literature of what I refer to as the reality and the uniqueness of the experience of debriefing. Personal stories were difficult to find in the literature which all seemed rather bland and lacked feeling and depth. Whereas I believe the four participants in this study told their stories with much feeling, emotion and humour, revealing a true picture of their inner self in relation to the experience.

This chapter seeks to uncover the reality of debriefing for one firefighter, Fit. I will begin with a brief personal introduction to Fit and discuss how he became involved in the research and our interview discussions. I will then discuss how I uncovered the patterns and themes of his story while journeying with Fit through his experience.

I uncovered the meaning of Fit's experience by deeply reflecting on his narrative and this has enabled me to further develop my model of practice from his insights of the experience of Critical Incident Stress Debriefing.

8.2 FIT - OUR JOURNEY TOGETHER BEGINS

My journey with Fit began several months before he agreed to participate in a pilot interview for the research. I received an urgent call from one of his superiors requesting that I visit Fit at his home as he was severely distressed following an incident some 24 hours prior to the call. Fit and his crew had attended a major fire in which he and his crews' lives were threatened.

I drove some distance to his home and as always I began to think, plan and

mentally rehearse how I would assist Fit. Upon arrival at his home, his partner, Fit and myself sat in the lounge and Fit began to discuss at length the firecall and the subsequent events that led to his significant distress and sadness. He graphically portrayed the events in several stages. I had a sense of being with him during the fire, particularly when he described how he and his and crew had difficulty extricating themselves from the fire. During the time of his recalling the incident and subsequent events following the fire, he became acutely distressed, both emotionally and physically. He discussed how some 16 to 24 hours following the call he had woken and couldn't get out of bed.

> *"I started to think about it and I could see a situation that..... I was uncontrollable..... I cried uncontrollably..... and it wasn't for five minutes, probably an hour. I thought I had come right. I would get up and as soon as I stood up I would collapse".*

Fit subsequently recovered and went to work earlier than is usual as he felt he needed to be around his colleagues. He recalled how he was able to perform his duties. By keeping himself occupied with his duties he was able to carry on as long as he had something else on his mind. However, he recalled

> *"at the forefront of my mind.... I hadn't forgotten what had happened".*

His Senior Officer noticed that he was distressed and rang Fit the following day to say that he would like to visit him. Fit discussed how he felt that this was the beginning of his ability to start talking about the incident and its effects on him, when the Senior Officer visited him to offer support. The Senior Officer suggested that he might benefit from discussing his situation in greater depth with a member of the Critical Incident Stress Debriefing Peer Support Team.

Initially I spoke with Fit and his partner together. Fit had shared some of his fears and anxieties with his partner around the incident and she was really concerned about his personal safety. She realised the seriousness of his distress as it was most unusual for him to share his work stress with her.

Sometime later his partner left Fit and I to discuss in greater detail the incident and the negative impact that it had had on him. He was very tearful, had several periods where he broke down and was unable to continue. With time, understanding and encouragement he continued to tell his story with greater clarity. He described his thoughts and feelings of sadness, guilt, a loss of control, disempowerment, fear and his own vulnerability in relation to the potential loss of his life.

After allowing Fit the space to tell his story and share his innermost thoughts and feelings, I then asked him what he wanted to happen following the one-on-one session we had shared together. Personally I believed that it was important that he and his crew participate in a formal CISD. I was aware of his feelings of disempowerment and wanted to empower him in his decision making in regard to his ongoing journey of recovery from the critical incident. I discussed the options available and he opted for a formal CISD which I believed was imperative to assist him and his crew in mitigating the negative affects of attending the critical incident. It was obvious that Fit needed to share his story of the incident with his crew.

A debriefing was carried out some 24 hours following our meeting with all his crew members who had attended the incident. I facilitated the debriefing and was assisted by a Peer Support Team member who was well known to most of the participants, was well respected and had many years of firefighting experience. While Fit reported that he felt much improved following our one-on-one meeting, he believed he needed a further CISM strategy to assist him in his full recovery. The one-on-one CISM strategy had assisted him in recovering from the acute stress reaction but it was necessary for him to be able to share his story of his experience at the critical incident in order

for his crew to have a better understanding of what happened from his perspective.

8.3 RESEARCHER'S INTERPRETATION

Before presenting and analysing Fit's narrative, I believe that it is important that I reflect on this particular incident and subsequent CISD in order to validate Fit's experience and narrative. I would classify this particular incident as a major critical incident, an event which would be considered generally outside the range of ordinary everyday human experiences (Mitchell & Everly, 1995). It had the potential to cause serious injury and even death to the firefighters involved. Fit and his crew had difficulty exiting the fire due to the intensity of the fire in terms of intense heat and poor visibility. Air from their breathing apparatus sets was empty some minutes before they were able to find their way out and as a consequence they were hypoxic and somewhat confused following their exit from the fire. Due to issues of confidentiality it is not possible to discuss any further details except to say that all crew were placed in a serious situation where there was the potential for loss of life. Fortunately all crew eventually exited the fire and while seriously fatigued and distressed, no major injuries were sustained.

In my analysis of Fit's narrative, two major issues stand out. One was the fear of being trapped and being unable to visualise an exit point and with a decreasing oxygen supply there was the potential for his own loss of life, and secondly the potential loss of his crew for whom he was responsible. In my experience the majority of firefighters would say that these two scenarios would be their worst nightmare. As Fit was the Officer-in-Charge of the crew he felt an immense sense of guilt and believed he had lost credibility with his crew. Under the circumstances his emotional reaction was understandable. He needed to discuss it on a one-on-one basis, but he also needed to share his story and the reasons why the crews safety had been threatened, in a more formalised process with his crew. A formal CISD, I believe was the most appropriate strategy for Fit to tell his story and hear the story of his crew

members in a safe and caring environment.

While it was some months following the one-on-one and subsequent CISD, I had been very moved by the intensity of Fit's and his crew's sharing in relation to their experience of the incident and its subsequent impact on their lives. As previously discussed in Chapter 7 I approached Fit and requested his participation in a pilot interview. He willingly accepted my request after I discussed with him the potential to resurface the painful thoughts, feelings and memories attached to the incident. I was ever mindful of protecting his safety as I had personally witnessed his pain and distress following the incident. However, I believed that he had a made an excellent recovery and hoped that by participating in the research, this might further assist him in the healing process.

I arranged the first interview at a time and place that was suitable to Fit. While travelling the lengthy distance to carry out the first interview I had mixed emotions. I was excited at the prospect of at last conducting an interview into the experience of CISD on a firefighter within the New Zealand Fire Service where I had worked for the last 8 years, but I was also really anxious about the process of conducting the interview. Would my questions be the right questions in order to assist Fit in the telling of his story? Would I be able to pick up the cues that required further discussion or illumination? And most importantly would I resurface past painful thoughts, feelings and emotions that had the potential to cause further significant distress for Fit? Fortunately my fears were unfounded. Once the interview began Fit became relaxed very quickly and his story flowed freely and I became less anxious and really excited at his recall, insights and frank conversation. At times I needed to hold back with my questions in order to give him the necessary space and time to tell "his" story. At other times I felt that I had to reflect on his story to keep the threads of his story clear so I could compile questions which might add clarity to certain parts of his story. However, as I became more relaxed as the interview progressed I realised that many of the queries and questions I had, could be clarified at the next interview.

During the first interview Fit had several periods where he became acutely distressed and tearful when he related how painful his experience had been. I believed that it was only natural that the telling of his story would cause him some distress. As a consequence of his tears and distress, I acknowledged his pain and gave him the necessary space and time to reveal these emotions in a safe and caring environment. At no time did I attempt to stop his tears or distress. However, I continually checked with him that he was happy to proceed. At no time did he express his wish to terminate the interview. At the end of the interview I enquired into his wellbeing and he said

> *"It's, you know, it's been excellent and it's still there and a couple of points still hurt and I didn't realise that they were still hurting that much and uh. It's not hurting but uh it affects me, still there".*

At the conclusion of the interview, I stayed for some time and debriefed with Fit over the pain and distress associated with resurfacing the disturbing thoughts, feelings and emotions. I discussed with him that he could feel some ongoing distress following the interview, that this was normal but that these effects would dissipate very quickly as I believed that Fit had made an excellent recovery from the effects of Critical Incident Stress. If these distressing effects had the potential to cause ongoing problems for Fit, I had employed a professional psychologist who was able to assist him. He reassured me that he was fine but had been somewhat surprised at the resurgence of the feelings and emotions. I sought Fit's permission to contact him every few days over the next week to enquire into his wellbeing, as there was the potential that by his participating in the interview it may cause significant ongoing distress which could require professional assistance. I also told him that if he became distressed or had any questions or concerns he could ring me at any time. My personal philosophy in working in the field of CISM and research is to do no harm.

At the beginning of the second and third interviews I began by enquiring into Fit's wellbeing. At the beginning of the second interview I enquired into how he had been since we last meet?

> *"Excellent. Yes, no problems from doing the interview with you. It proved to bring out some extra points which was still deep within me. That proved to be beneficial. No I felt really good after that".*

I felt reassured that my professional judgement had been correct and that no harm had come to Fit from his participation in this research. I discussed with him that while he would always have the memory of the incident, the pain associated with it should become less or even absent with time.

He replied

> *"No, it is not painful, it is only a memory. It is definitely not painful, and I think that last time.....it came out but it was only a memory. It wasn't painful.....yes I had no problems with it and again when you rang back and we talked on the phone, you know I probably sounded quite happy. You know I felt quite good".*

After leaving the first interview with Fit, I drove to a quiet place and reflected on the interview process and the content of Fit's story. While I felt fatigued, I also felt elated. I had a sense that the interview had progressed really well and was beneficial to both parties. In fact I really enjoyed the interview and suspected that Fit had found it to be a very therapeutic process. I was really impressed with Fit's recall and the generous spirit in which he had told his story. I felt really excited about the positive effects that debriefing had had on both Fit and his crew. It was very affirming that what the CISD Peer Support Team was providing in terms of a stress management strategy was truly effective and had ongoing benefits to both firefighting personnel, their families and the New Zealand Fire Service generally.

With the interview still current in my mind, I wanted to transcribe each interview as soon as possible. Following the transcribing, I sent a copy of the transcribed narrative to Fit for him to read and make comments, deletions or additions. At no time did Fit or any of the participants request that any of the narrative discourse be deleted. There were additions and this often related to the need to clarify or verify some of their stories.

Following the interviews my aim prior to analysing the stories was to become deeply immersed or engaged with the data. Streubert & Carpenter (1995) state that "*becoming immersed in data is also called dwelling with them*" (p.24).

8.4 FIT – TELLING HIS STORY TO HIS CREW

Prior to the debriefing, Fit had received a one-on-one supportive session with myself. As previously discussed he made the decision that a debriefing be held with his crew. He discussed very early on in the first interview, when I asked him to discuss his experience related to participating in a recent CISD, why he had involved the Critical Incident Stress Debriefing Team. He had a strong desire to **tell his story** to his crew. This appeared to be the most prominent of the themes in relation to the debriefing experience for Fit.

> *"From the initial debrief (the one-on-one) I knew that I hadn't totally satisfied myself maybe that I was back on the road to recovery and that I needed to involve other people. I was happy about the emotions that I needed to get out and to tell the story of what happened to myself. To let them know how I felt and my feelings towards them at the incident".*

Fit had a strong desire to tell his side of the story to his crew. Without the crew knowing his position, then they could not know what really happened from his perspective. While the one-on-one session had assisted him somewhat to recover from the immediate shock, he needed to share his

experience, his story, to assist him in a full recovery from the impact of the incident.

> *"Once I had relayed, used the CISD Team to relay those feelings, my mind was mainly at ease. That everyone knew the situation, what I was in and from there the road to recovery was easier to take".*

> *"Using the Team got me back on the road very quickly. I believe that if I hadn't had the Team's support both on an individual basis and on a crew basis, it would have taken me a long time to face, especially my own crew".*

While it was necessary to provide Fit with a one-on-one session in order to help him work through the initial Critical Incident Stress symptoms, Fit acknowledged that it was important to debrief with his crew so his could **tell his side of the story**.

> *"I needed some more help.....something more....."*

While I thought I understood what he meant by this, I wanted to reassure myself that my interpretation was valid. I asked Fit to talk about this a little more.

> *"The one-on-one, the reason I believed that it wasn't enough was there were other people involved in the incident who were in a situation themselves that was very dangerous and my mind didn't know why they had got into that situation. And I felt that I needed to explain to them, to satisfy myself that they did know that situation. On a one-on-one basis I can talk about it but no one else who was involved is finding out and I wasn't letting on my feelings on the rest of that crew knowing. The one-on-one certainly helped me overcome the stress of the situation*

from my own personal wellbeing and how close to death maybe I had come, but there were other people involved where I got close to maybe falling into this fire".

Fit acknowledged the positive effects of the one-on-one session in terms of addressing his physical needs and some of his emotional needs, but he needed to further address his emotional and cognitive effects of the stress, particularly in relation to his position with his crew. Not only did he need to tell his own story but also needed to hear the individual crew members perspective both during and following the incident. He discussed his own situation and how, because of his own safety being compromised, that he looked after his own personal safety. He needed to tell his crew why he had forgotten them.

"The getting myself out the last minute situation when I ran out of oxygen, got out of the fire. I was virtually out, I then took on the role of looking after number one which meant that as a leader of a team I forgot about those people and I had to explain to them why I had forgotten about them in those last few seconds of the incident. Without getting those feelings, and there was no other way of doing that than having the team debriefed and that part of it was extremely important to finish off my recovery".

Traditionally firefighters often come back after a major incident and sit around their campfire, the "smoko"' table, and discuss the incident which is akin to an informal defusing. This informal way of supporting each other following distressing incidents has been part of the culture of the Fire Service for many years. Fit talked about how he didn't believe this informal process would have assisted him.

".....that shock to me was too great to sit around over a cup of coffee. It needed a different intervention. A set program that the Critical Incident Team are trained to bring out my

fears, and over a cup of tea I think the wrong thing could have been said".

"This was a personal situation to myself and to other members of the team, who I don't believe at the time knew how much of a serious situation they were in and I could not have personally relayed that to them straight away. I knew that to do that I needed help for myself to be able to stand up first before I could help the other people stand up and get on their feet again".

He acknowledged the importance of the one-on-one session in assisting him to move onto the next stage of his recovery, the debriefing. It was obvious that he was aware that he needed more than just the one-on-one intervention. I questioned him about the environment that was established to provide a safe and comfortable situation and whether he found it conducive and safe in which to tell his story.

"..... I was so stressed out, I was still in a situation where I was upset with coming so close to death, upset with putting other people in a situation. I think if someone had said to me the wrong thing in an uncontrolled environment sitting around over a cup of tea, when someone just wasn't keeping an eye on what's going on, the wrong thing would have, and I say would have because I believe it would of, caused great stress to myself to the point where maybe I don't know what I would have done at the time".

"I was extremely fragile, that's the point I don't know where or what direction I could have taken. Whether to walk off the job, maybe someone might have said something that really hit a nerve and I could have gone out in violent anger or something like that and I don't know what direction. I was so, as you say fragile. That anything could have happened".

Once again Fit discussed how the one-on-one session had given him the opportunity to look at his own vulnerable situation of being so close to death. He acknowledged that there were parts of the incident that he was unaware of and this was revealed during the debriefing.

> *"I needed the group situation to let everyone else know who was there. Some were directly involved and some indirectly involved. And sitting outside and aloof from the incident, but were part of that team and didn't know what was happening as well. That came out in the debrief that I hadn't thought about but it was something they had in their mind. .....we needed to get out and draw out for me, to be able to look at my team and for them to know what actually happened and why I had put them in such a situation".*

On reflection it was important for Fit to tell his story so that his crew could have a true understanding of what really happened from his perspective. He was their Senior Officer and he had this strong feeling that he had let them down with his operational decisionmaking. It was important that they understood why he had made the decisions that he had under circumstances that some were unaware of. They had a mental picture in their mind of what happened. However, often this is distorted and is able to be clarified as each participant tells their own story.

8.5 PEER SUPPORT - "HE LIFTED ME UP"

Some of the other major themes that Fit discussed in some detail related to the role of the Peer Supporter. He found him helpful in terms of his role as a firefighter as he was able to assist him when he had some doubts about some of his operational decisions. However, he did discuss how he had had some anxiety around who the Peer Support was going to be .

> *"At the time we were doing the debrief I was concerned about who the Peer Support was going to be actually. And I did have*

concerns to start with who it was going to be but I just can't remember exactly unfortunately whether it was in that debriefing or something he said afterwards as well, but in the debriefing he did talk about a situation that we had been in that very few firefighters in New Zealand, including himself, he put into that category, had not been in such a close death situation. And he said it is very hard, to help someone who has been there when you really are not sure what had happened, but his support saying that you had done, not done something, but being somewhere and coming out of it, and this is the afterwards part that come out of it extremely well".

The Peer Supporter personalised the situation, acknowledged the severity of the incident and how close Fit had come to dying in the incident. By acknowledging the seriousness of the situation, the Peer Supporter assisted Fit and his crew to process the incident.

"The support he gave me and the comments he was making during the debrief and personal comments he made to me afterwards were amazing help to me. I am just trying to find the words just to explain how, how I felt from it, was probably be put at ease. He set me at ease a lot more and made me feel good about myself. That I had come through a situation I handled it in an appropriate way. The results were showing in what was happening. It was all happening, the results were being seen on my crews reaction, talking and feeling free and I felt really good that he, because I was so open trying to explain how I felt, that the other members of the crew had done the same thing. He was building me back up as a peer, as a equal as everybody else which was what I needed at the time. That's probably the point, he was lifting me back out of a hole. He got close to me saying, he did say he had been in serious situations but nothing quite like that and he really ***lifted me up****, and I was quite amazed at how much better I felt in having my*

own fellow officer helping me. He just touched on the right things, just to pick me up and that was probably what I needed at that stage, was a pick me up".

Fit went onto discuss how the Peer Supporter continued to assist him both during and following the debriefing.

"He was doing reinforcement work and it was just building me back up to get on with my life, and on with my job. It was, I don't know how to explain it. Different parts of the debrief picked me up really well and I can remember standing on the stairs on the way back down (following the debriefing) *on the landing and him talking to me, talking to me about this. A couple of things he said just really picked me up".*

Fit discussed that there were three major parts to his recovery. It is important to acknowledge that debriefing is one of seven components of Critical Incident Stress Management. Fit accessed two parts, a one-on-one support and a CISD. He acknowledged that the support of the Peer Support Team member was one of the major parts to his recovery.

"It was just probably three major parts to my recovery and that was one of them (peer support). *Letting out my feelings as in the team situation was the other one that I could explain what had happened to me and my crew. Why they were in the situation and why I had put them in that situation. It was one of them* (debriefing). *And the other one was the one-on-one. Without that I wouldn't even got to two or three. I feel I really believe that".*

He acknowledged the role of the Peer Support Team member having a big impact on his recovery.

"Extremely big impact. As I say it was probably the third most

important part of it, of my recovery. You know it was just great and that firefighter has an experienced role and it was marvellous".

Fit discussed how he was empowered by the one-on-one session which assisted him to move into the next phase of his recovery. He focussed on his need to have an individual debrief before he felt able emotionally to move into the next stress management strategy, the group debrief.

"My initial one-on-one gave me the power, I suppose to move on to the next part of my recovery if you like. If this is the word. Without doing that initial one-on-one I felt as though I wouldn't have been stable enough to be able to just sit with the group because I had too many emotions initially of death to start with. I had to look at that in my mind. I had to look at that before I could help other people and to finish off where I was. I felt that death was imminent. And without and because we got through that stage one, it had shocked me so much I had to look at it. Without looking at that I couldn't look at where the situation that anyone else was in because I just wasn't ready to go on. I needed to analyse..... Maybe I had to put my arms back on, my legs back on before I could use my toes to stand up straight".

While Fit discussed how important the one-on-one session assisted him partially in recovering from the many stresses attached to attending the incident, he reflected on how he still needed a further strategy to assist him to a full recovery.

"I still needed extra to talk to them on this, the next stage of recovery for me.....I asked them if they would be part of it (debriefing) *for me because I had things I wanted to talk about, and it would give them the opportunity as well to talk about it".*

Once again Fit discusses how he wanted to tell his story, so that his side of the story be heard, and also how others needed to tell their story of the incident. By all gaining an overview of the incident and what happened for each person at the incident, this assisted the crew to have a greater understanding of what really happened and why crew members were placed in certain situations.

8.6 CREW PEER SUPPORT – DEBRIEFING POST-DEBRIEFING

A further theme that Fit discussed, which I have not seen referred to in the literature was that of **crew peer support following the debriefing.** As is usual following a debriefing, the facilitator and Peer Support Team members remain for light refreshments. This allows participants the chance to talk informally to the Team and those who require more individual assistance to feel more able to approach the team in a less formal and more relaxed setting. I questioned Fit regarding what positive benefits, if any, the debriefing had had on his ongoing relationship with his crew.

> *"After having that cup of tea afterwards, that also gave my crew and myself the opportunity as well during the next hour to have cross communication between each other on an individual basis. We could all, I could see that everyone had spoken to everyone else individually and talked about what had happened... I talked to everyone individually and they had talked to each other so there was really cross communication going on and I would like to think that they got the benefit out of that, that I got as well. It was our own* ***crew peer support****".*

I discussed with Fit, after he had spoken about how maturely the participants had behaved throughout the debrief, and how they had responded to the seriousness of the incident and its effects. I shared that I didn't think It was a situation where it was appropriate to make insensitive comments, which is

what often happens following an incident and often causes significant pain in terms of personal distress and crew disharmony. He acknowledged the benefit of the debriefing and long term effects.

> *"For them they could see, I think they could see that it was worthwhile for me as well and I was probably at ease really quickly after that. Able to get back onto maybe a level playing field much easier".*

In terms of all the participants having a clearer understanding of each and everyone's position like pieces of a jigsaw puzzle, each participant had parts of the puzzle but not the full puzzle.

> *"The picture was made up. We had the picture and we could talk about the picture and that what communication my group, I think we talked about the whole picture, that's everyone's story and that was very important that everyone saw the picture now and not just their part of it".*

In the second interview, Fit further discussed the positive effects of the debriefing for himself and his crew where the debriefing carried on in an informal manner following the formal debriefing and departure of the CISD Team members.

> *"After the debrief there was certainly personnel talking to each other, about what had happened that day, that morning of the debrief. There was a different air, they were still talking about it and it proved to be very effective time is a way of putting it. An effective time to carry on that debriefing, so really the debrief went on all day. The rest of the day as we were passing each other working together doing our jobs, we were talking about it. So it was virtually a full days debrief so from that point of view I would say having the formal debrief earlier in the day left the rest of the day to continue it in an informal basis and I believe that proved to be very effective".*

In the second interview Fit further discussed the peer crew support in terms of its positive benefits both to the crew as a whole and to himself personally.

> *"We supported each other, it was good. It brought the morale of each of us back and bonded us back together again. I, for one had grave fears that I had lost support of some of my crew. I think that continued, however I felt it came back to me that I hadn't lost the support and what I had done as a Manager and getting them together in that team environment had been good. It proved to be very effective".*

Fit discussed how if he had failed to get the team together for the debriefing, he may have lost his credibility and they may have had difficulty working together as a bonded team. He suffered much distress due to his concern that he had lost his crew's support. This concern was lessened by getting his crew together for the debriefing where each and every member of the team in a safe environment had been able to share his or her experience of the critical incident. As a consequence of the debriefing, the crew began to bond together as "peer crew support".

> *"Who knows I may have totally lost it if I hadn't of done and didn't get them together. So in talking to each other was very important in building our bond back together as a team. It did, it felt really good and we got back together".*

The ongoing benefits to Fit and his crew from participating in the debriefing were highlighted by Fit.

> *"Probably a bonding thing really. It kept us together and probably built a bigger bond amongst the crew.....definitely have bonded together and have respect for each other and look after each other".*

He further discussed other positive benefits, such as teamwork, doing the job well, working well together and job satisfaction.

> *"Teamwork. We work as a team. I have got my respect back. I mean I felt I have, they respect me for helping them. Giving them the opportunity to talk in a group situation. I think it has been a good learning curve for them and the respect that I have gained from them and they have gained from me. It has kept us going as a team. As an effective team".*

I was very conscious at the end of the first interview that I had resurfaced painful thoughts and feelings associated with the incident. Fit acknowledged that he was surprised that certain aspects of the incident still did affect him when he recalled them.

> *"Its, you know, its been excellent and its still there and a couple of points still hurt, and I didn't realise that they were still hurting that much. Its not hurting but it affects me. Still there".*

At the beginning of the second interview I wanted to check out how Fit had been since our last meeting. Had I caused him to suffer more significant pain by requesting his involvement in this research and asking him to tell his story?

> *"Have no problems from doing the interview with you. It proved to bring out some extra points which was still deep within me. That proved to be beneficial".*

While Fit acknowledged that he had resurfaced the memory attached to the incident, it was not painful.

> *"It is definitely not painful and I think that last time. It came out but it was only a memory. It wasn't painful.....* Yes

it is just a memory and I was talking about it with my partner, funny enough at lunchtime....with in relation to the incident and the interviews and the..... participating with you and those memories are different now..... it doesn't hold any pain for me".

At the third and final interview, Fit once again discussed the positive aspect of participating in the interview.

"A marvellous learning curve doing these interviews have been for me. How much a learning curve the whole initial incident was. I just hope that I can take away all the experiences and continue to help people as I have been helped".

At the end of each interview I thanked Fit for his contribution to my research and to the ongoing practice and training of the Peer Support Team. He stated how he had found the interview process helpful by recalling the incident and the debriefing process. He discussed how he was happy to be interviewed.

"Definitely, its opened my mind up again, its I think, I feel a lot more relaxed from it. Its great. Oh excellent, I am really rapted. I felt you know, I felt really good".

Fit had obviously found it a therapeutic process recalling his story and the experience of debriefing. Engaging in the telling of his story clarified the meaning of his experience, which resulted in closure or a resolution. Recalling past experiences assists individuals to resolve unfinished business, which is an important element of affording closure which engenders meaning (Lichter, Mooney & Boyd, 1993).

8.7 PERSONAL EFFECTS FROM THE ONE-ON-ONE SESSION AND THE CISD

I questioned Fit on the different effects of the one-on-one session versus the debriefing. I was interested to know why he felt he required both the one-on-one and the CISD Critical Incident Stress Management strategy.

> *"My personal and family immediate needs and that was, that had to be done for me to be able to, for my own satisfaction, to get up and to be able to go, to walk back to work and do my job".*

The debriefing had the effect of Fit gaining an understanding of not only his stress effects, but also his crews.

> *"I was also tied up with my own, still tied up with my own personal grief that I would call it at the time or stress..... and if I hadn't of spoken to the team in a controlled situation, I don't think I would have heard all the feelings that they had. And each of them had a totally different perspective and feelings in their own unique little situation of where they were".*

Fit discussed how they had to work together to understand what happened for all the crew who attended the incident, to gain an understanding of all the crews perspective. It was important to regain trust in order to move on from the incident and work as a team again.

> *"So we tended to work together and I can look at them and say that they knew that I did that for such and such a reason and not to have doubts still. They couldn't trust me maybe in another situation. I needed to get trust in them again".*

I asked Fit whether he was able to regain the crews trust by the participation of himself and his crew in the debriefing in order to begin working cohesively again.

*".....getting the trust back from them. For them to know that I was human was a big, big plus, getting their trust back. When I spoke to them one-on-one afterwards (*the debriefing*), just again, that was over like a cup of tea or just walking around, I spoke to each of them about how they felt with the situation that I was in and put them in. The results came back were tremendous, plus being able to do that in a controlled situation because we all listened to each other's story without interjection which I think we wouldn't get over a cup of team, and that's, that's why it was excellent. We had, we were each able to tell our story, how emotional each got telling our story was varied. There was no interruption which could have put someone out. I am sure it could have put myself off as I was the most emotional (*laugh*), emotional".*

Fit shared with me how being involved in a CISD had affected him and how he had doubts about his personal safety if he had not taken the opportunity to tell his story in a debriefing.

"I really don't think I would still be in the Fire Service. I think I would have needed medical help in the end.....I would say I would have ended up physically sick as in the whole body packing it in and going into shock somewhere and I would have been at the Doctor's and I am only surmising this is what would have happened really.....I could have been sent away to specialists. Because I was having a psychological problem with it.....you know it could have got worse to the point of suicide in the end".

I believe Fit shared how grave the situation was for him and his fears around his own personal safety. If he had not been given the opportunity to participate in a CISD with his crew, he may not have been able to recover from the incident. He felt severely traumatised and overwhelmed by the seriousness of the incident and the potential for his own loss of life and the loss of some of his crew. The one-on-one support provided him with an

opportunity to share his own story and subsequent personal distress in a safe and caring environment. This intervention enabled him to have the power to face his crew in order to tell his story and hear their stories. However, he needed more than what the one-on-one intervention was able to provide. He needed a forum in which to tell his own story in a safe and controlled environment and also to hear his crews' stories so that he could gain a better understanding of their situation and reactions to the incident. Without this opportunity I believe Fit may have had serious long term mental health problems. While I acknowledge there is a place for mental health services, I don't believe the services that exist in the present context were in a position to offer Fit the most appropriate assistance in the immediate phase following the incident, as what the debriefing was able to offer him in terms of the sharing his story with his crew.

8.9 CONCLUSION.

While there were several common themes that were highlighted by the four participants, which I will discuss in a later chapter titled "Patterns and Themes", I have focussed on several main themes that I interpreted as being of great significance to Fit's story. The main theme in Fit's story was, I believe, the need for him to tell his story. Fit needed the crew to hear what really happened from his position, from his and not from others' perspectives. He needed to tell his story in a safe and caring environment where he was given the space, time and respect to do so. In order to regain his self-respect and credibility, he needed to reveal not only what happened to him, but also share his feelings, emotions and stresses associated with attending and following the incident. He felt a great sense of relief when he was "heard" in the debriefing and was then able to hear the others' stories more clearly in a safe and caring environment which is imperative to the success of a debriefing. The formality of the debriefing permitted participants their "turn" to speak uninterrupted. He discussed how very often, when firefighters share over the "smoko" table upon returning after an incident, often insensitive

comments are made, which for him may have had the potential to cause him serious harm.

Fit's story, his journey and the making of meaning unfolded with the telling of his story. He reflected on his story and made further meaning of his experience in the second and third interviews where he clarified issues in terms of his own experience and the experience of others involved in the debriefing. He shared what was important to him, the choices he made and the reasons for some of these choices. His story illustrated his experience of the incident and subsequent debriefing by clarifying and interpreting the complexities of his experience into a vivid and rich narrative.

While I have attempted to make some meaning of Fit's story, I have been cautious with my interpretation as I believe this is Fit's story. He shared his story with much emotion and in great detail, and it was evident to Fit and myself that it had been a very therapeutic process which he acknowledged on several occasions. However, it is Fit's story and my interpretation of his experience was written alongside his direct story, which I requested Fit to verify, in order to give credibility to his story and my interpretation of his experience. I have not over interpreted the text of his narrative as I chose to keep the researcher's voice quiet in the interview so as to remain close to the original telling of his story. I consider that this experience enabled me to discover deep insights into the experience of debriefing.

Fit and I grew through the experience of the sharing of his story. He became empowered and validated in some of his decision making in relation to the incident and the subsequent organising of the debriefing and I became more grounded in my practice particularly in relation to CISD. Making visible, the invisibility of the experience of debriefing, helped both Fit and I understand the process of debriefing with greater clarity and vision.

In the following chapter I will uncover the narratives of three other firefighters by discussing, in some depth, their unique experience of participating in a CISD.

9. OTHER STORIES – EACH IS A UNIQUE STORY

9.1 INTRODUCTION

This chapter seeks to uncover the stories of three further firefighters who were all involved in the same critical incident and subsequent Critical Incident Stress Debriefing. I will begin with a discussion on the background to the particular critical incident that the participants attended. Following this I will divide the chapter into three sections. Each participant's unique story will be contained in an individual section and an interpretation of their experience will be addressed individually.

As previously discussed, when interpreting the data I became aware that each individual participant had a particular theme that was unique to their experience. Because of this discovery, I have decided to present their unique themes individually and in a later chapter discuss the common themes that were elucidated during the interpretation of the data of all the four participants' interviews. When I immersed myself in interpreting the narratives for the essence of the experience of debriefing for the four participants, it became obvious to me that while there were several common themes, each participant had some aspect of the experience that was particularly unique to their experience. I will begin each section with some background on each of the four firefighters in terms of their length of service, rank and social circumstances. As in the previous chapter on Fit's experience, each story will be presented using some text as close to the original conversation and the narratives will be presented as a whole.

9.2 THE CRITICAL INCIDENT

Before discussing the participants' experiences of a Critical Incident Stress Debriefing, it is important to have some understanding of the background to the particular critical incident, which subsequently required the Critical

Incident Stress Management strategy of a debriefing. All the participants attended an incident which on first impression they believed to be in their terms, "an ordinary old housefire". However, due to unforeseen circumstances the incident resulted in significant numbers of firefighters' lives being very nearly lost and their safety was severely threatened. Several firefighters were injured and required hospitalisation and for some of the injured firefighters, they required a lengthy period of rehabilitation. While in firefighting terms it was considered a routine housefire, it was subsequently upgraded to a major incident that required multiple resources, had the potential for loss of life and firefighters safety was severely threatened.

Unfortunately, due to confidentiality reasons to protect the identifiability of the firefighters in a very highly publicised event, I am unable to discuss the incident in greater detail. However, it is important to understand that the way this incident progressed from a routine fire and was upgraded to a major incident took all those attending the incident by surprise. Because of the surprise element, and the belief that firefighters had died at the incident and there had been serious injury, the incident caused significant distress to all firefighters who attended the incident. This distress was felt by all firefighters, irrespective of rank, and had the potential to cause significant critical incident stress to all those who attended the incident.

The debriefing which the following three participants attended followed a modified version of the Mitchell model (1983) of debriefing. The seven phases of the Mitchell model (1983) were followed but was not facilitated by a mental health professional, but by myself, a Registered Nurse with 10 years experience in the field of CISD and CISM. As the facilitator, I was assisted and supported in the debriefing process by two Peer Support Team members. One of the Team members had extensive experience in the debriefing process with over 20 years firefighting experience; the other team member had much less experience in the field of CISM. The debriefing team jointly shared the leadership role, though the newer member tended to be less active in their involvement.

Following the debriefing I discussed with the participants whether they would be willing to participate in my research study. I also provided them with an information sheet outlining in detail the research project and issues around their participation. I stated that I would follow-up all participants, with their permission, by telephone within the next 24 - 48 hours. However, one participant, who was to become known as Instantaneous, rang me within 24 hours of the debriefing and stated that he would be willing to participate in the research study. I felt really affirmed by his positive and generous offer and his statements in regard to his amazement at how effective the debriefing process had been for him and his crew. The next two participants, Flick and Red, were the first two firefighters who responded positively to my telephone call enquiring into their willingness to participate in the study.

The initial (first) interviews were all conducted within 3 - 6 weeks following the debriefing. Initially I planned to interview the participants 7 - 10 days following a debriefing. However, after further reading I discovered that the literature supported an extension of this time in order for the negative stress effects experienced following their exposure to the critical incident to dissipate. All three interviews for the three research participants were carried out in the private homes of the participants or the researcher, and one participant's interviews were carried out on Fire Service property.

At the beginning of the first interview of the three participants, as discussed in the previous chapter, I explained the process of the research, gained informed consent and discussed with them in depth the sensitive nature of the questioning and that there was the potential to cause some further distress. They all stated that they understood the implications but were happy to proceed. It was my belief that if they had had any serious concerns or reservations about their safety, they would very likely have refused to participate.

I was ever mindful of the importance of establishing a comfortable and trusting presence with the participants in order to gain the rich data that was

necessary to truly uncover in detail the experience of debriefing. From the beginning of my initial contact with the participants, I worked diligently to establish an open and honest relationship in order to foster trust and rapport. I had previously worked extremely hard at establishing this level of relationship in the late 1980s when I had worked as an Occupational Health Nurse in the New Zealand Fire Service. When I joined the Service, women did not work closely with the men or work at the Fire Stations so I felt like I was blazing a new trail. In retrospect, at times I felt like I was trying to assimilate myself into a totally foreign culture. Now ten years later, I had gained a breadth of understanding of the Fire Service operational aspects, and more importantly the culture that had been established. While my return to the Fire Service was relatively recent, I believed that I was well respected and it made the process of gaining participants consent to participate in the study that much easier.

9.3 THE STORY OF INSTANTANEOUS. *"I WANTED TO TALK ABOUT MY GUILITY FEELINGS"*

Instantaneous holds a rank of Senior Firefighter and had over 20 years experience of firefighting. He is well respected within the Service both for his Fire Service experience and expertise and belongs to several voluntary groups both within the Service and within his community. He is married with adult children.

The interviews with Instantaneous were held on Fire Service property in a quiet isolated area of the building in order to ensure privacy. However it was interesting to note that I believed both the participant and myself were less relaxed than those interviews that were conducted in the private homes of the firefighters or the researcher. Background noise was a problem that subsequently caused great difficulties transcribing the tapes and I was ever conscious that privacy and confidentiality could be breached by intrusion of

the Fire Service support staff, even though I had attempted to find a private and quiet space in which to conduct the interview. However, in spite of these concerns Instantaneous did share openly and honestly. On several occasions he did become tearful, particularly when discussing how he believed during the incident that members of his crew had lost their lives. I felt privileged and humbled by his sharing of both his story and his thoughts, feelings and emotions around the incident. At no time, when questioned, did Instantaneous want to stop the interview, though quiet spaces were provided for him to regain his composure in order for him to carry on with his story.

In my first leading open-ended question I asked Instantaneous to discuss his own personal experience related to participating in the recent debriefing. He immediately began discussing what I believe was the most important issue for him in relation to attending the incident and subsequent debriefing. He discussed what I have referred to as **"survivor guilt"** which I believed was Instantaneous's unique theme. It was the first time in my experience with debriefing that a firefighter had highlighted this issue as being paramount to their experience. In past debriefings, firefighters have discussed their guilt attached to not being able to save an injured or cardiac compromised individual. I found it fascinating listening to Instantaneous's narrative around his guilt. He began his story with the following statement:

> *"I had an overall feeling that I wanted to talk about my guilty feelings attached to the situation that I found myself in. I was separated from the rest of my crew. I genuinely believed that they had died. And it was some time believing that. I had a really strong feeling that I should have been with them. I wanted to say that to them".*

It became more and more evident on further questioning that it was imperative that he inform his crew in the debriefing that he felt guilty and that the debriefing had assisted him in doing so.

> *"To express my guilt. Fairly illogical but that is the way I felt".*

I discussed with him the environment that was provided and whether that felt right for him?

> *"Probably the only environment where I could express that. I did say to the crew concerned shortly afterwards, but I think I needed to say that again in the larger group. I just thought it was an appropriate place to say it and that maybe other guys would have similar feelings and I wanted to hear what they had to say. No one else expressed a similar feeling but no one quite knew the situation I was in".*

Instantaneous discussed in depth the stress effects on the firefighters and how they had never experienced such shock and disbelief.

> *"In all my experience with the Fire Service I have never really been stressed out by fire or other incidents. I mean what stress there is, is short-lived for us. I mean if you see a motor accident and a child dies, I feel really sad about that. But I have never been plagued by stress, the operational side of it. I have been stressed and sad, but it is short-lived".*

> *"I have had similar incidents but I have never been so shocked, so emotional as this one because it was a terrific surprise to everyone. The actual incident. It was a terrific surprise. We were all experienced firefighters. We had seen houses burnt down before, but never expected what actually happened. The actual incident caused great shock. So this is the most unusual and it brought up a great deal of shock".*

Instantaneous made a significant statement in relation to how effective the debriefing had been for him personally. He discussed the potential consequences for him if he had not participated in the debriefing.

"I think if I hadn't been debriefed I might have forever in my Fire Service career continued to apologise to that crew for not being with them when they died".

I questioned him about his need to do this again and if not why?

"No, No. Because I have got it out of my system. Yes, I told them". (In the formal process of debriefing)

He obviously found the formal process of debriefing beneficial in terms of sharing his emotions with regard to his guilt.

"For me it was like a release of emotions, I suppose. Once it was out, it was over. But it had to come out".

When I questioned Instantaneous about the positive benefits for him personally, for both the present and for the future he answered:

"When I let out the emotions I felt I had a sense of relief, a release if you like. I am sure I might have gone on like the Ancient Mariner..... Forever saying to the firemen I should have been with them when they died".

"I thought it was a good experience and for me. it brought a final lid on the incident. Although I will probably talk about it for the next 20 years. Emotionally it is finished with".

While Instantaneous highlighted the positive benefits to him emotionally in terms of sharing his guilt attached to his own survival, he has since shared with me informally how powerful he believes the debriefing was. In his above comment regarding firefighters talking about the incident for the next 20 years, he now says that his crew rarely mentions the incident. He believes this is related to the participants in the debriefing talking about it in the depth

that the debriefing encourages and permits and since it has been *"laid on the table"*, it is no longer an issue.

In the second interview Instantaneous began by stating that he was happy with the transcript and did not want any of the details deleted. However, he was disappointed that much of the humour and emotion was absent in the printed form. He felt that some of his comments appeared rather bland and pompous. I reassured him that while he and I were aware of both humour and emotion that it was pertinent that he raise this concern. I acknowledged that it was necessary for me as the researcher to skilfully highlight the humour and emotion when appropriate. We discussed how humour was used by some of the participants in the debriefing as a kind of mask to disguise their discomfort, particularly in the introductory phase, until they felt more comfortable to share some of their feelings, thoughts and emotions.

During the second interview Instantaneous appeared to feel more relaxed and I believed a strong trusting relationship had been established during the previous interview. He appeared more able to share some of his discomfort in relation to his emotions and survivor guilt.

> *"I mean it's ridiculous to think I should have died with them, you know".* (Embarrassed laughter)

I acknowledged that this was how he felt and questioned him around what this feeling was related to.

> *"I think it's a natural part of sort of grieving…. That you're in a crew, during a group or a crew, that you should have been doing some task and they all got killed except you. You are bound to feel guilty. It's quite natural, but you have to get it out of your system sooner or later".*

He further acknowledged his guilt around his own survival when he thought

others had died and how this had been the most important emotion that he had felt around the incident.

> *"For some reason on that particular incident, that was really the only big emotion I felt and I felt guilty that I wasn't there with them and I was convinced, of course, that they'd all died. Not just my crew but I thought we'd have at least six fatalities. It turned out there were more firefighters actually injured or trapped or involved in the collapse".*

It was important for me to acknowledge Instantaneous's guilt. I discussed with him that while it was a natural emotion for him, particularly as he was convinced that he had lost all his crew who he had worked closely with for a number of years, that guilt was both a powerful and a destructive emotion if not dealt with effectively.

The above parts of Instantaneous's narrative highlight the intensity of what I believe was the unique theme for him in relation to his experience of debriefing. The debriefing provided him with a safe and caring environment in which to share his guilt attached to his survival. While he acknowledged he felt some discomfort with this emotion, it was imperative that he share this emotion in order for him to progress and lay that emotion aside. By sharing his guilt he was able to resolve his inner conflict and move on.

In the third and final interview, Instantaneous stated that he had experienced no negative effects from participating in the interviews. Like several of the other participants he had found the interviews therapeutic. While the interviews had surfaced some strong emotions attached to the critical incident he had found it *"Very much therapeutic".*

I am familiar with the culture of the Fire Service and have in the past heard firefighters discuss in great depth and detail particular major incidents where there has been major property loss or loss of life many years previously. The

incident continues to be a great source of conversation which is resurfaced and talked about in great detail, which Instantaneous discussed. Instantaneous viewed this incident as probably the most significant for him in all of his firefighting career. However he believes that it is now discussed less than previous incidents. I had to ask the question, is this a positive effect of the debriefing? Instantaneous stated:

> *"I thought this was probably…..this incident was the most dramatic in some respects of any incident I've ever attended in the Fire Service. But it's the one that we've discussed the least and I think that's probably because there is no need to discuss it. We did the debrief and got it out of our systems".*

From working in the area of debriefing for the last 10 years I believe it most certainly is a positive effect. In concluding, the unique theme that was elucidated during the three interviews with Instantaneous, was **survivor guilt** and the need to express this within the process of debriefing was the most paramount issue for him. Survivor guilt is an emotion experienced by individuals who have remained alive when others have lost their lives in an incident. There were also other common themes that he discussed, such as regaining respect for a fellow-firefighter, the value of the Peer Supporter, hearing other firefighter's perspective of the incident and a feeling that he was not alone with some of the feelings, thoughts and emotions. However survivor guilt was by far the most important issue for him.

9.4 THE STORY OF FLICK "THEY HEARD MY STORY"

Flick is a firefighter with over 20 years experience in the New Zealand Fire Service. He is married with children. He was situated in the heart of the incident where he played an active role in fighting the fire and the subsequent rescue of several of his crew. At times, during the interview, Flick seemed to

me to contradict himself in terms of how effective he had found the debriefing. I believed he was confused over the difference between the operational debriefing which would address his professional role in the incident, and the Critical Incident Stress Debriefing which would address his personal needs in terms of stress management. I clarified the two different types of debriefing with Flick. On several occasions he said that he would have preferred the debriefing earlier which I will discuss later in this section. Unfortunately he had not received any other Critical Incident Stress Management strategies before the debriefing, such as a demobilisation, a defusing or a one-on-one offer of assistance or support. The Peer Support Team had made themselves available to assist crews either on a crew basis or for individual one-on-one support, but few firefighters had availed themselves of this service.

> *"I like to get it all over and done with while the incident really is still going on. To come back, I felt sort of not resentment, but it was sort of..... I thought I knew my stress levels had built up having to come into a debrief and so late. To me personally I would have liked to, probably.... that morning. I feel that morning would have suited me a lot better than sort of flowed away from there".*

I acknowledged Flick's lack of support in the initial stages following the incident and explained what other CISM support services could have been offered to him, but that a CISD is usually held 24 – 72 hours following the incident and the reasons why it is not held earlier. The debriefing that Flick attended was held on the fourth day following the incident. The reason for the delay in holding the debriefing was due to those firefighters who had attended the incident having their four days off which began immediately after the incident. I acknowledged that he was making a very useful point to be mindful of in future planning following critical incidents.

The Peer Support Team contacted some firefighters at their homes over this time period, as they were considered severely traumatised either due to injury or because of the role they played at the incident. Flick was not contacted but it is my belief he should have been as he was considered to be at the "heart" of the fire in terms of firefighting and in terms of rescuing others. In fact it is very likely that he had saved other firefighters' lives because of his actions.

However, Flick stated that he found the debriefing did assist him particularly in terms of hearing the other firefighters discuss the incident from their perspective.

> *"Yes definitely, it was good to hear others. It affirms to you the guy sitting next to you in the downhill job was no different to me. Basically your feelings are still the same".*

It was quite difficult to get Flick to discuss the experience of the debriefing from his own perspective. I believed he needed time and supportive prompting in order to tell his story of the experience, which I provided. I continually acknowledged his contribution to the rescuing of some of his crew members. However, on more gentle but direct questioning he answered:

> *"It was a very, very neutral feeling to go into it because I didn't know, not having a debrief of that sort of critical stress way. I didn't know what, basically what to expect. It certainly got deeper into the subject while we were there. It was to me .... personally..... it brought it right back to the incident. Clearer, straight in front of me again. And hearing the other firefighters versions of it put a better picture and I knew where I fitted in, in that particular incident. It was quite good in that respect."*

As the interview progressed Flick discussed how he had felt safe in the debriefing and he expressed how he believed the participants had **heard his story.**

"And I was quite pleased with the people who were there, who heard my story. Now in their mind, they have said to me afterwards, they said to me afterwards, that they didn't actually know what was happening in my little part of the woods. And they were just so pleased with that. It made me feel quite good".

Flick obviously found it really affirming and important to him personally to have had his story heard by the other firefighters.

"Yes, yes, I actually found the other firefighters, because they didn't know what had happened to me. When they heard my story, they came back to me and I felt a lot of satisfaction. More satisfaction from that rather than being sort of in the dark, and no one knowing what they were doing or done. In the dark of what happened. Now they know".

It was obviously important that Flick share his experience of the trauma attached to the critical incident and I believe the debriefing process was the most appropriate and effective method in which to do so. He stated that it wouldn't have mattered where the debriefing was held since all he wanted was to tell his story and be heard.

"Because of what had happened, I personally, if it had been at the local Railway Station, it didn't matter to me where it was. I felt quite, I had cheated death so what else can come second. Nothing. So as it was, it was in the Fire Station environment, it didn't really worry me. Personally I felt, I thought I would tell my story to my fellow firefighters and there was nothing that I had to hide so being in a little safe haven wasn't a problem. I had the complete freedom to say what, when and how I felt. People were listening without any outside influences whatsoever".

Flick discussed how he had shared some of his personal feelings and reactions by telling his story.

> *"I went through my story as it happened. Nothing was altered and even now I would hope I could put the same story through and not alter anything as this is the way I saw it".*

The power of the debriefing for Flick was that he was **heard** and he felt "lifted" by this. Another participant, Fit, used this term when he recalled the positive effect of the presence of the Peer Supporter in the debriefing. Once again Flick tended to contradict himself in terms of whether he felt he would have been heard as effectively telling his story over the "smoko" table. At times I became a little frustrated with his responses but kept reminding myself during the interview that this was the way Flick wanted to tell his story and to trust the process of his storytelling. When questioned about whether he felt the participants in the debriefing had heard him more effectively in the debriefing he answered:

> *"Oh yes most definitely. As you said in the beginning* (in the introduction phase of the debriefing where the ground rules are discussed) *the four walls, nothing was to go outside. But still it wouldn't have mattered. They heard what I had to say and that's when I felt quite lifted by this".*

He confirmed my own feelings regarding the benefit for him personally by saying how the debriefing assisted him.

> *"You feel a strong part of the team. And immensely it does lift you".*

Flick stated on several occasions that he was so intent on telling his story that it didn't matter where the debriefing was held. It is not uncommon for firefighters, because of their own personal stress attached to the critical

incident, to deflect their own stresses onto other firefighters. They tend not to actively listen, often apportion blame, and make "wisecracks" about other firefighters' actions, and criticise their colleagues. Often this is in a "tongue in cheek" manner, but which has the power to cause severe distress to already traumatised or vulnerable firefighters. I believe that around the "smoko" table would have been a very unsafe environment for Flick to tell his story in any great depth. It was vital that he could be heard and acknowledged as to how well he had performed under difficult circumstances. I truly believe that the firefighters in the unstructured environment around the "smoko table" would not have given Flick the time to tell his story and the opportunity to be really heard. It affirmed to me an interesting observation I have made, that it is imperative to provide a safe and caring environment where participants are encouraged to share their experience from their own perspective without critique, ridicule or interruption from other participants.

Flick did discuss how he had felt some discomfort at the presence of some of the firefighters in the debriefing, but due to the safe environment he was able to share his story.

> *"There was definitely one there that I wouldn't have felt at ease. Certain things in front of him, but if I may say that person actually rang me a day afterwards and said that he respected what I had said and respected my actions, in what I had done at the incident. And though I wouldn't see him as my enemy, it is just a person I wouldn't have a lot of time for and now maybe……".*

I don't believe Flick would have shared so freely and been heard in an informal setting and that this firefighter who subsequently rang him and acknowledged his actions may never have been given the opportunity to hear Flick's full story of his experience. This must surely be a positive effect of the debriefing for Flick.

A further positive effect of the debriefing for Flick was that he felt stronger mentally and better prepared for an operational debriefing which occurred sometime after the CISD. However, once again he confused the CISD or stress debriefing, with the operational debriefing. While many clinicians refer to CISD as a psychological debriefing, I always refer to it as a stress debriefing as I feel it is more acceptable term and less threatening and intimidating to firefighters. This change of terminology I use in my practice resulted from a comment a peer supporter made to me following a debriefing when we were debriefing ourselves before leaving the debriefing venue. She made the comment that she felt some discomfort around the word psychological debriefing and wondered whether there was a more acceptable term to use for emergency service personnel. By using the word psychological they believe they are going to be psychoanalysed during the debriefing. The operational debriefing looks at the operational procedures that were followed at the incident and in the past many firefighters have been anxious and angry about attending an operational debriefing as they often view it as a "witch hunt" to apportion blame on individual firefighters. I had to highlight the clear differences between the two debriefings in order to clarify what Flick was referring to. He did acknowledge the positive effect for him from attending the CISD.

> *"I feel probably a little bit stronger mentally for it because what has gone on in the past, in the past debriefings* (referring to the operational debriefing), *I am not prepared to put up with that. What we went through in that incident, it didn't warrant it. Certainly not warranted".*

In the second interview Flick discussed again how participating in the debriefing had made him a stronger person which could benefit him in future incidents.

> *"Definitely it makes you a stronger person for it. Maybe the same incident again might not affect me as badly as this one has".*

He acknowledged that by attending the CISD he felt more able to handle an operational debriefing without being significantly traumatised.

"You don't feel so vulnerable, the reserves knocked down. They weren't at the debrief. Things were resolved".

In concluding a discussion on Flick's unique experience in relation to attending a CISD, I believe the most important issue for Flick was that the other participants heard his story. Because of this he felt affirmed by positive comments made by fellow firefighters both during and following the debriefing. I feel sure that his story would not have been heard as effectively in an informal process such as over the "smoko" table. He stated on several occasions during the three interviews that he was experiencing no negative affects from attending the incident, the subsequent CISD or participating in the interviews.

"It's drifting away quite quick. It doesn't take a talk like this to resurface it strongly again. I'm just quite neutral on it now".

To me this was really affirming of the process of debriefing. Flick's story was able to be told and heard in a safe and caring environment where he was given the opportunity to not only tell his story and be heard, but also vent some of the strong feelings, reactions and emotions that he experienced both during and following the incident.

On further reflection, I noted with interest that Flick's name was not one of those that was given to the Peer Support Team by Management who they considered at risk of being severely traumatised by the incident and who required follow-up by the Team following the incident. I wondered why his name was not included in the list? I would have considered him at significant risk of being severely traumatised by the incident as his own life was severely compromised and he played a significant role in the rescue of other firefighters. It is my opinion that he certainly was at risk of suffering from

critical incident stress. However, Management and those who provided the names of personnel who they considered most at risk of significant stress were unaware of Flick's story. While Flick received little formal Critical Incident Stress Management in the time leading up to the CISD, at least his story was able to be heard in the debriefing without interruption. Those participating in the debriefing were able to get a true picture of his role in the incident. They were able to acknowledge and affirm his role in the saving of lives. I believe this played a significant role in his speedy recovery from a major critical incident. As a result of this information I asked myself the following question - how many other firefighters stories have been left unheard in the past? I resolved to consider this further and made moves to modify the way that I considered the list of affected personnel in the future.

9.5 THE STORY OF RED
"I DIDN'T HAVE ANYONE AT HOME TO TALK WITH"

Red is a firefighter with less experience in comparison with the other participants. He is separated from his partner and has several dependent children. He was injured during the critical incident and required hospital treatment. What was unique to Red's experience of debriefing was that it allowed him the time, space and a caring environment in which to share his story. At the time he was separated from his partner and shared that he was not in a relationship in which he could have sought comfort and a listening ear.

It was shared at the beginning of the interviews that Red had found the process of debriefing therapeutic because he was not able to share his experience on a deeper level with a close loved one. He began the first interview by discussing why he thought the debriefing was important for him.

"I think really to me it was important for me to go to the debriefing on the incident mainly because of the physical nature of what happened to me. I got injured. Also I think it was important to me to get into an environment where there was a lot of people there that were actually at the job. Sort of like everything, they lived it. For me the big thing about going and talking about it was because ***I didn't have anyone at home to talk with.*** *That was what really sort of hit home, that it was a good thing and it was important. I did feel a bit uneasy though to sit in a larger group and actually talk about my emotions and that. Normally if I am going to do that I will probably do a one-on-one, its probably not with a guy, it is normally with a lady. But because at the moment I don't have a lady it was a good environment to be in. So that is why I sort of came and why I thought it was good".*

This was Red's first experience of debriefing though he did discuss that he had attended debriefings, but these were operational debriefings which, as discussed previously, are very different to a CISD. Red had been through a period of severe stress in relation to his domestic situation and was already traumatised by his family circumstances. As a Nurse Clinician I believe that Red was at risk of being severely traumatised by this particular incident because of several critical factors. Firstly, because of the existing stresses that Red had been exposed to in relation to his distressing domestic circumstances prior to the critical incident; secondly he had been injured, required hospitalisation and had faced the threat of death; and thirdly this incident was considered a major critical incident in which there had been the potential for significant loss of firefighters' lives. It was vital that Red receive some form of crisis intervention in order to assist him to recover from this major critical incident. He had pre-existing stressors that had the potential to lead to cumulative stress which could have caused Red to suffer from Post Traumatic Stress Disorder, if assistance had not been made available to support him.

"I think in a way I have handled things quite well recently in the past. But because the added emotions of what has gone down in my life it was good to have another, another place to talk".

He did discuss how, in the past he found it difficult sharing in a large group situation. However, once he felt safe, due to the format or structure that was provided in the debriefing, which is referred to as the seven stages of debriefing, he felt more able to share.

"I am not actually a good sort of like speaker in front of a lot of people. I can speak to a few people, but not too many. I am not a good public speaker and also to speak of such quite emotional type things in an environment like that, it is quite hard".

He found the process where the participants were asked to state who they were, what was their role in the incident and what happened from their perspective, where it was structured and the participants were aware of what was required of them in the debriefing, as helpful to him personally.

"I suppose it gave me a format on which to say who I am and then sort of what actually happened. And a bit more about your feelings to the whole subject. Actually it was good and you need, and to me you needed to have sort of like a simple guideline in which to follow and that's exactly what it did and it was great. Really great. If you had said okay anyone in the room stand up and just talk, hell it would have been terrible".

He further affirmed the benefit of the debriefing for him personally by discussing the need to ventilate his feelings as he had no one at home to share these feelings with.

"As I said before I have not got anyone at home to go through, it was good to get a few things off my chest. It was definitely a way of getting things off my chest and to realise that there were other people in the room that would probably, have the same sort of feelings as me…..".

If Red had not been given the opportunity to discuss his experience with those who had been exposed to the same incident, there was the potential for him to suffer significant unresolved stress. By speaking out in front of his fellow firefighters who attended the incident and debriefing, he was able to share his feelings, thoughts and emotions. Remember this was the first time Red had shared so personally within in a group situation. Usually he felt more comfortable with a female partner.

"To me its really just the, having the ability to speak out in front of people. Okay. Which I probably wouldn't normally. It would be just like a one-on-one. Now I think I probably, just by doing that, I would bottle it up more. Whereas by speaking out in front of a pile of people, it did really get it off my chest and otherwise what I think I would do, I would just live with it and it wouldn't really affect me too well. By getting it off my chest it sort of made me deal with it, even though I probably don't want to deal with it".

He acknowledged how he had experienced unpleasant feelings following the incident and that if he had not been given the opportunity to discuss the incident his current stresses could have been exacerbated.

"And I think it has given me, it has forced me to actually, to have a few of the bad feelings I have had in the past week or two. So unless you get it off your chest, you are going to carry that baggage around and I don't want to and I have enough on my plate at the moment. With relationship

problems. To start piling more on it, and I want to be....
and when I am at a fire, at work, I want to be a good fireman.
I don't want to carry stuff around that I don't need to".

As Red's family had been recently divided, he found the debriefing made him feel like part of another family and he valued the team concept.

"I suppose one of the other things that it does, is that it
makes you realise that you are part of a big network
and a big team. It does give you, it reassures you
that what you do, is a good job.. And you think I do
this by myself, a total individual, but you're not, you are
a link in the chain. And it makes you feel good.
Especially at the moment. Being part of the family".

Red acknowledged how the debriefing had been positive for him personally.

"To me the debriefing was positive. I can't think of
anything that shouldn't have been said or was downright
bad. It was cool, it really was".

I believe that in the past firefighters have taken home some of the stresses associated with their attendance at critical incidents and their families have suffered the consequences of these unresolved stresses attached to the incident. Red stated how his participation in the debriefing had not only assisted him but also his family.

"To me it's to get it off your chest. You can't bottle it up
and as I have said before not having anyone at home with
me now to discuss it with, it was great. I could talk to someone
and feel being listened. And when it comes to like my family,
it meant that I didn't have, because I have personal problems,
familywise anyway, it was better to be able to concentrate when

I see my children and laugh, carry on, have fun with my kids, than bring it up. It was better familywise for me to concentrate on things that were important to my children than for them to see their Dad hungup on a bit of emotional stuff, trying to deal with it. They can't understand it. So it was better that the debriefing helped me out there".

Red discussed how he would encourage others to attend a debriefing and because of the high divorce rate in the Fire Service, there were other firefighters who were in a similar situation to himself, without anyone to share the stress of the incident.

"I would definitely encourage people and I don't want to get back to this, but especially people in my circumstances, where they have got like some emotional load at the moment and don't have anyone to come home to and cuddle up to and talk about..... Sure I was lucky. When I was lying there underneath all the rubble burning, I visualised my funeral, okay.....and as we know firefighters have one of the worst divorce rates in New Zealand so a lot of the time guys are between relationships or have just been coming out of one or into anther one. Yeah it is important".

Towards the end of the interview, I asked Red whether there was anything else he would like to add in regard to his experience of debriefing. He answered:

"It has actually helped me to deal with my relationship better because even talking about that and not dwelling on, because of my partner running off and just talking to someone, it was great".

As with all the other participants, I wanted to be reassured that they had not suffered any negative effects from their participation in the interviews. Red, like the other three participants, discussed how therapeutic it had been for him.

> *"I seem to sort of think..... in a way it's like a ..... sort of like a counselling session again and you actually, it's a way to sort of like finalise it..... and you know, put it out of your mind and away you go sort of thing.....carry on. I am actually starting to feel so much more at peace with everything okay.... There's a lot going on in my private life....but I feel so much at peace and work-wise really good".*

While reflecting on the participants' comments when reporting the research interviews as being very therapeutic, I began to question myself about the debriefed firefighters requiring more assistance following the debriefing? Should they be followed-up individually several days after the debriefing irrespective of whether we believed they require it or not? Since conducting the interviews, I now ensure that all the debriefed participants are followed-up by telephone contact within 24 – 48 hours following the debriefing to ensure that they require no further assistance. This follow-up telephone call is always made with the consent of the debriefed firefighters, which is sought at the conclusion of the debriefing. I have found their response to the follow-up telephone call as being very positive. I believe this further enables the channels of communication, support and assistance to be kept open. This is particularly pertinent for those who are still suffering the negative stress effects but are reluctant to seek individual assistance or those firefighters like Red, who have no immediate close social support at home.

As the interviews progressed it became clearer and clearer that the main theme for Red was that **"I didn't have anyone at home to talk with"** and that the debriefing was positive for him, particularly in relation to his present family circumstances. Once he felt safe and reassured with the process that

was to be followed during the debriefing, he felt more able to share his significant story of his personal situation at the critical incident. He was amazed at how comfortable and confident he became with the telling of his story to the group. He stated on several occasions that he had always felt some discomfort in speaking to a larger group. I believed that the formal process of debriefing, particularly where time is spent on the introductory phase in relation to confidentiality, speaking for oneself, explaining that it is a stress debriefing and not an operational debriefing, all assisted Red to feel safe, confident and competent to share with the other participants.

9.6 CONCLUSION.

In this chapter I have discussed the unique themes that were highlighted in the interviews that were held with the three participants, Instantenaous, Flick and Red. While they all attended the same incident and subsequent debriefing, each had a particularly unique theme that was paramount to their experience of debriefing. Instantaneous had this strong desire to **"talk about my guilty feelings",** Flick found that **"they heard my story"** and Red **"didn't have anyone at home to talk with"**.

On reflection I believe these themes were all very pertinent, particularly in relation to the need to share one's guilt when a firefighter believed his crew had all died in the incident. Firefighters work as a team and they have this strong sense of looking after their crew. If a crew member or members safety is threatened or lives are lost, there is a strong sense of guilt related to these circumstances even though the cause may have been beyond the surviving firefighter or firefighters control. The second theme relates to having one's story heard. I believe that for some firefighters their stories are not heard. Often the more dominant and controlling firefighters tend to tell their stories and be heard, particularly in the informal environment, whereas the less dominate firefighter often is given little space and respect in which to do so. This is all part of the culture of the Fire Service in relation to the "macho" image where the bigger and better you tell your story with the

loudest voice, the more you will be heard. I believe this image is slowly changing and firefighters are beginning to challenge these individuals who dominate the group. The third theme relates to a firefighter having no one at home to share his experience. As previously discussed, the relationship breakup in the New Zealand Fire Service is particularly high and many firefighters are in similar circumstances to Red. The debriefing is a CISM strategy that has been highlighted by Red as being particularly valuable in which to assist those firefighters who are not able to share their experiences with a close partner.

In the following chapter I will discuss the overriding pattern and dominant themes that emerged during the analysis of the data in relation to the series of three interviews with Fit, Instantaneous, Red and Flick.

10. PATTERNS & THEMES

10.1 INTRODUCTION

In this chapter I will illuminate the overall pattern and the eight major themes that were uncovered during my journey with the four participants, Fit, Flick, Instantaneous and Red. I will begin with a discussion on the overall pattern, that of the **formalised process** and follow this up with a discussion on the eight major themes which I have named **safe environment, ventilating the stress reaction, similar feelings, getting the whole picture, peer support, bonding, respect and resolution.** By highlighting and understanding the main pattern that was illuminated in the texts, a more indepth discussion can be woven into the themes that were discovered and the true meaning of the participants experience of debriefing will be made visible.

The process of uncovering or illuminating the complexities of the participants world in relation to the experience of CISD was a very humbling experience. I felt honoured and privileged that the four participants were happy to share their experience of debriefing when there was always the potential to cause further pain and suffering attached to the recent critical incident and subsequent CISD. However, I was really encouraged when participants discussed how they had found the interview process therapeutic and even stated that they enjoyed their journey with me into the world of research.

Analysis of the narratives showed several striking similarities that stood out in the data. A careful study of the individuals' narratives elicited the uncovering of the experience of CISD and the meanings they attached to the experience. One main overriding pattern became obvious as I journeyed in gaining a greater depth of understanding of the interview texts. The formalised, structured process of the debriefing became the overriding pattern that I believe assisted the participants share their experience of the critical incident.

From this pattern, which I have named **formalised process,** eight major themes were illuminated. Overall, the participants highlighted the positive benefits of CISD on themselves, the organisation, and the positive benefits of the formalised process that was followed throughout the debriefing. I will also highlight some of the negative comments that were stated in relation to the CISD which requires consideration, particularly for my own and others future practice.

10.2 FORMALISED PROCESS

The process of Critical Incident Stress Debriefing provides a framework where there is a clear beginning and a clear ending and where participants are informed at the beginning in the introductory phase where the process will lead them during the debriefing. Clear guidelines are established at the beginning of the debriefing so that the participants feel a sense of confidence that their story will be heard without interruption or ridicule, that they will not be psychoanalysed, or participate in psychotherapy. By following and participating in the process they will be able to have a clearer picture of what happened at the incident from all the participants perspective and be able to find some meaning or "silver lining" in the critical incident. The formalised process is completed in the re-entry phase where the participants are asked if they have any questions or concerns. Any ambiguities are addressed and the incident and the effects are summarised. This last phase of debriefing puts closure on the discussions that have occurred during the CISD.

I highlighted in Chapter 4 the common profile of the personality traits of firefighters. One of these common traits is that of being in control of the situation. On reflection from my readings and research findings, I now believe that the process of debriefing is particularly applicable to utilise with firefighters because of their need to maintain a sense of control. Following attendance at a critical incident, firefighters may suffer from Critical Incident Stress and may begin to feel a sense of loss of control. To place these individuals in an uncontrolled environment could further exacerbate these

feelings which has the potential to cause serious long-term harm. Because of the formalised and structured process that debriefing follows, the firefighters are less likely to feel disempowered, out of control and more psychologically receptive to the process of debriefing.

It is important that the providers of CISD are not over-zealous with their intervention, which may further aggravate the firefighters feeling of being out of control. By acknowledging that each and every person has been affected differently, though there are similarities and that these effects are normal in normal individuals to an abnormal event, this empowers the participants to maintain a sense of control.

The research participants discussed the process whereby they felt a sense of "knowing" what was to happen which engendered in them a feeling of safety to share their experience. Several participants used the word control. I personally feel some discomfort with the word control as I view it as a very disempowering word. However, it is a word which is important to firefighters. I prefer to use the word caring, as by providing the controlled, formalised, structured process there is a sense of true caring where everyone is respected and valued for their contribution, not only in the debriefing but also in the critical incident. This enables the participants to share their experience in safety.

> **Fit** *"The process, the more serious, it was talked about having it around the situation of debriefing.....the more serious the incident gets, the more control I believe in now. The result being the debrief needs to be in that controlled situation with the Critical Incident Stress Team".*

> **Fit** *"The results that came back were tremendous, of being able to do that in a controlled situation because we all listened to each others story without interjection which I think we wouldn't get over a cup of tea and that's, that's why it was excellent.*

We were each able to tell our story, how emotional each got telling our story was varied, and there was no interruption which could have put someone out. I am sure it could have put myself off as I was the most emotional at the time I think that could have put me off if someone had interjected and put me off my stride where I was going. I have got great admiration for having that done in a controlled environment".

Fit discussed how, without the process, his credibility could have been further undermined which may have resulted in him exiting from the Fire Service. The debriefing had a positive effect on him personally, his family and also the Fire Service, who may have lost an experienced and well respected firefighter.

Fit *"I believe without that control I may not even be in the Fire Service today. I could have lost the trust of all my crew, the other crew members on the Station, because I may not have been able to tell my story effectively. Under the controlled situation I thought I could do that.....to relay relay my fears and my stress problems at the time. So it was, it wasn't easy to do in a team because I was so emotional but I certainly couldn't have done it if someone had said the wrong thing or just around the cup of coffee and the interjections that generally do come out of an uncontrolled situation".*

A further participant discussed how everyone had the opportunity to ventilate and that the more powerful firefighters were not able to dominate in the formalised process that was followed.

Red *"It just means that everyone has their say. Everyone gets things off their chest, and they've got to do that same sort*

of like....hi, I'm so and so from watch station, this is what I saw, this is what I felt....okay it was good. Because I've done quite a lot of debriefings (operational) *and while I know quite a few and I know some of the powerful people....yeah....sometimes can be quite destructive. I mean they don't mean maybe consciously, don't mean to be but...just makes the rest of them sort of shut up a little bit".*

"I don't think they looked at me and said bloody idiot you shouldn't been where you were. Or anything like that which is really good. It gave me confidence to speak my mind. I didn't have to speak as a macho firefighter. I could say my true feelings and not be scared of it".

Red, like several other participants, felt protected by the formalised process that was followed and with that protection he felt safe to share his own experience in relation to the incident.

Red *"I think they feel quite protected, especially seeing there's sort of like the golden rules that no-one sort of, you know, let's out any information about anyone.... Then the confidence is there. It felt safe. And I think also people looked upon me without any criticism when you sat there talking. Everyone had something slightly different to say even though everyone had seen virtually the same sort of thing. But no one judges, no one sort of says you should, or you made a mess of that or you shouldn't been there".*

Red discussed how humour was present in the debriefing, which he found helpful in what he termed "it breaks the old ice". While critical incidents cause significant pain and suffering to the primary, secondary and tertiary victims from their differing involvement in the incident, it is important to always find something lighthearted in order to assist in making some sense

of the incident. It is well recognised in the emergency services field that the use of "black humour" or the other commonly used term, "sick humour", by personnel following their exposure to critical incidents is common. It is understood as a natural way of personnel coping with the incident immediately following their exposure. However, when this sick humour persists I would question how well the individual/s were coping with the incident.

> **Red** *"I like the lighthearted side of things too. Okay, and if there is a bit of humour, I think it is really good and it breaks the old ice, and you know a few things were said and they didn't mean it like that. It was the more lighthearted it is, I think the more people sort of relaxed and shared more. Good to have the humour, and as we know from debriefs after a bad motor accident or all that sort of stuff, there is some pretty sicko corny kind of jokes that come out and things like that. It is not a good thing. I think a little bit of humour in it just relaxes people. Yeah it just sort of relaxed people a bit more. And I think in a situation like that they need to be, they need whatever needs to relax. Have coffee, have a bit of a laugh at times, is quite good".*

Flick felt a sense of freedom to share his experience of the incident. The formalised process was important to him, as this was the first CISD he had ever attended. He liked the quiet, calm environment that was established at the outset.

> **Flick** *"This is in a low key sort of environment, and it's….. that is the way it is. It's no high-rise building, laying on a couch or anything like that….it's low key".*
>
> *"I had the complete freedom to say what, when and how I felt and people were listening without any outside influences whatsoever".*

"Well being the first Critical Stress Debriefing I've been to, you don't know really what to expect and it's basically knowing the procedure, why things are done and having things explained to you, the way you're feeling, that's the benefit. And the positive thing that I think that's really….. enlightening you on what's happening….rather than once you're in the dark you get up to all sorts of things and your mind plays funny things on you because you just don't know".

Generally the participants preferred the formalised process where everyone was given the opportunity to share their experience. Not just the dominant and controlling firefighters were heard, but all those attending were given the space to share also.

Instantaneous *"Just the way the meeting was run, each person had their turn to tell their story. No one interrupted them. It was just a caring meeting really. I listened to everyone else for the other side which was good".*

"That's good actually to say your story without someone saying no that wasn't it. It was like this. Because that is usually what happens…..not so much ridicule but that when you're trying to tell a story around the "smoke" table you say I did this, no you didn't, no you didn't, that was me, or people will butt in and say something else was happening. But there, because you could tell your story, it was your story, from your perspective. Other people might have seen your story from a different perspective but they allowed you to tell it from your perspective which was good".

The above examples of the participants' narratives in relation to their experience of CISD, highlight how following the formalised, structured and caring process enabled them to feel a sense of maintaining control. Firefighters also follow a formalised set of standard operating procedures that

are required to be followed at all incidents. The facilitator in the introductory phase of a CISD clearly outlines where, how and what direction the debriefing will proceed, which is akin to following a set of procedures. With these clearly stated guidelines, the participants are empowered and encouraged to share their experience without fear of interruption or ridicule.

It is clear from my intensive readings of their stories and interpretation of the narratives, that the predominant and overriding pattern was that of the formalised process. From this predominant pattern emerged eight major themes which I will discuss as the dominant themes.

10.3 DOMINANT THEMES

The participants all discussed the CISD process as being a very positive experience. However, several participants did discuss their anxiety and fear in relation to their attending the debriefing prior to the intervention. For those who expressed this concern, it became evident through the interviews that they had not attended a pre-incident education session which would have allowed them the opportunity to understand the process with more clarity and hopefully less fear. Nevertheless, overall they positively expressed the benefits they received from their attendance at the debriefing. In their discussion I uncovered eight major themes, **safe environment, ventilating the stress reaction, similar feelings, getting the whole picture, peer support, bonding, respect and resolution**. I will now discuss in some depth with examples from the narratives to illuminate each theme.

10.3.1 SAFE ENVIRONMENT

In my experience it is important to provide a safe and caring environment that should be established at the outset of the debriefing. By creating a safe and nurturing environment, it enhances the debriefed participants capacity to share openly and honestly. In most instances the debriefing is carried out at

the Fire Station, which is familiar and safe for the participants. The debriefings that the participants in this research attended were all held at Fire Stations. The respective Communications Centres had been advised to take the particular fire appliances off the run so as not to interrupt the process of the debriefing, which could be detrimental to the effect of the debriefing. All pagers and cellphones were turned off and no incoming telephone calls were answered. The participants were made to feel that this was their time to share their experience of the incident in relation to what happened for them.

Several firefighters discussed how they had found the environment safe and conducive to sharing.

> **Fit** *"We had an environment which was set up nicely. We had an expansive room, we weren't crowded. It was an operational day. I took the truck off the run so we wouldn't go anywhere. We weren't going to be interrupted and it was on Station. There is no negatives. I felt comfortable maybe because I was at work and debriefing with the team I work with, so we were in our own environment. I was in my own environment, made me feel at ease".*

> ***Red*** *"I think definitely it was good. Actually I relate quite well to the Fire Station. To me it was good. The whole environment and to sit somewhere comfortable, being quite secure without people listening in or leaning through windows somewhere and having a talk out in the open. Everyone was very courteous and didn't interrupt".*

Because of the safe environment that was provided, the research participants felt more able to share their story and I believe be heard which often does not happen in many other environments. Some firefighters referred to some of the participants dropping their guard, which is not done easily by some firefighters and that they were surprised at this effect in those they least expected.

Instantaneous *"Well I think we were all in the same boat. We were all dropping the guard to a certain extent. Well, we were in a safe environment and as I say, we trust you. It was a good environment. My boss, I have never seen him drop his guard before. He was very scared at the incident. He thought he had lost his crew and he actually opened up at that meeting. I was surprised. He talked about the fact that he felt like he was loosing it during the rescue. He was looking around and nobody else seemed to be loosing it. And he wondered if they could see him loosing it. I felt it was quite a big thing for him to admit that sort of thing. He felt secure".*

Firefighters, due to their training and the need to maintain a sense of control keep their "guards" or surround themselves in their macho "shields". However, during the debriefing the participants did drop their guards somewhat. This could be related to a sense of feeling safe to share in the particular environment that was provided.

Instantaneous *"Being professionals I think the guards didn't come right down, but it came down as much as ever I've seen with a lot of those guys, and I think it was good because I think if guys can say how they feel you tend to respect them more. Particularly my boss. He's quite a good Fire Officer but he's got limitations but he'll never under normal circumstances admit he'd got any limitations. But he did there. He actually stood up and he said he felt that at one stage he was loosing it ……".*

From Instantaneous's comments it would appear that the safe environment that was established allowed this particular Officer to feel safe to share indepth some of his own vulnerability in relation to his own reaction, which under normal circumstances he would never have revealed. With his sharing he gained respect from his crew member.

10.3.2 VENTILATING THE STRESS REACTION

It has long been recognised that venting, catharsis, or expressing the stress reaction is an effective way of coping with a stressful event (Pennebaker, 1985). It is helpful to talk about an incident, to express feelings and to reveal what is on one's mind, akin to talking about something significant in one's life, which is causing or has the potential to cause significant stress. This is commonly referred to as "getting it off one's chest". The more stressful the incident, the more important it is to discuss the incident from one's own perspective.

Throughout the interviews it became obvious that the participants found it particularly useful to ventilate their own personal thoughts, feelings and reactions, to assist in reducing the stress effects and a resolution of the trauma attached to the incident.

> **Instantaneous** *"Yeah, it assisted me in talking out my perspective and also hearing other peoples ..... How they, what they did. Also it had helped to hear everyone of them had handled themselves well. Because it got it out of my system. For me, for me it was like a release of emotions, I suppose. Once it was out it was over. But it had to come out. When I let out the emotions I felt a sense of relief. A release if you like".*
>
> *"No, I thought it was a very good experience, and for me it brought a final lid on the incident. Although I will probably talk about it for the next 20 years, emotionally it is finished with".*
>
> ***Red*** *"It was definitely a way of getting things off my chest and to realise that there were other people in the room that were probably having the same sort of feelings as me..... Now I think probably by doing that, I would bottle it up more....whereas by speaking out in front of a pile of people did really get it off my chest and otherwise what I*

think I would do, I would just live with it and it wouldn't really affect me too well. By getting it off my chest it sort of made me deal with it, even though I probably don't want to deal with it. And I think it has given me, it has forced me to actually, to have a few of the bad feelings I have had in the past week or two. So unless you get it off your chest you are going to carry that baggage around and I don't want to and I have enough on my plate at the moment. It sort of got it off my chest. It needed to be said. I have never said it to so many people. It was the way I was feeling. I was feeling relieved. That was the biggest thing I felt, the relief. Yeah I think it just sort of like cleared a lot of things for me in my mind".

The debriefing process enabled participants to have their say in terms of what happened for them, their thoughts, feelings and reactions and to hear other firefighters share their experience. They repeatedly used the term "get if off my chest" and that if they had not had the opportunity of catharsis they may have never resolved some of the stressful issues around the incident.

One participant referred to several of his crew members and the effect of allowing them to ventilate in relation to their own experience. Several of these firefighters were not known for expressing their emotions openly so it came as a surprise when they did share, though the sharing was mostly factual, but it obviously had a positive effect for a particular firefighter.

Instantaneous *"I know one guy who was quite shocked. Quite frightened and he said this job isn't worth the money they're paying us or it's not worth any money to lose your life.....and he was going to go out right away and look for another job, but after the debrief he quietened down. He's the same old guy. He is carrying on as long as he can go. It's quietened him down a bit and got things into perspective.*

"The one guy…..he was really cut up afterwards. He was buried in rubble and extracted himself. And afterwards he was shaken, really shocked. Even when he came back to work the next shift, he was still talking about leaving the Fire Service. Probably the one who was the most reluctant to let his emotions go deeply, but I still think by actually talking with everybody else and saying what he did, it has helped. He is quite relaxed now".

"And then talking about it afterwards help that sharing of emotion. I know he was reluctant to share too much emotion and stayed fairly factual…… but even for him that was quite a long speech and quite a lot of detail and I think its helped him. I'm pretty close to the guy and I know him fairly well and I think it's helped him and after the debrief he has never mentioned giving the job up or giving it away. He is content with what he is doing".

I have found that those who are particularly resistant to share in an open forum do begin to feel safe to share their own experience once they begin to feel confident with the process. In previous debriefings I have witnessed firefighters resistance to share by their tense body language and their suspicious facial expressions. However, during the introductory phase a caring and safe environment is established with the group where all the participants in the debriefing begin to feel a sense of trust, rapport and respect The introductory phase provides a structure for the CISD, clearly defines the boundaries, builds trust and decreases the anxiety which most of the participants have when entering the debriefing.

Flick *"I think the guys were a little bit more honest with themselves and everyone else there expressed their feelings. Depending on what they wanted to say because there is still reserve, a lot".*

However, I believe in reality there will always be a certain amount of reserve in the firefighters sharing. This is in part related to society's expectations of them as emergency service personnel, the image that has to be portrayed, their personality type of being in control and of course the culture of the Fire Service.

10.3.3 SIMILAR FEELINGS

When the firefighters vented their own personal feelings, thoughts and reactions they realised that they were not alone in the stressful effects they were experiencing.

> **Flick** *"Have a little bit of insight. It is good to know that the feelings the other guys were feeling are your feelings too. No one will say anything about them. But now with the debriefing you have got others' stories…. After hearing everyone's version of what had happened, and the near death situation of some of their colleagues had been in, I think they were quite astounded on what had actually happened. They were probably going on their own, of what they were told. But when they actually hear from the persons it is a little bit different".*
>
> *"I think you can look at people a little bit different in the respect that you…. before they were just work colleagues you know, and as I say that shield was always there, but it doesn't matter what they're saying, their thoughts are basically what you're saying and I'm saying you know, they're not much different than anyone else".*
>
> *"I think it was quite sombre. Everyone was, you know, it was quite a horrific sort of incident and I think people had their reactions the way that you had them, so they weren't much different than you".*

As the participants shared their own experiences, firefighters began to acknowledge that they were experiencing similar feelings, thoughts and reactions, and therefore felt more comfortable to share in the same way as others had shared in the debriefing.

> **Flick** *"The thing that's good to know is that the other people are feeling the same way. And that I think is a major thing. It's....you get someone here who mouths off about you know..... they're alright and that and then you think well maybe there's something wrong with me or not, but no everyone's the same".*

> **Fit** *"Others had the same stress levels too. But firemen being firemen, they would try to hide those sorts of things right to the last minute, I think. And a lot of people won't talk about things, about being stressed otherwise..... I felt as though I was them when they were saying what I knew".*

This last comment highlights once again the reserve of firefighters in sharing some of their personal pain and suffering in relation to their exposure to critical incidents, but when they begin hearing the similar feelings of their peers they begin to feel more comfortable in sharing their own reactions.

10.3.4 GETTING THE WHOLE PICTURE

A further significant theme identified was that by each of the debriefed participants sharing their own perspective, all of the participants were able to get the whole picture or perspective of the incident. An analogy I use in my teaching of this process is that this is akin to all the participants putting their own pieces of the jigsaw puzzle together. By each person piecing together the parts, together they create the full jigsaw puzzle so that all are able to get an overview of the whole incident.

Flick *"To me personally, it brought it right back to the incident. Clearer, straight in front of me again. And hearing the other firefighters versions of it, put a better picture and I knew where I fitted in, in that particular incident. It was quite good in that respect".*

"I had crews, firefighters who didn't realise my situation. I didn't know their situation. I know what went on in my little sector of the world, where we were sort of understanding what happened, the overall picture, all I could see. Basically now I understand their perspective of what was going on".

"To hear other persons' versions of it, was the main thing that helped me. It is all put into perspective. To hear the process, yes, that assisted me to understand others. I could slot it into, not where you wanted it to be, but where it was, where you were at".

There was an appreciation by the debriefed participants that others had a different part of the puzzle which they were able to piece together and put the whole puzzle together. This was an important part of the debriefing in order to have a real sense of what happened at the incident.

Red *"Because even when talking about the critical incident stress type things it is hard to know, sort of relive it, work out your feelings of what's going down, until you knew the picture because I only had my small section of the jigsaw".*

"Well that's what I sort of mentioned last time as part of... you know, puts the jigsaw together. And it's good to hear the physical jigsaw and bringing up the emotional side of things as well. It's all good for the morale is what it's all about".

Flick *"The picture was made up. We had the picture and we could talk about the picture and that what communication my group, I think we talked about the whole picture, that's everyone's story and that was very important that everyone saw the picture now and not just their part of it".*

"I think that is quite important. Because every member that was there with you is debriefed, even though we were in different areas because he didn't know what I was doing and I didn't know what he was doing….".

Often the firefighters, through their own informal debriefing around the "smoko" table, believe they have a good understanding or the full picture of what happened at the incident. However, I believe that in the main they are not able to gain a full picture of the incident as well as what can be elicited at a CISD. The following comment highlights my belief.

Instantaneous *"It is quite interesting as we went around the room talking I assumed they had parts of the jigsaw which I guessed they had an understanding. I found that a particular guy I mentioned to you turned out very well. I hadn't expected that".*

"After the ….. I was remote from the action and I wanted to be there…trying to help rescue the guys. So I felt a little bit out of it and I didn't quite know what had gone on. And then I heard some of their stories. In the debrief I learnt who'd done what and who'd done well and I think everybody really did well".

Fit *"Yes, if everyone can end up seeing the whole picture it makes life so much easier and you don't get idle chat about what has gone on and misinformation which can lead to*

problems. So if everyone who is involved can sit together and end up seeing the big overall picture it has got to be good for you".

By putting the jigsaw puzzle together, the firefighters were able to gain a clearer understanding of what really happened at the incident, not just from their own individual perspective but from all those that attended the incident. As a CISD is not an operational debriefing, which is a critique of the incident from an operational perspective, it is my view that given the right environment and process, the firefighters feel more able to share their own pieces of the jigsaw puzzle. They are more open to seeing other parts of the puzzle from the other participants perspective. The benefits of seeing the whole picture was highlighted from some of the comments in relation to the correct information being made available, not the misinformation or rumour that is well recognised as being widespread in the Fire Service. This is particularly applicable following major incidents. With these rumours comes much finger pointing and blaming, without the opportunity for those involved presenting their side of the story.

The operational debriefing, which is a critique of the operating procedures and an opportunity to inform personnel on the details relevant to the incident, usually occurs 1 – 7 days following the incident. In most instances the operational debriefing usually follows a CISD. It is my belief, that due to the positive effects of the debriefing, it assists the firefighters to cope with the anxiety and stresses that they often experience when participating in a operational debriefing. As previously stated, there is always the fear of the apportioning of blame or even ridicule associated with their performance at the incident.

10.3.5 PEER SUPPORT

It is well recognised in the literature that peer support personnel who are part of a CISM Peer Support Team, provide a valuable service in mitigating the

harmful effects of Critical Incident Stress. In the early 1980s when the CISM concept was in its infancy there was a general mistrust, especially amongst mental health professionals, that peer support personnel had the potential to do more harm to those they were assisting and the organisation as a whole (Mitchell & Everly, 1995). This fear was based on the belief that there was the potential for the peer supporters to work outside clearly established guidelines and act as mini-counsellors. However, this fear is unfounded. With the appropriate and professional initial basic training and ongoing training, supported with clinical supervision and expertise, Peer Supporters provide an extremely valuable service in assisting their fellow-firefighters to cope with the negative impact of attending distressing and traumatic incidents.

During my years of practice I have witnessed the obvious benefits a Peer Supporter offers his peers, especially in understanding the true impact of attending critical incidents. I refer to this as having walked a mile in the shoes of those they are assisting and are therefore more able to empathise than other non-firefighters. I have seen how participants in a debriefing have felt unsure about their firefighting ability and the Peer Supporters have validated their ability by what has been referred to by several participants in the study as being "lifted up by him". As an example, one of the research participants discussed how the Peer Supporter acknowledged the seriousness of the incident, the firefighting skills that were required and how well the debriefed participant/s had managed under extreme conditions. It is a powerful process to witness as one watches the confidence flow back into the previously unconfident and disempowered firefighter/s, who prior to the debriefing, has been doubting their firefighting ability and were even considering exiting the job.

In Chapter 9 where I discussed the unique themes for each individual participant, I discussed how Fit felt particularly empowered by the Peer Supporter in the debriefing that he attended. He found that by having a fellow firefighter who had a good understanding of the operational side of

firefighting and the culture of the Service, this assisted him in recovering and regaining his confidence which was severely compromised following the critical incident.

> **Fit** *"Having a peer member there as well proved to be extremely beneficial. I was fairly worried about that to start with but I would recommend it to anybody if they had that same situation. Have a peer there as well".*

Several participants discussed the benefits of having a Peer Supporter present during the debriefing and their contribution to the process.

> **Flick** *"His feelings, his understanding of the culture of the place, how it worked, what we were going through. They could appreciate exactly that. His presence. I like to talk about it once I have said it. It was good".*

> ***Instantaneous*** *"Because we respect him for his Fire Service role. A couple of times we got off track, he was able to suggest we get back onto what we actually did. No, I thought it was really good. It worked, it worked really well. He wasn't intrusive or forcing us back onto track".*

The research participants appreciated the value of having a person who understood what the debriefed participants were saying. They were able to easily relate to the Peer Supporter and established a trusting rapport with this person in the early stages of the debriefing, which I believe is vital to the success of the debriefing. While I personally have a good understanding of the culture of the Fire Service and have some understanding of the operational side, the Peer Supporter's understanding of the operational side of firefighting far exceeds that of myself or others outside the organisation. It is because of this aspect that I believe the Peer Supporter, with the necessary training and personal qualities (such as respect by fellow

firefighters and good listening skills) and who understands and may have experienced Critical Incident Stress personally, plays such a pivotal role in the success of the debriefing.

> **Red** *"Yes, so he can relate. And I think it is important to have someone like that.....but I think definitely you need to have some Fire Service personnel. Even though they weren't there* (the critical incident), *it was good".*
>
> *"Well to me really, you actually realise that these guys are the same as you and have been through the same things as you have....experienced what you've experienced...and they are your friends...and there is a confident thing that you can.... feel comfortable and they can relate. They know what you're talking about. They know, they've been there. The people who have seen a bit of work have felt and experienced and so it's quite easy to be open to those people and not feel too judged by it".*

From my experience I believe that without belonging to the culture, having a comprehensive understanding of the culture and the operational aspect of firefighting, mental health professionals and others providing professional services for Critical Incident Stress Debriefing, are severely compromised. They are very often not able to easily gain the trust and respect of the debriefed participants. Several participants highlighted this.

> **Flick** *"You talk to a firefighter they know exactly what you are feeling and they can imagine what was going on. A family member or friend doesn't have that same understanding. With firefighters there is no grey areas at the top".*
>
> ***Instantaneous*** *"With that guy that was there....we all knew him... We've all served with him and has respect for his abilities and that is quite important I think in those situations".*

As previously discussed, the value of the Peer Supporter was initially viewed with some suspicion in the early days of the development of Critical Incident Stress Debriefing programme. However, the more debriefings I facilitate the more aware I become of the value of the Peer Supporters. I really value their contributions and the empathetic listening ear they are able to provide to their fellow firefighters. It is my personal belief that the success of the programme is associated with the support of the Peer Support Team members who have been there, done that and genuinely understand what Critical Incident Stress is in relation to firefighting.

10.3.6 BONDING

The firefighters work a shift system where a bonding or team-building ethos develops over time. This is mainly due to the nature of their work and the close interdependent relationships that are established due to living and working together over lengthy periods of time. This is particularly relevant to permanent and Community Service Team firefighters. However a bonding or team ethos also exists with the volunteer firefighters. Not only do they have an affiliation to the New Zealand Fire Service but also to their small and close communities. Trust and bonding between firefighters are key ingredients in the success of their working lives together (Stuhlmiller, 1996). A sense of belonging to a team engenders confidence in knowing that whatever dangers they may confront, their team will be there to support them. With this comes a feeling of being safe when working alongside their team members.

The participants discussed that as a consequence of their participation in the debriefing there had been a feeling of increased bonding or camaraderie. It is well recognised worldwide that there is a real sense of bonding, which is related to the culture of the Fire Service. Their close working relationship and the need to feel a sense of bonding is important in terms of their personal safety in potentially unsafe working environments.

Fit *"It was just a big teambuilding exercise which has stayed*

together…. The team has been really excellent. All the members that were there definitely have bonded together and have a bit of respect for each other and look after each other".

One participant discussed how following the debriefing he felt a real sense of bonding which assisted him and his crew in rebuilding their previous bond which was somewhat fragile following the incident.

Fit *"Again, as the day went on we supported each other. It was very good. It brought the morale of each of us back and bonded us back together again. I, for one had grave fears that I had lost support of some of my crew……. I felt it came back to me that I hadn't lost the support and what I had done as a Manager and getting them together in that team environment* (debriefing) *had been good. It proved to be very effective. Who knows I may have totally lost it if I hadn't of done and didn't get them together. So in talking to each other was very important in building our bond back together as a team. It felt really good and we got back together. It kept us together and probably built a bigger bond amongst the crew".*

Instantaneous *"I think there was a feeling of camaraderie. We had all been through a difficult situation so it was good in that respect. It brought us closer together. The incident and being part of the debriefing together".*

The personal safety of the firefighters is always paramount when placed in uncertain and unsafe environments. Firefighters work in pairs for safety reasons. When some of the participants discussed an increase in bonding, they also said that they had a greater sense of being safer with these participants.

Fit *"Maybe been a bigger bond than existed prior to the incident.*

A more cohesive…. And that even though you are always very aware of each others safety, maybe you are even more so now".

Instantaneous *"You'd work better as a team at a fire, you'd be safer together, you'd know that you could trust guys and that probably if you're in trouble, you know they're going to come and get you".*

10.3.7 RESPECT

Several participants discussed how they had gained more respect for some of the participants and one particular firefighter talked about how prior to the incident and the debriefing he had very little respect for one of the participants in the debriefing. By hearing this participant's story he was able to gain respect for this person.

Instantaneous *"Yeah, he's gone up in my estimation. And I also sort of questioned how I thought about him before. Maybe I hadn't given him the benefit of the doubt…….. That's the first time I'd heard him put his side of the story and you know in the Fire Brigade all you've got to do is say so and so didn't pull his weight and so and so couldn't get his gear to work and there's a feeling that somehow those guys are inadequate. Then someone else will say it and it reinforces things. And lots of incidents you don't have debriefings so nobody knows their side of the story. I was really impressed with what he did and what he had to say at the debrief".*

Instantaneous acknowledged that in the Fire Service rumour is rife and often personnel are criticised for their performance at a incident. As a result of widespread rumour, their story is not heard but in this debriefing he heard a particular firefighter's story and gained a new respect for him where previously he had not believed this firefighter to be truly competent in his duties. He was able to reflect on this by stating how he had never heard his

side of the story and his opinion of this firefighter could have been influenced by the preponderance of hearsay in the Fire Service. Instantaneous discussed how he acknowledged with this firefighter sometime later, how well he had performed both at the incident and at the debriefing.

Another participant discussed how he had gained new respect for another participant in the debriefing.

> **Red** *".....I have different thoughts about him now. Okay and the other one I actually think, well personally I think so much more highly for both of them for what they did on the job, for what came through in the debriefing was quite good. I was really impressed with their ability. I was shocked. And it was good to see them again, to see them in an environment like that. Incredibly. Not only their firefighting side of things and they kept their cool, but for actually coming back and bloody chucking it on the table In front of the guys. It was good".*
>
> *"I did gain increased respect for them and also feel that they gained respect for me. And in a situation like that it was a good feeling to know that those guys had respect for what went down on the night".*
>
> **Instantaneous** *"We have all stood up and spoken honestly about our role. Nobody tried to hide or pretend they were super heroes. We all spoke honestly what we did, admitted our inadequacies, so I think I respect the guys for being honest about it. And we have all gone through a difficult situation. Spoken about it and I think emotionally have put it behind us".*

The positive effect of gaining or increasing respect for their fellow firefighters had a positive benefit for individual firefighters and the overall crew. Red summed this up.

Red *"Just as I've said, it gives me a lot more respect for them. We can actually joke and laugh and carry on and yeah…. just closer to them. You look at them and think, yeah you are worthwhile. I don't mind being part of your crew. You know, whereas before I think, oh my God, got to watch my backside now".*

10.3.8 RESOLUTION

Debriefing has become an accepted method of crisis intervention because it provides an opportunity to process the critical incident both cognitively and emotionally. It also plays in important role in that following any critical incident there is a need for closure or resolution and debriefing provides a social ritual for closure (Havassy, 1991).

Venting of the distressing effects from their exposure to a critical incident in a safe, formalised environment, the participants are able to understand what happened at the incident and to make some sense of the incident. By piecing all the parts of the jigsaw together they are able to put the incident into its rightful context and move on in their lives. The ultimate result is that there is a **resolution** to the incident and it can now be laid to rest. This was highlighted by Instantaneous's comments.

Instantaneous *'I have hardly given the incident a thought, and the guys at work have, are clear of the incident, and they don't have any concerns about it or referring back to it. We have talked about it occasionally but only in a joking, humorous way…..certainly for me there has, when I think of the others and me involved, there's been a resolution".*

Flick *"They don't dictate the way I think anymore. That's I think one of the main things that what we are six weeks down the course from the incident and probably as I said in the first*

interview, that time will heal it and I can actually feel that happening…..it's not in my thoughts as much now as it was. It's happened and it's just drifting away…….. And now as I say things with the debrief and hearing the other peoples point of view, everything was in perspective and it's just drifting away".

Flick *"It's drifting away quite quick. It doesn't take a talk like this to resurface it strongly again. I'm just quite neutral on it now".*

The critical incidents that the participants attended were very dramatic in terms of the trauma attached and would be classified as a major incidents. In my experience of working with firefighters they tend to ruminate over past major incidents in terms of what happened, who was involved, how the fire was handled operationally and very often criticise those who were responsible for the decisionmaking at the incident. However, Instantaneous discussed how he was surprised at how little his crew members now discussed this particular incident.

Instantaneous *"I thought this was probably…. this incident was the most dramatic in some respects of any incident I've ever attended in the Fire Service. But it is the one that we've discussed the least and I think that's probably because there is no need to discuss it. We did the debrief and got it out of our systems. This time nobody's bothered, it's almost like it finished at the debrief".*

Flick *"With my story being told people had come up to me since and said they didn't know exactly my role in it and now that they did, they said you know… that they could have a better understanding of the whole incident".*

By bringing the incident out into its full context, everyone discussing their own personal experience attached to the incident, and the group cohesion that results by participants listening to and hearing others' experiences, it facilities an understanding of what happened. The participants are able to make some sense of the incident and are able to resolve the issues in terms of its impact on their lives.

10.4 NEGATIVE ASPECTS

The participants were questioned in regard to any negative aspects they had in relation to participating in the debriefing. While there was an overwhelming response to discuss the positive aspects, it is important to acknowledge and discuss the negatives aspects for two of the participants.

10.4.1 *"I LIKE TO GET IT ALL OVER AND DONE WITH"*

Flick repeatedly focussed on his need to address his stress immediately following the incident. While many of the firefighters who attended this incident were followed up with one-on-one support, Flick did not receive this form of support even though I would have considered him to be at risk of significant stress considering his close involvement in the incident.

> **Flick** *"I like to get it all over and done with while the incident really is still going on. To come back, I felt sort of not resentment, but it was sort of, I thought I knew my stress levels had built having to come into a debrief, and so late. To me personally I would have liked to, probably that morning* (of the incident). *I feel that morning would have suited me a lot better than sort of flowed away from there".*

While I acknowledged Flick's comments, I explained to him that the CISM Team would not have held a debriefing immediately following the incident. This is due to existing evidence that suggests emergency service personnel are cognitively defended immediately after a critical incident, and a debriefing has the potential to do more harm in this early stage. I discussed with Flick that what was required was other CISM interventions such as on-scene support, one-on-one support, a demobilisation or a defusing which is a shortened version of debriefing.

I further explained that the debriefing he attended was held on the fifth day following the critical incident, and while he felt this was too long, that debriefings are ideally held approximately 1 – 7 days following a critical incident. I agreed with Flick that it may have been preferable for him to have had a debriefing earlier because of the intensity and the significant distress that it had caused. However, the timing of the debriefing was related to bringing all the affected personnel together on their first day back on shift after their four days off-duty which commenced immediately following the incident. I discussed, how in the future, I would make a recommendation to Management following a distressing critical incident, that approval be granted to bring the affected firefighters back for a debriefing on their day off if this was appropriate.

While Flick understood the rationale behind the timing of the debriefing, he remained clear on his need for earlier support. This is illustrated by Flick's following comments.

> **Flick** *"I personally would have liked it earlier. I went home that morning and you had to do your own sort of recovery. That is the thing I found the longer it does, my personal thing is to have the debrief. I like to have it over and done with so that it is, while the mind can say….. I like to get it out of the way as quick as possible".*

Even though Flick would have preferred some form of crisis intervention sooner than what he was offered, he did admit that he had found the debriefing a positive experience.

> **Flick** *"It's basically knowing the procedure of why things are done and having things explained to you. The way you are feeling, that's the benefit and the positive thing I think that's really enlightening you on what's happening rather than once you were in the dark, you get up to all sorts of things and your mind plays funny things on you because you don't know".*

10.4.2 ANXIETY AROUND PARTICIPATION

While some participants expressed the reservations they had prior to beginning the process of debriefing, it is my belief that this was related to a natural fear of the unknown. When questioned about this fear or anxiety their responses were more in relation to how they might cope with their emotions during the debriefing.

> **Instantaneous** *"I was a bit anxious that I might make a fool of myself emotionally".*

As discussed previously Red had reservations about sharing in front of a large group, but was surprised at how well he was able to tell the participants his story in relation to his own situation.

> **Red** *"Because of so many people there, I am not actually a good sort of speaker in front of a lot of people. I can speak to some few people, but not too many. I am not a good public speaker so, and also to speak of such quite emotional type things in an environment like that, it is quite hard. Once I got into it, it was alright and suppose once you got through the embarrassment and all that. I suppose everyone in the room knew who everyone was".*

Their concerns around how they might cope with the debriefing could be related to some of the participants not having received a pre-incident education session which discusses the different types of CISM strategies, particularly in relation to CISD. This issue highlighted the need to regularly update firefighting personnel on the activities of the CISM Peer Support Team by carrying out pre-incident education sessions.

10.5 BENEFITS OUTWEIGH THE NEGATIVES

While the negative comments require consideration for my own and others future practice, the overriding feeling was that the debriefing had been a very positive experience for all those in attendance.

> **Red** *"There is nothing negative about the debriefing that I could think of and I think it is bloody great that you give up your time. The Fire Service in general needs to take heed that we do have emotions, that we are not bloody robots, that even though we see some horrific things at times and go through some horrific things, we need to have an area where we can go, feel comfortable, secure, safe, the whole bit, get it off your chest. And yeah let Management know that we are human. This is sort of our voice".*

Red acknowledged that he would be willing to participate in another debriefing if required. However, he discussed that debriefing needed to be reserved for the high impact incident that had the potential to cause serious emotional distress to firefighters.

> **Red** *"The average scrubbie* (scrub fire) *when a couple of acres is burnt, the average housefire; you can handle it, have a laugh and look mate you did well. But when there is a life risk, there is a life risk.....".*

Red discussed how he would encourage others to attend a debriefing in the future and believed that it was particularly useful for those who were already suffering from significant stress prior to the critical incident. Red's comment further affirms my belief that personnel who have pre-existing significant stresses prior to the incident, are potentially more vulnerable to suffer from the negative affects of attending a critical incident. Often the other members of the crew may not consider the critical incident to be all that significant, but for this particular firefighter it may have been a catalyst for exacerbating his pre-existing significant stresses.

> **Red** *"I have said to a few people, you should have come along. And I would, I definitely would encourage people, and I don't want to get back to this, but especially people in my circumstances, where they have got like some emotional load at the moment. And I don't have anyone to come home to and cuddle up to.....".*

Several other participants concluded their interviews with their belief that the debriefing had been a very positive experience for them.

> **Fit** *"I haven't got enough praise for it. I am a real pusher now as I was before, always being very careful with my team that they were okay after. Especially with a new crew. After the suicides that we have been through in our Station".*

It was obvious from closer examination of the narratives that the participants reported ongoing benefits for themselves, their crew, family and the Fire Service overall. Several participants referred to an increase in their confidence that may have been undermined following their exposure to the incident.

> **Red** *"I had to sort of like be brought into a sense of confidence and once I was into that confidence part then I was alright but I needed the debriefing sort of situation to do that for me".*
>
> **Flick** *"And you feel an air of confidence about yourself talking like that. . It makes you a stronger person for it. Maybe the same incident*

again might not affect me as badly as this one has. The knowledge gained from things like this is strength for me for later on".

Fit *"I hope I am not just being too relaxed about it now. Yes I certainly feel that I handle these situations with greater ease. For myself it was amazing what I have learnt knowing my own capabilities in relation to the stress situation. It's probably a big learning curve. I can probably handle things better than I did before. I think I would know how to handle it. I would still need support. The Critical Incident Stress Team would still need to be there but I think I could certainly handle it much better".*

One firefighter acknowledged how he felt the debriefing process also had ongoing benefits for his family.

Instantaneous *"I think it did have a benefit for my family in that I came right quickly if you like...with the stress of the Fire Service...that's been going on for some time....I'd at times.....things have come up which have made me really irritable and I've gone home and inadvertently taken it out on the family, you know? Been short-tempered, but this time I suppose I had that potential but after the debriefing I felt really relaxed and I never took it home".*

In relation to the positive benefits to firefighters as a group and the organisation, this was highlighted by Flick. He discussed at length how the process of CISM and the subsequent use of CISD had allowed firefighters to be more open and honest in expressing their stresses attached to critical incidents.

Flick *"In the past there you know with things....we kept to the individual to and you had to suffer the.....pain and the traumas with it and everything, you know? Because if you say anything in a group that you were looked on as suspect or whatever but that has definitely changed. Definitely changed. You can actually....because even now they still don't like to talk about it....there's some sort of reserve.* Yes,

yes, but when they do talk about it, it's in a positive way. You do still get the ones who are quite negative about it but they haven't had to use the service".

Instantaneous discussed how Management has acknowledged the stresses attached to the job which he really valued.

> **Instantaneous** *"It's nice to think I feel that the Fire Service now is recognising that guys are under stress when they perhaps have a fatality or a car accident which is really messy or something happened like the housefire and they do suffer emotionally. And they are doing something about it. So it's been a long time coming. It's been needed for as long as I've been in the Service".*

10.6 CONCLUSION

In summarising I have highlighted the major pattern of the formalised process with eight major themes that were elicited after intensive reading and re-readings of the narrative, along with my personal journal detailing reflections, particularly in relation to the individual interviews. The eight major themes were dependent on the creation of a caring, formalised and structured environment which was established by the facilitator and the debriefing team. Insight has been gained into how the formalised process created a safe place to ventilate, share similar feelings, have a sense of bonding, increased or renewed respect for their peers and that there was a resolution of the critical incident, which is akin to laying it to rest. These positive effects were assisted by the presence of the Peer Support Team members who had a natural affinity to the participants by their common understanding of what firefighting under traumatic conditions really means.

I have also highlighted what I have called the ongoing benefits to not only the individual, but to other crew members, their families and also to the New Zealand Fire Service.

In the following chapter I will discuss the findings in relation to my model of practice and the model modifications that will be developed as a consequence of these findings.

11. RESEARCH FINDINGS AND IMPLICATIONS FOR FUTURE PRACTICE

11.1 INTRODUCTION

In this chapter I will discuss the research findings which were elicited from the four participants when they shared their experience of a Critical Incident Stress Debriefing. Over the last 15 years the group process called CISD has often been referred to as the "Mitchell Model". Professor Jeffrey Mitchell, who developed the model, has always advocated that CISD is only one part of a comprehensive, systematic and multi-component approach to managing traumatic stress (Mitchell, 1998). For the purpose of this research, I have studied in detail the experience of CISD on four firefighters who have participated in the seven-phase group process CISD based on Mitchell's model (1983). It is the findings from this model of practice which I will discuss in this chapter.

As a consequence of the research findings, I will discuss the implications for my own practice and others working in the area of Critical Incident Stress Debriefing, which is one of several interventions currently available to assist firefighting personnel following their exposure to critical incidents. Since beginning this research I was appointed as the Clinical Director of a Critical Incident Stress Management Peer Support Team in a Region of the New Zealand Fire Service. The research process which I have been immersed in over the last two years, together with the research findings, have enabled me to become more grounded in my practice in the area of CISD, and CISM in its totality. To bring the project full circle, I have reflected in detail on how the research has shaped my practice and the practice of the Peer Support Team members with whom I work in partnership in our continuing journey of providing a professional and credible Critical Incident Stress Management

programme within the New Zealand Fire Service context.

11.2 THE IMPORTANCE OF THEIR STORIES

The stories that Fit, Flick, Instantaneous and Red shared or entrusted to me, reinforced the value of the model of Critical Incident Stress Debriefing, namely that of Mitchell's model (1983). This was the model that was utilised in the debriefings that all the participants attended. The narrative discourse produced stories in relation to human action. Fit, Flick, Instantaneous and Red's stories were concerned with their attempts to advance to a resolution, an explanation whereby the experience of debriefing was unravelled.

> *"Narrative transforms a mere succession of actions and events into a coherent whole in which these happenings gain meanings as contributors to a common purpose" (Polkinghorne, 1997, p13).*

The narrative discourse was found to be an effective methodology to describe the experience of debriefing. It was a process that drew together the threads of the stories of the four participants different actions, events and issues that contributed to the research findings. While it took many months to choose a methodology that would reveal the true essence of the experience of debriefing, I now feel justified in the choice of the narrative methodology as being the most appropriate to use for this research study. I feel secure with the decision in terms of it "fitting" my own practice philosophy, but also that it will be able to be easily accessed by organisations with a special interest in Critical Incident Stress Management services. Also that it be acceptable and accessible to the consumers of CISM services. Of even greater importance is that it will be able to be read by others working in the area of CISM, particularly the Peer Support Team members, whose ongoing education in the field of CISM is of utmost importance.

The stories of Fit, Flick, Instantaneous and Red are the stories of four firefighters who have experienced the group process of a CISD. Unique and common themes have been illuminated and they also represent the experience of many others who have participated in a CISD. The eight themes that were uncovered through narrative discourse represent a common thread to a greater or lesser extent for all the participants. What do practitioners working in the field of Critical Incident Stress Management have to learn from these firefighters and their respective stories?

The free flow of the narrative epitomised the experience of CISD and their personal views in answer to the open-ended questions which was posed for them. Of the many hazards that challenge the emotional wellbeing of firefighters, their most overpowering enemy may be their response and subsequent reactions to critical incidents. It was obvious from the narrative discourse that the critical incidents the research participants attended, carried two significant stresses which had the potential to cause significant long-term stress effects. The first significant stress was that of the threat of physical loss, that is serious injury or death either to themselves or their fellow firefighters. The second was the threat to emotional loss, irrespective of the physical danger whereby they could become emotionally aloof, moody, irritable and absorbed with the critical incident. These distressing effects had the potential to intrude on their lives and the lives of significant others, such as their spouses, families, work colleagues and friends. Therefore the effects of attending a critical incident without any post-incident crisis intervention strategies such as CISD has the potential to cause serious stress symptoms with devastating consequences both personally and professionally.

The findings illuminated the strength of the process of CISD as perceived by the four participants. The **formalised process** was the overriding pattern that was analysed from the data with eight major themes being illuminated. While the participants' narratives attested to the positive benefits to both themselves and the organisation, it was not an overriding pattern or prominent theme as highlighted in Hanneman's (1994) study. I have

discussed in the previous chapter in some detail what some of these positive benefits were to both themselves, their families and to the New Zealand Fire Service generally. The participants did discuss the positive benefits in some depth but I do not believe they gave it as much prominence as the formalised process and eight themes.

The eight major themes that were uncovered from their narratives were **safe environment, ventilating the stress reaction, similar feelings, getting the whole picture, peer support, bonding, respect and resolution**. These are visually presented in Figure 1.

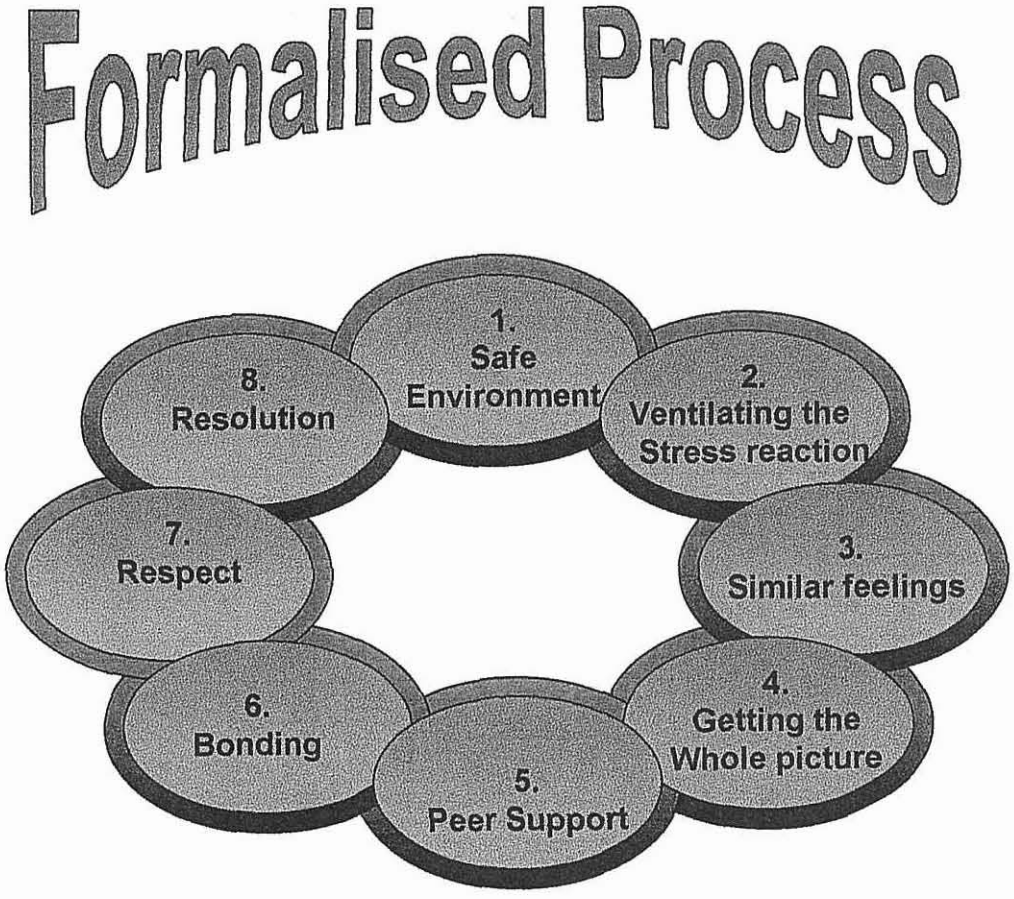

Figure 1 The pattern of the formalised process which encircles the eight interlocking themes.

Since discussing the themes in the previous chapter, I now believe I have named the eight major themes in order of priority as upon analysing the data it was obvious from the participants' narratives what were the most important themes they highlighted in their storying. The first theme, **safe environment**, related to providing a safe haven in which to share their personal experience in relation to the critical incident. With the provision of a safe environment, particularly in relation to ensuring strict confidentiality; that the debriefing was not an operational critique of the incident; that no onlookers be present in the debriefing; only those who were directly involved with the incident; that the participants speak on behalf of themselves; and that no ridiculing or apportioning blame on any participants was permitted. With these rules or guidelines the participants felt a sense of safety and comfort which enabled them to begin to ventilate some of the stress reactions that they had or were experiencing. An important component of establishing a safe environment involves establishing a climate of trust and rapport with the facilitator and the Peer Support Team members involved in the debriefing.

The participants shared their experience of debriefing by discussing that once an environment of rapport and trust was established they could tell their story and in doing so were able to ventilate some of their strong feelings associated with the incident and its aftermath. These feelings they identified as being grief, depression, guilt, anger, vulnerability, feeling of failure, inadequacy and anxiety. By providing a **formalised process** of debriefing, it also provided the catalyst for uncovering previously repressed thoughts and feelings which could be related back to previous critical incidents where no formal crisis intervention strategies had been made available. It is not uncommon for earlier painful and distressing incidents to be resurfaced by attending further critical incidents and the sharing of the sights, sounds and smells of a current critical incident. This effect was highlighted by Red who discussed an incident where a young child died sometime later following an extremely unpleasant home accident. He discussed how when he was carrying out cardio-pulmonary resuscitation that he kept personalising the

young child to his own child. He completed his discussion of this event by saying:-

> "*That is the sort of thing I needed* (Critical Incident Stress Debriefing). *All I could see was my little child on the table. So that is the sort of thing the Critical Incident Stress Team is needed for".*

It is well recognised that by expressing emotions or **ventilating the stress reaction** openly improves psychological and physical wellbeing (Raphael, Singh & Bradbury, 1980; Pennebaker,1985, 1990; Roemer & Borkovec, 1994). A key ingredient of Mitchell's model (1983) of debriefing is cathartic discussion which has been found to be useful in reducing the stress response (Everly, 1990). It is seen as being a critical criterion of the healing process. In my practice experience I believe this process of establishing a sense of trust and safety does not occur simultaneously for all participants. When it is first felt or experienced, which hopefully should be within the introductory phase, then one or two participants usually begin to **ventilate** their stress reactions. When these individuals ventilate their personal stress reactions, this enables others to share their stress reactions. It is akin to a snow-balling effect. Once one person begins to vent, this usually assists others to share their stress reactions. With this venting it enables others to acknowledge that they are not alone with their reactions and that all those who are participating generally have **similar feelings**. Those who have been resistant to share their experience then begin to feel more comfortable to share their own experience.

Debriefing is culturally condoned, that is the model utilised has been specifically prepared for emergency service personnel. Individuals of similar experience and background who have been exposed to the same incident, share it. They are encouraged to participate in the process of piecing the incident together and assist each other in recovering as quickly as possible in order to return to their normal everyday activities without any lasting negative consequences. With the venting of their feelings, thoughts, emotions and

reactions are validated as being normal, common and to be expected. This assists in mitigating feelings of guilt and shame, and prevents those individuals or groups from isolating themselves because they feared these feelings were theirs alone. The research participants shared how once they heard others venting, they acknowledged that they had **similar feelings** and therefore felt more comfortable sharing these with the group.

The participants discussed how the facilitator of the debriefing encouraged them in the telling of their own story. They all had a particular story to tell and how the critical incident had been experienced by them. They acknowledged that very often there were misconceptions or the truth was distorted in regard to what really happened at the incident. It is acknowledged in the literature that under stress, incoming information related to a critical incident is often subjected to a partial or frenzied focus and is therefore prone to misinformation or a twisting of the truth (Blak, 1991).

When the participants heard other participants perspective of the incident during the debriefing, they were able to **get the whole picture of the incident**. With the piecing together they were able to gain the full picture and also the truth of what really happened at the incident from all the participants' perspectives. The participants discussed how they were surprised at some of the pieces of information that were shared by individual participants and how some participants operational performance was admirable at the incident, which surprised them. With the piecing together of the incident the participants then gained a greater understanding of how particular participants performed and gained a new respect for these individuals. With that renewed respect came a sense of **bonding.**

The importance of the **Peer Support** lending credence to the debriefing was discussed by the participants. The participants trusted the Peer Supporters as they recognised that they had also, in many instances had walked in their shoes. Because of this they believed the Peer Supporters had a greater understanding of what they were experiencing. The participants believed

that a Peer Supporter could understand their turmoil and pain if they had experienced similar incidents. They postulated that the Peer Supporters were able to understand both the operational language and many of the feelings, thoughts and reactions they had experienced in relation to the critical incident and its aftermath.

As the Peer Supporters understand the Fire Service culture, the operational procedures and what the debriefed firefighters were saying, they were able to establish a trusting rapport with the participants at an early stage of the debriefing. The debriefed participants felt safer and trusted the Peer Supporters and felt less stigmatised when they shared their feelings, thoughts and reactions to the critical incident.

Professional firefighting is recognised as being a stressful and dangerous occupation. To cope with the inherently stressful and dangerous occupational demands, firefighters are reliant upon their fellow firefighters for support (Beaton, Murphy, Pike & Corneil, 1997). They work long shifts together, eat, sleep and play sport together, and belong to a unique occupational culture. Due to these factors the social relations of firefighters are rather unique. They therefore build a strong bond, particularly with those on their particular shift.

Participants discussed how the other firefighters in the debriefing shared their own perspective of the incident in a deeper and more indepth meaningful manner than is usual. The participants discussed that with the sharing of the experiences in relation to the critical incident, and the feelings, thoughts and reactions that was shared, it brought about a greater sense of cohesion and understanding of other firefighters that were involved in the debriefing. With this sharing a sense of **bonding,** brotherhood or camaraderie was realised or appreciated more by the participants following the debriefing. With this sense of an increased awareness of bonding, some of the participants saw the positive benefits of the debriefing being a teambuilding exercise which continued following the debriefing. As a consequence of the critical incident

in one instance, the bond between the crew had been somewhat eroded. This effect was due to what some of the participants believed had happened at the incident. When the participants heard the full story of what really happened for all the participants, there was a renewed sense of **bonding** which is imperative for the safe workings of all the members of the crew.

Respect was a further theme that was highlighted from the narratives. Several participants discussed how they had regained **respect** for several of the participants. These were firefighters who they had little respect for prior to the incident and the debriefing. Because of their sharing of their perspective and hearing what really happened and how well they had performed during the incident, they now had greater **respect** for these firefighters than prior to the incident and debriefing. Also some participants discussed how they respected the participants for being open and honest in their sharing of their experience of the incident. They were surprised at how open the participants were in telling their story.

Dealing with the trauma of death and destruction requires some social ritual to provide a closure or **resolution**. It was obvious that the participants experienced a sense of closure or **resolution** to the incident. This they found rather surprising as in the past major incidents were never totally laid to rest. They usually remained a frequent topic of conversation months or even years following the incident. However, with both these major incidents they believed that the incidents had been laid to rest and they now referred to and discussed the incident rarely, which they acknowledged as being very unusual. By encouraging the participants to discuss the incident, ventilate their feelings, thoughts and reactions, and validate their feelings and reactions as being normal, and acknowledging the contribution to the stressful and dangerous role they had performed, this provided a **resolution** to the incident. The experience of a CISD where there was a shared social ritual within a homogenous group, and with the knowledge that there was ongoing support available from their colleagues and the CISM Peer Support Team, greatly facilitated the **resolution** and the integration of the critical incident.

From the narratives it became evident that the ritual of debriefing is culturally appropriate for firefighters and that the formalised process of debriefing is effective. The effects of debriefing are maximised by the facilitator having a good understanding of the culture of the Fire Service and the Peer Support Team members belong to, and work within the Service. Therefore the debriefing is a shared experience which is both positive and validating to the participants. Other members of the Service also experience this positive effect, the organisation as a whole and of course the spouses, family and friends of the debriefed participants.

In summary, the formalised process was identified as the overriding prominent pattern which related to Mitchell's model (1983). It was found by the participants to be a culturally appropriate and safe model of crisis intervention. The eight major themes highlighted the perceived positive benefit of the CISD on the firefighters who participated. The research findings supported most of the basic assumptions and the rationale that is the basic foundation of Mitchell's model (1983). The CISD was found to be useful in ventilating the stress reaction, which assisted participants in reducing the stressful effects, and was very reassuring in affirming that one's reaction was normal in response to exposure to an abnormal event. It had a very positive effect in that misinformation was reduced or eliminated and it assisted in enhancing the bonding process and respect of other participants. The Peer Supporters were identified by the participants as being a very valuable member of the CISM Team.

CISD meets an urgent need in addressing the stress and reducing the ongoing harmful effects on firefighting personnel who have been exposed to critical incidents. The CISD strategy provides a forum for an open and confidential discussion of the painful effects suffered by firefighters who often view themselves as being underpaid, poorly resourced and undervalued.

11.3 IMPLICATIONS FOR PRACTICE

The research findings have assisted me considerably in validating my practice in the area of Critical Incident Stress Debriefing. It has given me insights into what the four participants perceived as being valuable to them personally, their peers, family, friends and the organisation as a whole. After being deeply immersed in the research process and analysing the data (which I surfaced), I found it has greatly assisted me in further developing my practice in partnership with the Peer Support Team members. The journey that I walk in the area of CISM with the Peer Support Team members is a collaborative one using a collective approach with mutual support in order to provide a professional and credible service for the consumers of our service, the firefighters.

11.3.1 CISD FACILITATORS

When using CISD it must be remembered that participants in the debriefing are usually part of a homogeneous group and as a result they bring to the debriefing their own history of rules, regulations, values, beliefs, culture, interpersonal relationships and other unique characteristics of the occupational work environment (Wollman, 1993). The occupational group also bring to the debriefing their unique professional language or jargon with their own humour, particularly black humour, which is often found to be offensive by those who have not been immersed within the culture and all its nuances. This is particularly pertinent to firefighting personnel who traditionally use black humour as a coping strategy in the immediacy of the incident. This has the potential to cause serious communication difficulties for facilitators of debriefings who lack the inside knowledge and understanding of the specific workings of the organisation. Ideally a facilitator should have local knowledge of the organisation in order to establish a credible working relationship with personnel.

Not only is it important to understand the culture of the organisation but it is

imperative to direct a debriefing with a sense of confidence, cohesion and professionalism. This is required in order to gain the trust and rapport in the early stages of the debriefing to enable the participants to be open and tell their story. In my experience firefighters do have their own language and culture which I now understand and this understanding has helped me greatly in providing a culturally appropriate and effective practice. However, I acknowledge that I also have my own history, values, beliefs, culture and practice language. I have realised over time that it is particularly important that in order to gain a speedy rapport with the firefighters, I need to drop my own professional language or jargon, while acknowledging that it is still part of me. Failing to make this shift has the potential to seriously hinder the effectiveness of debriefing.

I have found that an intervention such as CISD is the most appropriate strategy for assisting firefighting personnel to handle the overwhelming effects of trauma in normal, well-functioning personnel. However, where the post-traumatic symptoms persist, or where psychological problems in relation to long-term maladaptive behaviour interferes with the firefighters personal and professional life, then more intensive individual psychological assistance is required. This is outside the boundaries of what the CISM Peer Support Team is able to provide. To have the greatest effect, psychological services should be, and are part of our integrated programme of CISM services. It is imperative that the programme has the full administrative support and commitment from top management through to all levels of management. Their support and confidence in the programme is paramount to the success of the programme.

11.3.2 TIMING

Timing of a debriefing is viewed as being important. There is an overall consensus amongst clinicians that debriefing is most effective if carried out sooner rather than later following a critical incident (Miller, 1995). A problem which was highlighted in the research findings was that one participant, Flick,

discussed in some depth how he would have preferred to have had the debriefing earlier. In Flick's words *"I wanted to get it all over and done with. I like to deal with it straight away".* While I acknowledged his feelings in relation to having a debriefing earlier, I discussed with Flick the most suitable timing of a debriefing and the reasons why a debriefing was not the most appropriate CISM strategy immediately following the critical incident. A typical debriefing usually takes place within 24 - 72 hours following a critical incident (Mitchell & Bray, 1990) when the immediate psychological defence of denial has lessened somewhat and intrusive reactions are being strongly experienced. However, there may be some variation for the most suitable time. Debriefings are ideally conducted when the participants are most psychologically receptive to the intervention. I believe it is imperative that a CISD is not forced upon firefighters following a major critical incident, but they are asked if they would like to participate in a debriefing or offered some other CISM strategies that they may find more suitable.

There are other CISM strategies that could have been made available to Flick, such as a demobilisation, a defusing or a one-on-one support session. Often the CISM Team is not mobilised early enough in order to make these strategies available to personnel at the most appropriate time. An added complication is that the critical incident may have occurred on the last day of their set of shifts and they are not due back on shift again for up to four days. There is often difficulty bring the crew together within the recommended timeframe due to their off-duty time, their commitments to their secondary jobs and the geographical spread of firefighters who often live some distance from their stations. In many instances it is difficult to carry out a debriefing before they return to duty for their next set of shifts. Also there can be difficulty mobilising Peer Support Team members due to the geographical distance that has to be travelled when the request for CISM support is received. However I do not believe it is ever too late to offer a CISD if personnel request a debriefing or agree to the offer.

Critical Incident Stress Debriefing is not a substitute for psychotherapy but

belongs in the field of crisis intervention. It is usually a one-off intervention strategy with the bulk of the work carried out in a single session. Occasionally there is the need for a follow-up debriefing. A recognised major constraint in brief group crisis intervention is the limited time available (Aveline, 1993). Because of the brevity of working with individuals requiring debriefing, a clear structure, which I refer to as the formalised process, is required in order to achieve a positive effect in a single, time limited session. Once again an environment of trust, rapport, respect, authority and structure is required in order to direct a debriefing and achieve positive results. It is my belief and others (Mitchell & Everly, 1995; Dyregrov, 1997) that this environment must be established in the very early stages of debriefing. I refer to this as establishing a therapeutic relationship with the participants, to establish a favourable climate in order for the participants to feel safe to share factual information in relation to the incident, but most importantly their intimate thoughts, feelings and emotions which many of them find difficult to understand and cope with. It is recognised that some participants following a debriefing require more individual support and the CISD brief intervention is not able to totally meet the needs of some individuals. While these individuals may not necessarily require more expert psychological assistance, they may require a more individualised therapeutic relationship with a Peer Supporter. Often some participants feel more comfortable sharing in the one-on-one setting. It must be remembered that CISD is not a miracle cure, and that some participants may feel little or no benefit from their attendance. However, it is important that no serious consequences should result from their attendance by forcing them to share their experience in the debriefing. If they require more individual or professional assistance, it is imperative that these services be offered to them.

11.3.3 PRE-INCIDENT EDUCATION

How can some of the above difficulties be addressed? It is important to carry out comprehensive pre-incident education training sessions to all levels of firefighting personnel. It is vital to provide stress management education

and crisis mitigation training to all levels of firefighters, from the new recruit to senior management. If firefighting personnel have a good understanding of Critical Incident Stress and it's effects and the CISM strategies available to assist them in mitigating some of the harmful effects, this knowledge empowers them in coping with the distressing effects of attending a critical incident. If Management are fully aware and supportive of the CISM programme and are familiar with the different levels of CISM, then they are more likely to mobilise the CISM Team following critical incidents.

It is important to periodically update personnel with continuing education sessions on stress management and CISM in order to keep them abreast with new knowledge in the field of CISM and to provide additional knowledge in preventing and mitigating the effects of stress. Another important aspect of the continuing education sessions is to promote the team's activities which is a marketing strategy to make team visible.

11.3.4 MARKETING THE CISM PROGRAMME

It is important to continually market the concept of CISM and the strategies available to assist firefighting personnel following their exposure to critical incidents. A method of raising the profile of the CISM Team's activities which I have found successful is to publish articles in the local Regional newsletter, professional journals, provide a fact sheet for all personnel on the CISM programme and at each Station display a colourful poster which further highlights the Team's activities. I encourage Peer Support Team members to write articles following their attendance at regular training sessions and often firefighters will write a letter of thanks to the Team after receiving CISM services. These are often printed, with the permission of all the debriefed participants, in the local Regional newsletter. I have found these strategies are a useful marketing tool to continually raise the visibility of the CISM Team.

11.3.5 PEER SUPPORT

While the literature heavily supports mental health professionals as being the most appropriate leaders or facilitators of debriefing, I have found through experience, that mental health professionals do not always make the most effective facilitators in this context. Many Peer Support Team members from within the emergency service organisations have shown remarkable skill at understanding and facilitating the group process of debriefing. With the necessary advanced training in group process and debriefing, and with particular personal qualities such as a genuine caring attitude, an ethos of assisting one's fellow peers in an empathetic, warm and caring manner, walking a journey together, without disempowering those they are assisting, then it is my belief that they are able to conduct a debriefing in a professional and caring manner. Peer debriefers are the key ingredients of a CISM team as they are seen as being credible by their peers and are thus more readily able to establish a rapport with emergency service personnel (Clark & Friedman, 1992).

From my own practice perspective as a Clinical Leader of a Critical Incident Stress Management Peer Support Team, I value those Peer Support Team personnel who have the advanced training and personal qualities necessary to facilitate a debriefing. In many aspects I believe they are better able to provide a very credible and professional debriefing as they understand the culture, the language and even the black humour better than those who live outside the organisation. This is akin to Taylor's (1994b) "being in the world" by their immersion in the culture, inextricably in their everyday realities and understanding of self and others within the organisation by having a sense of belonging. I acknowledge that not all Peer Support personnel have the necessary qualities or the indepth understanding of the group process of debriefing and that it would be unsafe to place them in a situation where they were required to conduct a debriefing. With the necessary clinical guidance and supervision that I see as being paramount to my role as Clinical Director, then those who have the necessary skills are able to provide a safe and professional debriefing.

I have found, through experience, that not all Peer Supporters are suitable for every debriefing. It is important to choose the right Peer Supporters for a debriefing in order to increase the potential for a successful debriefing. I refer to this as "matching up" the most suitable Peer Supporters with the particular crew to be debriefed. The overall aim of any debriefing is to mitigate the harmful effects of the stress reaction and return firefighting personnel to their normal function as expeditiously as possible. To expose participants to a Peer Supporter who they may not respect or trust has the potential to cause further harm. The potential for this to occur in the New Zealand Fire Service in the current climate of disharmony amongst the three tiered level of firefighting personnel, is great. The three tiers consist of D1 firefighters who are professional fulltime firefighters who remain on the old contract; the Community Service Teams (CSTs) who were introduced in 1996 and who work a completely different shift system to the D1s. This includes longer working hours and an increase in hours of productivity. Lastly, there are the volunteer firefighters who are essentially unpaid and are recruited from within the local communities.

As I understand the culture and the inherent stresses that exist for personnel within the New Zealand Fire Service today, I am ever mindful of choosing the most appropriate Peer Supporters in which to support myself or other mental health professionals in facilitating a debriefing. It would be unsafe to place a Peer Supporter who I and others recognise would have difficulty in establishing his/her credentials with a different tier of firefighting personnel. However, there are some Peer Supporters who may not come from the same tier as those who they are assisting in the debriefing. Because of their personal qualities, the relationship they have established in their area, their personal skills and particular occupations such as a being a Chaplain, a counsellor etc, they may be seen as being credible to a different tier of firefighters. In my practice I always give the selection of the Peer Supporters much thought when preparing for a debriefing. As I view the Peer Supporters as being pivotal to the success of the debriefing, it is imperative to choose the most appropriate Peer Supporters. The importance of

selecting the most appropriate Peer Supporter was highlighted in the narratives from the four participants.

The critical incidents that the research participants were exposed to were considered extremely traumatic and required Peer Supporters who were not only highly skilled in the peer support role but had extensive firefighting knowledge and experience. It was obvious from the narratives that the participants valued and trusted the Peer Supporters both for their peer support qualities but also for their operational experience.

It is imperative to provide the Peer Support Team members with clinical support, supervision and expertise. They are individuals who have been selected from within the Service who are deemed to have specific characteristics that engender in those they are assisting confidence in their abilities to assist them in times of stress. They have received intensive training in CISM and the problems they are likely to experience and are competent in dealing with them in a professional manner. It is important that they are able to work under clinical supervision as part of a disciplined professional group. I see my own role of providing that clinical supervision and expertise having worked in the area of CISM for the last ten years. An important role I value is empowering them in their role as Peer Supporters. Often, because of geographical isolation, I am unable to meet with Peer Supporters before they provide a defusing or other CISM strategy. However, I always make myself available by telephone to talk them through the process of whatever strategy they are to provide. I engender in them a feeling of confidence and competence and that I and other Peer Supporters are there to assist them if required. My motto, when discussing the strategy to be provided by the Peer Supporters is "**keep it simple**". Fire Service personnel are often very sceptical of 'fakes' and they very quickly put up barriers if they distrust those trying to provide a service that is outside their expertise. I always follow-up with the Peer Supporters who have provided a defusing or a debriefing to discuss how the strategy went. It is like a post-defusing, post-debriefing meeting where we discuss what went well and what

can be learnt for the future. I always affirm their contribution to their fellow-firefighters and to the CISM programme as a whole.

It is always encouraging and humbling to work with Peer Supporters as they progress in the field of CISM. They share their personal experiences of working in the field with much openness and honesty. Recently I supported several newly appointed but incredibly valuable Peer Supporters who carried out a defusing within their small community. It was their first defusing and I walked them through the process via telephone and as always encouraged them to **"keep it simple"**. I reiterated the importance of spending time on the introduction and setting the scene, to enable the participants to feel safe to ventilate, which has been highlighted as being important in this research. My follow-up telephone conversation with the Peer Supporters was one of confidence on how successful they felt the defusing had been. One Peer Supporter discussed how the participants had *"Come into the debriefing with their arms folded, tight as drums. They looked like funeral directors".* However, as the Peer Supporters introduced the defusing and set the scene for a feeling of safety to ventilate, the Peer Supporter said in his own words *"They started to loosen up and begin to relax. It was amazing watching them start to feel relaxed. Once they started to feel comfortable they all started to open up. It felt really great".* By supporting Peer Support Team members, it engenders in them a feeling of confidence and competence. My relationship with the Peer Support Team members is important to their own personal wellbeing, particularly in these times of acute unrest within the New Zealand Fire Service. They too, are experiencing the ongoing stresses of the long and protracted restructuring and need support.

My personal philosophy of practice centres on being in partnership with the team members. I value and respect their values, beliefs, culture, gender, spiritual beliefs and the experiences they bring to the Team. I value the partnership concept as being caring and like Watson's theory (1988) I value myself and the Team members as being cared for in our journey of working in the field of CISM. I value and acknowledge the team members unique

past experiences as being part of the caring relationship which is so pivotal to the relationship of all members of the team. I acknowledge their contribution both to my practice and to the CISM programme that they so generously contribute to. As partners together, we are an important link in the chain of providing the most effective CISM services where the Team members and myself become responsible and accountable for our own practice together.

I view my journey with the Peer Support Team members as a journey of care. As a nurse I have a professional obligation to care and feel I am in an unique and privileged position to assist them in their journey. By being present and connected with them, I can assist them in their journey of finding their house, travelling through their garden, cultivating and toiling their roots by supporting and encouraging them in their practice, and being there for them in times of wandering through the wilderness and in times of uncertainty. This relates back to Kelley's (1995) house-garden-wilderness metaphor.

11.3.6 ONGOING TEAM TRAINING

This research has not only highlighted the importance of the initial basic training but the need for ongoing training to reinforce or expand the Peer Supporters' skills. This ongoing training also provides the opportunity to share and learn from other Peer Supporters' experiences (Finn & Esselman Tomz, 1998). It is a form of networking where we can learn in partnership together in a safe environment. Bonding, teambuilding and cohesion was identified as one of the eight themes by the participants in the research. This is also a key function of ongoing training where it is important to continually focus on team building and develop a cohesive Peer Support Team. The ongoing training also provides an opportunity to gain an overview of the team's activities where the Team bonds as a group to work cohesively.

Training in the past has involved role-plays where Peers are given role-play exercises which are video taped and followed up by a critique in a safe and caring exchange. This has been found to be an effective method of training and increases the Peers confidence and competence in the area of CISD. A further method of training that the Team utilises is reviewing past CISM strategies that Peers have been involved in. In order to respect confidentiality, no firefighters' names are used or specific details about the critical incident revealed. The Peers present the critical incident and follow-up strategies implemented and discuss how they arranged the intervention, the planning that was required and the intervention strategy that was used. They then review the CISM strategy implemented and view this process as a shared learning experience.

Another positive aspect of ongoing regular Team training is that by presenting relevant and interesting topics which are supported by professional presentations, the enthusiasm and motivation of the Team members is maintained. A Team that fails to provide continuing education in upgrading the skills of its providers has the potential to stagnate. Instead of the CISM Peer Support Programme growing from strength to strength, there is a potential for a general decline in the effectiveness in the services being provided. When team members loose interest they often fail to meet their ongoing commitment to attend Team training and meetings. This usually results in a feeling of isolation and a loss of interest and direction, which eventually results in members resigning from the team.

The success or demise of any CISM programme is dependent on the knowledge, training and expertise of the Peer Support Team members who provide the mainstay of the services. Ensuring that team members receive ongoing training in order to update and enhance their skills, ensures that the most appropriate CISM strategy is provided at the right time. These are factors that can enhance or inhibit the success of any CISM programme (Mitchell & Everly, 1997).

11.3.7 CISD EVAULATIONS

Following Critical Incident Debriefings I have found it important to request and encourage the participants to complete an evaluation of the CISD intervention. The rationale for requesting this information is explained to the participants with regard to how we need to continually improve on the provision of CISM services. Their evaluation of the process of CISD is an important strategy on which to audit our programme. A stamped-addressed envelope marked 'confidential' is provided with the evaluation form in order to increase the likelihood of compliance. The evaluation results are also a useful tool for training purposes where we review the interventions that have been provided, what went well and how we could improve on future interventions.

On reviewing some of the evaluations that I have recently collated, many of the themes that have been highlighted in the research are also recorded by the participants in the evaluations. Examples include:-

> *"Gave me a chance to talk about the incident".* (Ventilate).
> *"Well controlled and ordered".* (Formalised process).
> *"Understanding that others felt the same emotions etc".*(Similar feelings).
> *"To appreciate what others did during the incident".* (Getting the whole picture, respect)
> *"Helped me hear what happened to the others".* (Getting the whole picture).

The timing of the intervention is addressed in the evaluation and the comments are variable, but often participants have commented that they would have liked the CISD *"sooner".* I believe this highlights the importance of pre-incident and ongoing education sessions in order to educate firefighting personnel on the different CISM interventions available, and what is the most appropriate intervention to apply at a particular time following the critical incident.

11.4 MANAGEMENT SUPPORT

I believe it is imperative to the success of any CISM programme to have the full support of management. Firstly it is vital that Management believe in the concept and benefits of a CISM programme. Their financial and administrative support is required otherwise without their full commitment the programme flounders. This was evident during the mid 1990s when the Occupational Health Services were under review within the New Zealand Fire Service and some Regions no longer employed an Occupational Health Nurse. The Occupational Health Nurse provided clinical leadership, but also played a pivotal role in marketing the concept to Management and also fulfilled a liaison role between the Team and Management. The cost of any CISM programme should not be as prohibitive (Bergman & Queen, 1986) as the cost of medically boarding a firefighter as a result of trauma far exceeds the cost both in financial and personal terms. As the CISM programme utilises Peer Support personnel who are unpaid volunteers, the programme is therefore less expensive to run in the long term. In my ten years of practice experience I have rarely had to refer distressed firefighters onto mental health professionals for more professional assistance. The CISM programme takes a proactive stance as opposed to a reactive stance.

To enlist Management support it is important to market the concept of CISM services. Current research data and exemplars from within the New Zealand scene should be made visible to Management by bringing to their attention the psychological risks associated with firefighting. The consequences of the ICI fire and its ongoing aftermath that still plague the Fire Service today is no greater exemplar on which to base the need to provide CISM services. Even up to the present time the Fire Service still bears the financial and personnel cost, in relation to a poorly co-ordinated health response following the ICI fire.

The success of the Region's CISM programme where I am employed is related to the support the team receives from the current Management, especially the Regional Commander/Manager. There is the commitment to

resource the team for the initial training and ongoing training, attendance at meetings and the cost of employing myself as the Clinical Director on a part-time basis. Recently the Regional Commander/Manager agreed to finance the cost of two Peer Support Team members to attend the Australasian Critical Incident Stress Association in Adelaide, Australia. I believe in the current climate of fiscal restraints, that Management in this particular Region values the CISM programme's contribution to the health and safety of its personnel. The need for psychological intervention such as Critical Incident Stress Debriefing for firefighters following exposure to a critical incident has become widely accepted within the New Zealand Fire Service. Debriefing has been one of the most common method of intervention utilised as it provides an opportunity for firefighters to process the incident both cognitively and emotionally, especially following a particularly distressing critical incident. It is also culturally acceptable to the Fire Service. Although firefighters in the main respond effectively following a critical incident they are not immune to its stresses. They must attend to and witness the pain and suffering of others regardless of their own needs which taxes even the toughest 'John Wayne". Debriefing meets an overwhelming need among Fire Service personnel as evidenced by its gradual acceptance over the last 10 years. In times of repeated calls for fiscal restraint with funding cutbacks and budget shortfalls, CISD provides a forum for honest and confidential narration of the often painful experiences that firefighters are exposed to, during and following critical incidents.

In today's tenuous industrial climate, firefighters within the New Zealand context feel grossly under-paid, undervalued and poorly resourced. I have personally witnessed their increased vulnerability to suffering from Critical Incident Stress due to the cumulative nature of the stresses that exist in their everyday life of working within the New Zealand Fire Service. The anger and resentment they exhibit particularly during a CISD, is very often directed not at the circumstances of the critical incident but at the organisational, industrial and operational circumstances. It is difficult, as a Clinician working in the field of CISM within the New Zealand context, to offer any concrete

suggestions on how to manage the stress attached to the ongoing industrial unrest. The strategy that I suggest, is that they draw from within their own resources of stress management, with the support of the Peer Support Team and myself, until the restructuring is finally settled. I see this as helping the distressed firefighter regain a sense of mastery and control of their environment, even when it remains in disorder. Unfortunately for some, their personal resources of stress management have reached breaking point. These are the firefighers for whom I have grave concerns for their personal well-being and safety. In some instances I have referred these firefighters on for professional psychological services which has assisted them in trying to regain some sense of control in their lives.

11.5 CONCLUSION

In this chapter I have discussed the findings of the research which supported some of the basic assumptions and rationales which are the structure of Mitchell's model (1983) of debriefing. CISD was found to be effective in reducing the significant stresses associated with attending a critical incident. I have also discussed how the findings have influenced my ongoing practice and my partnership relationship with the CISM Peer Support Team members. I have shared how some of these findings have significant implications for my ongoing practice. In the concluding chapter I will evaluate the aims of the study and briefly discuss the political implications for providing ongoing CISM services in relation to the current industrial climate. I will also discuss the suggestions for further research.

12. CONCLUSION

12.1 INTRODUCTION

In this chapter I will evaluate the aims and present the conclusion of the study. I will also discuss the political implications for providing ongoing Critical Incident Stress Management (CISM) services, which includes Critical Incident Stress Debriefing (CISD), one component of CISM, in relation to the research findings and the current industrial climate that presently exists within the New Zealand Fire Service. I will conclude with a discussion on the limitations of this study and suggestions for further research.

12.2 RESEARCH AIMS, PURPOSE AND OUTCOMES

To address this process it is important to return to the introduction of the research to examine whether I have met the intended outcome for this research. My aim was to "**explore within the New Zealand context, the experience of CISD on firefighters following attendance at a critical incident".** The purpose was to **"gain contextual meaning and an understanding of the experiences of firefighters who have participated in a CISD based on Mitchell's model (1983) of debriefing".**

The research explored the experience of debriefing on four firefighters following their participation in a Critical Incident Stress Debriefing. The participants described their personal experience in relation to participating in a Critical Incident Stress Debriefing following attendance at significant critical incidents. Their personal insights into the experience of debriefing, portrayed through narratives, were both moving and inspiring. The pattern of the formalised process and the eight themes that were uncovered in an analysis of the narratives highlighted the positive benefits of the experience of participating in a CISD to reduce and mitigate the harmful stress effects following exposure to a critical incident.

The research not only uncovered the positive aspects of the experience of debriefing, but it also afforded the research participants the opportunity to speak about their personal experiences in some depth in relation to the particular critical incident and its associated stresses. I felt privileged that they were willing to share their narratives, in such depth and honesty with me, whereby they were required to once again recall a distressing critical incident and the debriefing that followed the incident. During the exchange of discussion there was a shared warmth, understanding and compassion between myself and the participants. With the telling of their stories there were mixed emotions of sadness and tears, but also humour, intimacy and respect. All participants found the interviews a very healing process which I found really affirming. Initially, I had grave concerns that the interview process had the potential to resurface painful thoughts, feelings and memories associated with their attendance at the critical incident and subsequent CISD, which could have had serious negative consequences. Fortunately my fears were unfounded as the telling of their stories was therapeutic. This therapeutic process is well supported in the nursing literature (Sedney, Baker & Gross, 1994; Heiney, 1995; McDaniel, Hepworth & Doherty, 1995; Koch, 1998). Not only was it healing to the participants, but also to myself. I felt affirmed in hearing them share the positive aspects of the debriefing which made me feel more grounded and empowered in my practice in terms of its value to the participants, their family, friends, fellow-firefighters and the organisation, the New Zealand Fire Service.

The findings clearly indicated that the Critical Incident Stress Debriefing process was a very valuable CISM strategy to use, within the context of the New Zealand Fire Service, using a modified version of Mitchell's model (1983) following major incidents, or where there was evidence of cumulative stress that required debriefing. It affirmed that the services the Peer Support Team are providing are both appropriate and acceptable. I was grateful and humbled by their contribution to my research and their contribution to the ongoing development of knowledge in the field of CISM. The findings from

this study regarding the positive benefits of participating in a CISD are consistent with the literature.

The ultimate goal of this nursing research study was to provide information that would lead to improvement in the provision of services to the consumers of CISM services and to encourage other organisations to look at providing such services to their staff who may be exposed to critical incidents. As a Nurse Clinician working in the area of CISM, it is my opinion that the results of this research clearly indicate that CISD is a major factor in assisting firefighting personnel in coping with the stresses associated with attending a major critical incident. The positive benefits to the participants has been discussed in more detail in Chapters nine and ten. However, the research has clearly demonstrated that there were very real benefits to the four participants who experienced the process of CISD. The process provided them with an opportunity to discuss the incident with others who had experienced similar stresses following attendance at an incident, in a safe, controlled environment supported by Peer Support Team members and facilitated by a facilitator who had a genuine understanding of the New Zealand Fire Service culture and had the necessary training and skills in the group process. The facilitator was able to assess those participants who required further CISM interventions. As a consequence of attending a CISD, the participants found that a sense of bonding and respect was increased through the experience. A further finding was that the participants were able to resolve the stresses attached to attending the critical incident by their participation in the debriefing.

While this research has focussed specifically on CISD, I have repeatedly stated that the CISD group process is only one component of CISM services. It is part of the comprehensive, multi-component approach to CISM and was never intended to be a stand alone approach to the management of Critical Incident Stress for emergency service workers. The importance of providing a systematic approach to crisis management relates to providing multiple interventions to afford the greatest impact in order to achieve the goal of

crisis stabilisation and symptom mitigation (Everly & Mitchell, 1998). Unfortunately this concept is very often poorly understood as evidenced by Snelgrove (1998) who argues that the CISD process should not be a stand alone intervention strategy. However, it must be recognised that in the earlier history of CISM development, many programmes were referred to generically as Critical Incident Stress Debriefing programmes even though they provided other forms of CISM services. This could be where the confusion has arisen. In fact, when I was involved in the pilot programme in establishing a crisis intervention strategy for the New Zealand Fire Service in the late 1980's and early 1990s, we referred to our programme as a Critical Incident Stress Peer Support Programme. We provided a comprehensive and multi-component approach to CISM services. Since redeveloping the present Team that I work with as the Clinical Director, we have renamed our team as a Critical Incident Stress Management Peer Support Team which more truly represents our programme. The generic term of CISD has been replaced with the term CISM to more precisely represent the multi-component approach to CISM services (Everly & Mitchell, 1997).

Recently, Professor Jeffrey Mitchell, the founder of the CISD model suggests that the formal CISD process receive a name change in order to more accurately reflect the reality of the world of crisis intervention. While he is honoured by the application of his name to the CISD process, he believes that the CISM field has developed beyond one individual. He believes the name should reflect those working in the field, not just himself and has suggested the term ICISF (International Critical Incident Stress Foundation) Model as a replacement to the Mitchell (1983) model (Mitchell, 1998).

12.3 RECOMMENDATIONS TO MANAGEMENT

The data provided strong evidence in support of CISD as a valuable technique for firefighters. The narrative can inform social policy (Van der Staay, 1994) and can facilitate change in organisations (Gabriel, 1995:

Yanow, 1995). As discussed earlier, it is my belief that valuable personnel have left the service due to their inability to cope with the stresses attached to the job, particularly critical incident stress. The personal cost to the individual, to their families, to the organisation and to society can be reduced if appropriate CISM services are provided to reduce chronic disease and the incidence of Post-Traumatic Stress Disorder. I have personally witnessed the positive benefits of providing Critical Incident Stress Debriefings but I am ever mindful that it is just one component of the multi-component approach to CISM. I view CISD as a strategy that compliments other CISM strategies. Rarely is it utilised as a stand alone process. Often firefighting personnel have received one-on-one support either at the scene of the critical incident, or sometime later. A defusing may have been held and a decision made following the defusing that a more formalised intervention strategy such as a CISD was required. I believe that the model that is followed within the New Zealand Fire Service does meet the needs of its personnel in a culturally appropriate and acceptable manner. The research suggests that the traditional methods of counselling and psychotherapy are not seen as being effective or acceptable to firefighters involved in critical incidents. This has been highlighted, not only in this research, but by the increased utilisation of the CISM Peer Support Programmes that are currently operating within the New Zealand Fire Service.

My recommendation to the New Zealand Fire Service Management is that their commitment and support of the CISM programme needs to continue in its present form. This recommendation results not only from the research findings, but from my own personal knowledge of the long protracted and unresolved organisational change process which has had a negative impact on firefighters morale. In recent times I have facilitated debriefings where personnel have focussed more on the stresses attached to the current organisational unrest and uncertainty, than on the stresses attached to the actual critical incident. This indicates the seriousness of the present ongoing industrial relations issues. In many instances I have felt somewhat powerless to offer any concrete solutions. I have acknowledged and have

attempted to understand their situation but have not been able to offer them any immediate hope of a resolution. However, the debriefing and other forms of CISM services has provided them with an opportunity in which to express their anger, resentment and pain associated with the current organisational unrest and provided them with strategies in which to manage their stresses, until a resolution is reached. Also, increased bonding has been highlighted as being a positive aspect of the debriefing process which further assists the firefighters in maintaining some sense of control and cohesion.

In the particular Region of the New Zealand Fire Service where I am currently employed on a part-time consultancy basis, Management are clearly committed to the concept of providing a CISM Peer Support programme with clear leadership, employing a Clinical Director to provide the clinical support and expertise to the Peer Support Team members. Even though Management are ever mindful of the repeated calls from Government for fiscal restraints, in this particular Region they are committed to providing stress management strategies to provide a "duty of care" for their personnel in order to meet their obligations to the Health & Safety and Employment Act (1992). However, I do not believe that this commitment to the CISM programme is clearly evident throughout the New Zealand Fire Service. Some programmes in other Regions, that previously were considered to have strong leadership and supportive Peer Support Team members, have faltered due to the lack of the commitment and support of Management. As a consequence they may have lost their Clinical Directors who were previously employed as the Occupational Health Nurse. The Peer Support Team members enthusiasm has lessened, understandably, due to the lack of clear leadership, support and ongoing meetings and training. Management, in these Regions, needs to look at the commitment to the health and safety of their personnel, particularly in the current organisational context of widespread unrest.

The CISD model described in this study was designed specifically for emergency service personnel, but can be easily adapted for other

organisations such as hospitals, for their nursing and medical staff, in the mental health area, Hospice staff who care for the terminally ill, within the Education and Welfare sectors, and for organisations that provide community disaster workers. The key features of CISD is to provide a debriefing within 1 - 7 days after the incident, to have a skilled facilitator who has an understanding of the occupational group they are working with and who has credibility. I strongly support the training of Peer Support Team members from within these organisations who have "walked in the shoes of those they are assisting", are well respected, have excellent listening skills, respect confidentiality and have received the necessary training in CISM services.

Once again I acknowledge that debriefing is just one component of CISM services, and the particular programme that I am associated with has moved towards more one-on-one interventions and less group interventions. However, debriefing is an important component, particularly after unpleasant and distressing critical incidents or following cumulative stresses associated with critical incidents. As previously discussed, traditional methods of counselling or psychotherapy are not always acceptable or as effective for nursing, medical staff, emergency service personnel or community disaster workers who have been exposed to critical incidents. It must be acknowledged that the reactions associated with their exposure to a critical incident are normal in normal individuals to an abnormal event. It is important not to medicalise Critical Incident Stress, but to acknowledge it as a normal reaction in personnel who are often exposed to critical incidents in their occupational areas. I strongly recommend to organisations who have a commitment to care for the health and safety of their personnel, to look seriously at providing Critical Incident Stress Management strategies for the good of their staff. Not only is it cost-effective in terms of fiscal savings to the organisation, but also in reducing the cost to the individual, their families, their colleagues and to society.

12.4. LIMITATIONS OF THE STUDY

Limitations to the study relate to the descriptive and exploratory nature of the study, and the limited sample size of the four participants who were recruited for the study from within one Region of the New Zealand Fire Service.

In presenting the results of the research and the discussion in relation to implications for practice, and recommendations to Management and other relevant organisations, I have attempted at all times to remain faithful in retaining the narratives of the participants in their wholeness and completeness in order to demonstrate credibility. To ensure rigor and credibility, all the participants were sent a copy of the interpretations of their narratives to verify that they recognised the findings as true to their experiences. The purpose of returning the final results before presenting the research, is to ensure that those who have lived the experience of debriefing validate that the findings are a true representation of their experience.

Many purists from the scientific model of research would argue that the findings of this research could not be generalised due to the limited sample size. However it must be remembered that while only four cases were studied, they were studied in depth. Certain issues, activities and problems did appear in the study which were common to all the participants, therefore certain generalisations can be drawn. The real contribution of case study design, utilised in this research, is not generalisation but particularisation to depict events or experiences in one particular setting as it exists in reality for the participants. I believe that the knowledge gained from the powerful tool of the narratives cited in this study has the potential to be transferred to others working in the field of emergency services. The insights and illuminations highlighted in the study have the power to be useful to CISM service providers, that is mental health professionals and Peer Support Team members, and others working in the field of crisis intervention, to creatively develop their practices in order to provide the most appropriate and acceptable service.

Despite the limitations discussed, I have created an audit trail discussing clearly, decisions made throughout the research study in relation to theoretical, methodological and analytical choices (Sandelowski, 1986; Koch, 1998). The objective of the audit trail was to clearly articulate and demonstrate the evidence and thought processes which led to the conclusions. I have sign-posted what has gone on while carrying out the research to enable the readers of this research to journey with ease and enthusiasm through the worlds of Fit, Flick, Instantaneous, Red and myself as researcher, in order for them to decide whether the narrative is a legitimate research process.

12.5 RECOMMENDATIONS FOR FURTHER RESEARCH

Since beginning this research journey into the experience of CISD on firefighters, I believe the potential for further research is considerable. While this research study has focussed specifically on the experience of CISD, I believe it would be of value to further extend the study by increasing the number of research participants to include the three tiers of firefighting personnel. Only permanent (D1) firefighting personnel were included in this study. This would increase the chances of being able to generalise the results and to increase this possibility. The study participants could be recruited from all the Regions of the New Zealand Fire Service.

While I have studied debriefing only, a further area for research consideration would be to study the effects of the multi-component CISM services and their integrated service provision. Is one method more valuable and acceptable to personnel than other methods? I believe this would be a valuable area for further research utilising both qualitative and quantitative research.

Another area that I would like to research is the timeliness of Critical Incident Stress Debriefing. Is 1 – 7 days the most ideal time to conduct a debriefing? Should it be held sooner or later?

The areas for research development in the field of CISM are enormous. However, I believe given the current organisational unrest being experienced within the New Zealand Fire Service, an area for consideration that I would like to research would be to study the differing tiers/levels of firefighting personnel in order to evaluate whether one level is more liable to suffer Critical Incident Stress and require CISM services than other levels, particularly in relation to the present ongoing organisational change process?

Another recommendation for future research, is to interview members of the Peer Support Team members from the different Regions within the New Zealand Fire Service and evaluate the programme in terms of their initial and on-going training, the clinical support and supervision being provided, and how they are coping with the stress of being a member of a Peer Support Team while experiencing their own stresses in relation to the current organisational unrest.

12.6. CONCLUSION

While I began this journey looking to increase mine and others knowledge in the area of CISD, I had little understanding of what I and others would experience. It has been a journey of personal growth and practice development. My life has been enriched by the sharing and the intimate relationship that was established with all four participants who generously gave of their time and inner selves in order to provide the rich and powerful narratives that uncovered the value and importance of providing CSID following particularly distressing major events. The knowledge gained from this study has the potential to add to the increasing body of knowledge in the field of CISM services in order to improve service provision to emergency service personnel who, because of their particular work, are more likely to be exposed to critical incidents in their everyday working lives.

The journey with the participants has been one of true partnership. I have included them in decision making, particularly in relation to their participation in the study and, of course the final results of the study. The participants, by their sharing have found the process therapeutic and have been empowered with the knowledge that they have gained a sense of control over their lives, and with the sharing of their stories they have assisted not only myself but also others working in the field of CISM. Empowerment for me is the affirmation that the services provided by the Team are meeting the needs of our firefighting personnel. However, there are areas where we can improve that provision. With the knowledge gained from this study I hope I will be able to further empower the Peer Support Team members that I presently work with, in affirming that the service they so generously support and provide is valued by the consumers of their service.

It is my belief that our journey in the field of CISM services is only just beginning. As a Nurse Clinician, I believe an important role I have is in acknowledging the resilience of emergency service workers when exposed to the life-threatening and devastating effects of disaster work. Those working in the field of CISM need to respect and acknowledge their contributions to the saving of the lives or the rescue of the injured or the deceased. By this acknowledgement, it validates their practice, empowers them and assists emergency service personnel in regaining a sense of control (which this research has highlighted), so as to assist them in the recovery from the effects of Critical Incident Stress.

In conclusion, I feel more empowered in my personal philosophy and practice in the area of Critical Incident Stress Management. The personal narratives of Fit, Flick, Instantaneous and Red, will continue to provide me and others with a special interest in the area of CISM, with a greater depth of understanding of the experience of CISD. The four participants have all supported me in this journey, in my own house-garden-wilderness. The gift of their sharing, in all its depth, honesty, integrity and willingness to open up past experiences and pain are gratefully acknowledged.

"We must not cease from exploration and the end of all our exploring will be to arrive where we began and to know the place for the first time" (T.S.Elliot).

REFERENCES

Abma, T.A. (1998) Storytelling as inquiry in a mental hospital. *Qualitative Health Research,* 8(6), 821-838.

Accident Rehabilitation & Compensation Act (1992).

Alexander, D.A. & Wells, A. (1991) Reactions of police officers handling after a major disaster: A before and after comparison. *British Journal of Psychiatry,* 159, 547-555.

American Psychiatric Association (1980) *Diagnostic and statistical manual of mental disorders,* First Edition. Washington, D.C: APA Press.

American Psychiatric Association (1987) *Diagnostic and statistical manual of mental disorders,* Third Edition. Washington, D.C: APA Press.

American Psychiatric Association (1994) *Diagnostic and statistical manual of mental disorders,* Fourth Edition. Washington, D.C: APA Press.

Armstrong, K., O'Callaghan,W. & Marmar, C. (1991) Debriefing Red Cross disaster personnel: The multiple stressor debriefing model. *The Journal of Traumatic Stress,* 4(4), 581-592.

Aveline, M.O. (1993) Principles of leadership in brief training groups for mental health care professionals. *International Journal of Group Psychotherapy,* 43, 107-129.

Avery, A., King, S., Bretherton, R. & Orner, R. (1999) *Deconstructing psychological debriefing and the emergence of calls for evidence based practice.* Paper presented at the Australasian Critical Incident Stress Association Conference, Adelaide, Australia.

Baker, C. & Diekelmann, N. (1994) Connecting conversations of caring; Recalling the narrative to clinical practice. *Nursing Outlook,* 42(2), 65-70.

Banks-Wallace, J. (1998) Emancipatory potential of storytelling in a group. *Image: Journal of Nursing Scholarship,* 30(1), 17-21.

Bartone, P.T., Ursano, R.J., Wright, K.M. & Ingraham, L.H. (1989) Impact of a military air disaster on the health of assistance workers. *Journal of Nervous and Mental Disorders,* 177, 317-328.

Beaton, R.D. & Murphy, S.A. (1993) Sources of occupational stress among firefighters/EMTs and Firefighter/Paramedics and correlations with job-related outcomes. *Prehospital and Disaster Medicine,* 8(2), 140-150.

Beaton, R.D., Murphy, S.A., Pike, K.C. & Corneil, W. (1997) Social support and network conflict in firefighters and paramedics. *Western Journal of Nursing Research,* 19(3), 297-313.

Bell, N. (1991) Critical incident stress debriefing: Smoothing out the edges of rough calls. *Emergency,* September, 30-38.

Benner, P. (1984) *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, California: Addison-Wesley.

Benner, P. & Wrubel, J. (1989) *The primacy of caring, stress and coping in health and illness.* Menlo Park, California: Addison-Wesley.

Berah, E., Jones, H. & Valent, P. (1984) The experience of a mental health team involved in the early phase of a disaster. *Australia and New Zealand Journal of Psychiatry,* 18, 334-358.

Berg, B. (1995) *Qualitative research methods for the social sciences.* (2nd ed.). Boston: Allyn and Bacon.

Berg, J., Clifford, B. & Wheeler, A. (1998) *The Thredbo Landslide 30th July 1997: The New South Wales Brigades CISM Response.* Paper presented at the Australasian Critical Incident Stress Association Conference, Auckland, New Zealand, April 1998.

Bergman, L. & Queen, T. (1986) Responding to critical incident. *Fire Chief,* June, pp.43,44, 49.

Bisson, J., Jenkins, P., Alexander, J. & Bannister, C. (1997) Randomized controlled trial of psychological debriefing for victims of acute burn trauma. *British Journal of Psychiatry,* 171, 78-81.

Blak, R.A, (1991) Critical Incident Stress Debriefing for law enforcement personnel: A model. In J.Reese, J.Horn & C.Dunning (Eds.). *Critical incidents in policing.* Revised. Washington, D.C: Government Printing Office.

Bohl, N. (1988) *Effect of psychological interventions after critical incidents on anger, anxiety and depression.* A dissertation presented to the Faculty of the California Graduate Institute, Los Angeles, California.

Bowker, R. (1988) *Firefighters: A study of protective social mechanisms.* Victoria University of Wellington: Information and Publication Section.

Boyd, C.O. (1993) Toward a nursing practice research method. *Advances in Nursing Science,* 16(2), 9-25.

Brooks, W.C., Parsons-Nicota, J. & Richardson, G. (1998) Heart attack! "Kicking in the door" on the leading cause of fireground deaths. *Firehouse,* May, 58-62.

Buckle, P. & Hill, J. (1995) Community based management of social disruption following disasters. *The Australian Journal of Emergency Management,* 10(3), 31-38.

Burns, N. &. Grove, S. (1993) *The practice of nursing research, conduct, critique and utilisation.* (2ND ed.). Philadelphia: W.B.Saunders.

Burns, C. & Harm, N. (1993) Research: Emergency nurses' perceptions of critical incidents and debriefing. *Journal of Emergency Nursing,* 19(5), 431-436.

Carkhuff, R. & Truax, C. (1965) Lay mental health counseling. *Journal of Consulting Psychology*, 29, 426-431. In J.T.Mitchell & G.Everly, (Eds.). *Critical Incident Stress Debriefing: An operations manual for the prevention of traumatic stress among emergency services and disaster workers.* Maryland, U.S:A: Chevron Publishing.

Carlier, I., Lamberts, R., Van Uchelen, J. & Gersons, P. (1998) Disaster-related Post Traumatic Stress in police officers: a field study of the impact of debriefing. *Stress Medicine*, 14, 143-148.

Catherall, S. (1998) Volunteers fear big load. *Sunday Star Times,* 7 June, 3.

Chemtob, C.M., Tomas, S., Law, W. & Cremniter, D. (1997) Postdisaster psychosocial intervention: A field study of the impact of debriefing on psychological distress. *American Journal of Psychiatry,* 154(3), 415-417.

Chin, P. & Kramer, M. (1991) *Theory and nursing: A systematic approach.* St.Louis: Mosby Year Book, Nov/Dec., 251-256.

Christiansen, J. (1990) *Nursing partnership: A model for nursing practice.* New Zealand: Daphne Brassell Associates Press.

Clark, M. & Friedman, D. (1992) Pulling together: Building a community debriefing team. *Journal of Psychosocial Nursing,* 30(7), 27-32.

Cox, T. (1992) Stress research and stress management: Putting theory to work. *HSE Contract Research Report No.61.*

Creamer, M., Burgess, P., Buckingham, W. & Pattison, P. (1989) *The psychological aftermath of the Queen Street shootings. A summary of results.* Melbourne: Department of Psychology, University of Melbourne.

Denzin, N. & Lincoln, V. (Eds). (1994) *Handbook of qualitative research.* Thousand Oaks, California: Sage Publications.

Drew, N. (1993) Reenactment interviewing: A methodology for phenomenological research. *Image: Journal of Nursing Scholarship*, 25(4), 345-351.

Dunning.C. & Silva, M. (1980) isaster-induced trauma in rescue workers. *Victimology: An International Journal*, 5(24), 287-297. Dunning, C. (1988) Intervention strategies for emergency workers: In M.Lystad (Ed.). *Mental Health Response to Mass Emergencies*, 284-307. New York: Brunner/Mazel.

Dyregrov, A. (1989) Caring for helpers in disaster situations: Psychological debriefing. *Disaster Management,* 2, 25-30.

Dyregrov, A., Kristtoffersen, J.I. & Gjestad, R. (1996) Voluntary and professional disaster workers: Similarities and differences in reactions. *Journal of Traumatic Stress,* 9(3), 541-555.

Dyregrov, A. (1997) The process in psychological debriefing. *Journal of Traumatic Stress,* 10(4), 589-604.

Elias, S., Bandaranayake, D.R., Edwards, I.R. & Glass, W.I. (1990) *The health consequences of the ICI fire. Report to the Minister of Health of firefighters in the fire at the ICI Riverview store, Mount Wellington, Auckland, 21 December 1984.* Wellington: Department of Health.

Ellis, K. (1995) The organizational approach to stress management. *Psychological health in the workplace: Understanding and managing occupational stress.* P.Cotton (Ed.). Australian Psychological Society.

Ersland, S. & Weisaeth, L. & Sund, A., (1989) The stress upon rescuers involved in an oil rig disaster. "Alexander L. Kielland" 1980. *Acta.Psychiatr.Scandinavica, 80(355),38-49.*

Estall, R. 1997) *The way forward.* The New Zealand Fire Commission.

Estall, R. (1998) *The way forward: Modernisation of the Fire Service.* New Zealand Fire Service Commission.

Everly, G. (1990) The rationale for Critical Incident Stress Debriefing. *Life Net,* Summer.

Everly, G.S., Jr. & Boyle, S. (1997) *A meta-analysis of the critical incident stress debriefing (CISD).* Paper presented to the Fourth World Congress on Stress, Trauma and Coping in the Emergency Services Professions, Baltimore.

Everly, G.S. & Mitchell, J.T. (1997) *Critical Incident Stress Management: A new era and standard of care in crisis intervention.* Maryland, USA: Chevron.

Everly, G.S. & Mitchell, J.T. (1998) A primer on Critical Incident Stress Management (CISM). *Life Net,* 9(3), 10.

Finn, P. & Esselman Tomz, J. (1998) Using peer supporters to help address law enforcement stress. *FBI Law Enforcement Bulletin,* 67(5), 10-18.

Firefighters in the fire at the ICI Riverview Store, Mount Wellington, Auckland 21 December 1984. Wellington. Department of Health.

Fire Service Act 1975.

Fire Service Amendment Act 1990.

Frago, M.R.F. (1999) Psychological wellbeing. Profiling the firefighter. *Fire International,* 163,33.

Freire, P. (1972) *Pedagogy of the oppressed.* Ramos, M., Translator, Great Britain: Penguin Books.

Gadow, S (1995) Narrative and exploration: Toward a poetics of knowledge in nursing. *Nursing Inquiry,* 2, 211-214.

Gabriel, Y. (1995) The unmanaged organization: Stories, fantasies and subjectivity. *Organization Studies,* 16(3), 477-501.

Gee, J.P. (1985) The narrativization of experience in the oral style. *Journal of Education,* 167(1), 9-35.

Gist, R. (1995) Occupational stress in contemporary Fire Service. *Occupational Medicine,* 10(4), 763-787.

Gist, R 1996) Is CISD built on a foundation of sand? *Fire Chief,*40(8), 38-42.

Gist, R., Lohr, J., Kenardy, J., Bergmann, L., Meldrum, L., Redburn, B., Paton, D., Bissen, J., Woodall, J. & Rosen, G. (1997) Researchers speak out on CISM. *Journal of Emergency Medicine,* May, 27-28.

Glesne,C. & Pleshkin, A. (1992) *Becoming qualitative researchers.* New York: Longman Publishing Group.

Goldbeg, D.P. (1972) *The detection of psychiatric illness by questionnaire.* London: Oxford University Press.

Griffiths, J. & Watts, R. (1992) *The Kempsey and Grafton bus crashes: The aftermath.* Lismore, New South Wales, Australia, University of New England: Instructional Design Solutions.

Habermas, J. (1971) *Knowledge and human interest.* Boston: Beacon Press.

Hammer, J., Matthews, J., Lynons, J. & Johnson, N. (1986) Occupational stress within the paramedic profession: An initial report of stress levels compared to hospital employees. *Annual of Emergency Medicine,* 15, 536-539.

Hanneman, M.F. (1994) *Evaluation of Critical Incident Stress Debriefing as perceived by volunteer firefighters in Nova Scotia. Ann Arbor,* Michigan: UMI Dissertation Services.

Harkins, W.J. (1997) Post-trauma support for marines. *Marine Gazette,* April, 41-43.

Harris, V. (1992) Firefighters – stress and the psychological profile. *Fire & Rescue,* January, 20.

Hartsough, D.M. (1985) Stress and mental health interventions in three major disasters. In D.M.Hartsough & D.G.Myers (Eds.). *Disaster work and mental health: Prevention and control of stress among workers,* (pp.1-44),

Havassy, V.J. (1991) Critical Incident Stress Debriefing: Ritual for closure. In J.Reese. J.Horn & C.Dunning (Eds.) *Critical incidents in policing.* Revised. Washington, D.C: Government Printing Office.

Hawkins, B. (1998) Service dogged by failed reform. *Evening Post,* 12 May,.5.

Hawthorne, D. & Yurkovich, K. (1994) Caring: The raison d'etre of the professional nurse. *Canadian Journal of Nursing Administration,* 7(6), 33-45.

Health & Safety in Employment Act 1992.

Heiney, S.P. (1995) The healing power of story. *Oncology Nursing Forum,* 22(6), 899-904

Heron, J. (1981) Philosophical basis for a new paradigm. In P. Reason & J. Rowan (Eds.). *Human inquiry: A sourcebook of new paradigm research,* 19-36. New York: John Wiley & Sons

Hinder, G. (1997) Accompanying: The practice of public health nursing in New Zealand. *Nursing Praxis in New Zealand,* 12(2), 23-28.

Hobbs, M., Mayour, R. Harrison, B. & Worlock. (1996) A randomised controlled trial of psychological debriefing for victims of road traffic accidents. *British Medical Journal,* 313, 1438-1439.

Hodgkinson, P. & Stewart, M. (1991) *Coping with catastrophe: A handbook of disaster management.* London: Routledge.

Horowitz, M.J. (1976) *Stress response syndromes.* New York: Jason Aronson.

Horowitz, M.J., Wilner, N. & Alvarez, W. (1979) The Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine,* 41, 209-218.

Hughes, L. (1995) Teaching caring to nursing students. *Nurse Educator,* 20(3), 16-20.

Hutchinson, S.A., Wilson, M.E. & Wilson, H.S. (1994) Benefits of participating in research interviews. *Image: Journal of Nursing Scholarship,* 26(2), 161-164.

Hytten, K. & Hasle, A. (1989) Firefighters: A study of stress and coping. *Acta Psychiatra.Scandinanica,* 83(355), 50-55.

Information Centre, N.Z.Fire Service (1998).

Innes, J.M. & Clark, A. (1985) The response of professional firefighters to disaster. *Disasters,* 9(2), 149-153.

Janik, J. (1992) Addressing cognitive defenses in Critical Incident Stress. *Journal of Traumatic Stress,* 5(3), 497-503.

Jenkins, S.R. (1996) Social support and debriefing efficacy among emergency medical workers after a mass shooting incident. *Journal of Social Behavioural and Personality,* 11, 477-492.

Johnstone, M.J. (1999) Reflective topical autobiography: An under utilised interpretive research method in nursing. *Collegian,* 6(1), 24-29.
Kalimo, R., Lehtonen, A. & Daleva, M. (1980) Psychological and biochemical strain in firemen's work. *Scandanavia Journal of Environmental Health.* 6, 179-187.

Karasek, R., Theorell, T., Schwartz, J., Schnall, P., Pieper, C. & Michela, J. (1988) Job characteristics in relation to the prevalence of myocardial infarction in the U.S. Health Examination Survey (HES) and the Health and Nutrition Examination Survey (HANES). *American Journal of Public Health,* 78, 910-918.

Kelley, L.S. (1995) The house-garden-wilderness metaphor: Caring frameworks and the human becoming theory. In R.R.Parse (Ed.), *Illuminations: The human becoming theory in practice and research.* New York: National League for Nursing.

Kenardy, J.A., Webster, R.A., Lewin, T.J., Carr, V.J., Hazell, P.L. & Carter, G.L. (1996) Stress debriefing and patterns of recovery following a natural disaster. *Journal of Traumatic Stress,* 9(1), 37-49.

Knowles, M. (1987) Andragogy: An emerging technology for adult learning. In M.Tight (Ed.). *Adult learning and education.* London: Routledge.

Koch, T. (1998) Story telling: Is it really research? *Journal of Advanced Nursing,* 28(6), 1182-1190.

Kondora, L.L. (1993) A Heideggerian hermeneutical analysis of survivors. *Image: Journal of Nursing Scholarship,* 25(1), 11-16.

Kormos, H.R. (1978) The nature of combat stress. In C.R.Figley (Ed.). *Stress disorders amongst Vietnam veterans: Theory research and treatment,* 3-22. New York: Brunner Mazel.

Krysel, M. (1991) Sometimes a person needs a story more than food to stay alive. In *Curriculum Revolution: Community building and activism.* New York: National League for Nursing Press.

Kuorinka, I. & Korhonen, O. (1981) Firefighters' reaction to alarm, an ECG and heart rate study. *Journal of Occupational Medicine,* 23, 762-766.

Kutner, K.C. (1992) CISD: Critical to health and safety. *Fire Engineering,* April, 145(4), 51-55.

Langellier, K.M. (1989) Personal narratives: Perspectives on theory and research. *Text and Performance Quarterly,* 9(4), 243-276.

Lanning, J.K.S. (1987) Post-trauma recovery of public safety workers for the Delta 191 crash: Debriefing, personal characteristics and social systems. In Mitchell, J. T. & Everly, G.S. (1997). The scientific evidence of critical incident stress management. *Journal of Emergency Medical Services,* January, 86-93.

Lazarus, R.S. (1975) The self-regulation of emotion. In L.Levi (Ed.). *Emotions: Their parameters and measurement.* New York: Raven Press.

Lee, C., Slade, P. & Lygo, V. (1996) The influence of psychological debriefing on emotional adaptation in women following early miscarriage: A preliminary study. *British Journal of Medical Psychology,* 69, 47-58.

Lightfoot, S. (1991) Open wounds. *Emergency*, December, 26-27.

Lincoln, Y.S. & Guba, E.G. (1985) *Naturalist Inquiry.* Beverley Hills: Sage.

Lichter, I., Mooney, J. & Boyd, M. (1993) Biography as therapy. *Palliative Medicine,* 3, 133-137.

Lumby, J. (1992) *The making meaning from a woman's experience of illness.* Armidale, Australia: University of New England Press.

Lumby, J. (1994) *Exploring the experience of a life-threatening illness: The emergence of a feminist method for nursing. Ph.D. dissertation.* Deakin University, Australia, held on microfiche Victoria University of Wellington, New Zealand.

McDaniel, S.H., Hepworth, J. & Doherty, W.J. (1995) Medical family therapy with somaticizing patients: The co-creation of therapeutic stories. *Family Process,* 34, 349-361.

McFarlane, A.C. & Raphael, B. (1984) Ash Wednesday: The effects of a fire. *Australian New Zealand Journal of Psychiatry,* 19, 913-921.

McFarlane, A.C. (1988a) The longitudinal course of post-traumatic morbidity: The range of outcomes and their predictors. *The Journal of Nervous and Mental Disorders,* 176(1), 30-39.

McFarlane, A.C. (1988b) The aetiology of Post-Traumatic Stress Disorders following a natural disaster. *British Journal of Psychiatry,* 152, 116-121.

Manton, M. & Talbot, A. (1990) Crisis intervention after an armed hold up: Guidelines for counselors. *Journal of Traumatic Stress,* 3(4), 507-521.

Markowitz, J., Gutterman, E. & Link, B. (1987) Psychological responses of firefighters to a chemical fire. *Journal of Human Stress,* 13, 84-93.

Marrimer-Toomey, A. (1989) *Nursing theorists and their work.* St.Louis: Mosby.

Mason, J. (1996) *Qualitative Researching.* London: Sage Publications.

Mathieson, C.M. & Barrie, C.M. (1998) Probing the prime narrative: Illness, interviewing and identify. *Qualitative Health Research,* 8(5), 581-601.

Matthews, W.R. (1998) Effect of staff debriefing on Post-Traumatic Stress symptoms after assaults by community housing residents. *Psychiatric Services,* 49(2), 207-212.

Meier, P. & Pugh, E. (1986) The case study: A viable approach to clinical research. *Research in Nursing & Health,* 9, 195-202.

Miller, L. (1995) Tough guys: Psychotherapeutic strategies with law enforcement and emergency services personnel. *Psychotherapy,* 32(4), 592-600.

Miller, J. & Glassner, B. (1997) The 'inside' and the 'outside'. Finding realities in interviews. In D.Silverman (Ed.). *Qualitative research: Theory, method & practice.* London: Sage Publications.

Mishler, E. (1986) *Research Interviewing: Context & Narrative.* Cambridge, Massachusetts: Harvard University Press.

Mishler, E. (1991) "Once upon a time". *Journal of Narrative and Life History,* 1(2&3), 101-108.

Mitchell, J.T. (1983) When disaster strikes.....The Critical Incident Stress Debriefing Process. *Journal of Emergency Medical Services,* 8(1), 36-39.

Mitchell, J.T. (1988a) The history, status and future of Critical Incident Stress Debriefings. *Journal of Emergency Medical Services,* 13(11), 49-52.

Mitchell, J.T. (1988b) Development and functions of a Critical Incident Stress Debriefing Team. *Journal of Emergency Medical Services,* 13(12), 43-46.

Mitchell, J.T. (1988c) Coping with stress in the firefighter. Emergency medical stress. *New South Wales Firefighter,* December, 55-57.

Mitchell, J. T. (1989) Development and functions of a Critical Incident Stress Debriefing team. *Journal of Emergency Medical Services,* December, 43-46.

Mitchell J. & Bray, G. (1990) *Emergency service stress.* Cliffs, New Jersey: Brady.

Mitchell, J.T. (1992) Protecting your people from Critical Incident Stress. *Firechief,* May, 61-63.

Mitchell, J.T. & Everly, G.S. (1995) *Critical Incident Stress Debriefing: An operations manual for the prevention of traumatic stress among emergency services and_disaster workers.* Maryland, U.S.A: Chevron Publishing Corporation.

Mitchell, J.T. & Everly, G.S. (1997) Scientific evidence of CISM. *Journal of Emergency Medical Services,* January, 86-93.

Mitchell, J.T. (1998) International Critical Incident Stress Foundation Model. *Life Net,* 9(3), 7.

Mitchell, J.T. (1998a) Critical Incident Stress Management and Critical Incident Stress Debriefings: Evolutions, effects and outcomes. Presented at the ACISA Conference, Auckland, New Zealand, April, 1998.

Morse, J. (1988) Commentary on special issue. *Western Journal of Nursing Research,* 10, 213-216.

Moss, C. (1991) Exploring storytelling as method. *Nursing Research: Scholarship for Practice Conference.* Geelong: Deakin University.

Motowidlo, S.J., Packard, J.S. & Manning, M.R. (1986) Occupational stress: Its causes and consequences for job performance. *Journal of Applied Psychology,* 71, 618-629.

Munhall, P. & Oiler, C.J. (1986) *Nursing Research: A qualitative perspective.* Norwalk: Appleton-Century Crofts.

Munhall, P. (1988) Ethical considerations in qualitative research. *Western Journal of Nursing Research,* 10, 150-162.

Munhall, P. (1989) Philosophical ponderings on qualitative research methods in nursing. *Nursing Science Quarterly,* 2(1), 20-28.

Murdock, J. (1981) Stress: What a Chief can do. *Fire Chief Magazine,* September, 43-48.

New Zealand Fire Service Manual of Personnel Administration, 3 August 1994. Section G (G.15). Critical Incident Stress Debriefing.

Nightingale, F. (1969) *Notes on nursing: What it is and what it is not.* London: Harrison. (Reprinted 1946 by J.B.Lippincott).

Nightingale, R. (1998) Arapawa Fire Region's Safety & Health Service to be provided by Red Zebra Co. *Strait Talk,* August, (2), 1.

Nurmi, L. (1997) The sinking of the "Estonia". Paper presented at the *4th World Congress on stress, trauma and coping in the emergency services professions,* April 2-6, 1997, Baltimore, M.D.

Parkes, C.M. (1991) Planning for the aftermath. *Journal of the Royal Society of Medicine,* 84, 22-25.

Parse, R.R. (1981) *Man - living - health: A theory of nursing.* New York: John Wiley & Sons.

Parse, R.R. (1992) Human becoming: Parse's theory of nursing. *Nursing Science Quarterly,* 5, 35-42.

Paton, D. (1997) Managing work-related organizational psychological trauma: An organizational psychology of response and recovery. *Australian Psychologist,* 32, 46-55.

Paton, D. & Finn, R. (1999) Disaster stress: An emergency management perspective. *Disaster Prevention and Management,* 8(4), 261-267.

Patton, M.Q. (1990) *Qualitative evaluation and research methods.* (2nd ed.). Newbury Park, Carlifornia: Sage.

Pennebaker, J.W.(1985) Traumatic Experiences and psychosomatic disease. *Canadian Psychologist,* 26, 82-95.

Pennebaker, J.W. & Beall, S. (1986) Confronting a traumatic event. *Journal of Abnormal Psychology,* 95, 274-281.

Pennebaker, J.W. & Susman, J. (1988) Disclosure of trauma and psychosomatic disease. *Canadian Psychologist,* 26, 82-95.

Pennebaker, J.W. (1990) *Opening up: The healing power of confiding in others.* New York: Avon.

Pierce, M. (1993) Chief Concerns - Critical Incident Stress Debriefing. *Firehouse.* May, 18-19.

Polit, D.F. & Hungler, B.P. (1993) *Essentials of nursing research: Methods, appraisal and utilization.* (3rd ed.). Philadelphia: J.B.Lippincott.

Polkinghorne, D. (1988) *Narrative knowing and the human sciences.* Albany: State University of New York Press.

Polkinghorne, D. (1997) Mapping the conceptual terrain. In W.G.Tierney & Y.S.Lincoln, (Eds.). *Representation and the text: Re-framing the narrative voice.* Albany, New York: State University of New York Press.

Raphael, B. (1975) Crisis and loss: Counselling following a disaster. *Mental Health in Australia,* 1(1), 118-122.

Raphael, B., Singh, B. & Bradbury, L. (1980) Disaster: The helper's perspective. *Medical Journal of Australia,* 2,445-447.

Raphael, B., Singh, B., Bradbury, B. & Lambert, F. (1984) Who helps the helpers? The effects of a disaster on rescue workers. *Omega,* 14, 9-20.

Raphael, B. (1986) *When disaster strikes: How individuals and communities cope with catastrophe.* New York: Basic Books.

Raphael, B., Meldrum, L. & McFarlane, A.C. (1995) Does debriefing after psychological trauma work? *British Medical Journal,* 310, 1479-1480.

Ray, M. (1991) A philosophical method to study nursing phenomena. In J. Morse (Ed.). *Qualitative Nursing Research: A Contemporary Dialogue.* London: Sage Publications.

Reason, P. & Rowan, J. (1981) On making sense. In Reason and Rowan (Eds.). *Human enquiry: A source book of new paradigm research,* 113-141. Chichester: John Wiley & Sons.

Reason, P. (1988) Introduction. In P.Reason (Ed.). *Human enquiry in action,* 93-112. New York: John Wiley & Sons.

Reason, P. & Hawkins, P. (1998) Storytelling as inquiry. In P.Reason (Ed.). *Human inquiry in action: Developments in new research paradigm.* London: Sage Publications.

Reed, J. (1994) Phenomenology without phenomena: A discussion of the use of phenomenology to examine expertise in long-term care of elderly patients. *Journal of Advanced Nursing,*
19, 336-341.

Report on the Fire at ICI New Zealand Limited's Riverview Store, Mount Wellington. 21 December 1984. N.Z.F.S. No.1. Region.

Riessman, C. (1990) Strategic uses of narrative in the presentation of self and illness: A research note. *Social Science and Medicine,* 30, 1195-1200.

Riessman, C. (1993) *Narrative Analysis.* Thousand Oaks, California: Sage Publications.

Roberts, K. & Taylor, B. (1998) *Nursing research processes: An Australian perspective.* Melbourne, Australia: International Thompson Publishing Co.

Roberts, J.E. (1990) Uncover hidden caring. *Nursing Outlook,* 38(2), 67-69.

Robinson, R. (1984) *Health and stress in ambulance services.* Melbourne: Social Biology Resources Centre.

Robinson, R.C. & Mitchell, J.T. (1993) Evaluation of psychological debriefings. *Journal of Traumatic Stress,* 6(3), 367-382.

Robinson, R. (1994) *Follow-up study of health and stress in ambulance services, Victoria, Australia, Part 1.* Melbourne, Australia: Victoria Ambulance Services.

Roemer, L. & Borkovec, T. (1994) Effects of suppressing thoughts about emotional material. *Journal of Abnormal Psychology,* 103,467-474.

Rogers, O.W. (1993) *An examination of Critical Incident Stress Debriefing for emergency service providers: A quasi-experimental field study.* In Seligman, M.E. (1995) The effectiveness of psychotherapy. The consumers' reports study. *American Psychologist,* 50, 965-974.

Saigh, P.A. (1992) History, current nosology and epidemiology. In P.A.Saigh, (Ed.). *Post Traumatic Stress Disorder: A behavioral approach to assessment and treatment.* Needham Heights, MA: Allyn & Bacon.

Sandelowski, M. (1986) The problem with rigor in qualitative research. *Advances in Nursing Science,* 8(3), 27-37.

Sandelowski, M. (1991) Telling stories: Narrative approaches in qualitative research. *Image: Journal of Nursing Scholarship,* 23, 161-166.

Sandelowski, M. (1995) *Research in nursing & health,* 18, 179-183.

Sandelowski, M. (1996) Truth/storytelling in Nursing Inquiry. In Kikuchi, J., Simmons, H. & Romyn, D. (Eds.). *Truth in Nursing Enquiry.* Thousand Oaks: Sage Publications.

Sandelowski, M. (1997) "To be of use": Enhancing the utility of qualitative research. *Nursing Outlook,* 45(3), 125-132.

Searle, M.M. & Bisson, J.I. (1992) Psychological sequelae of friendly fire. In *Proceedings of Military Psychiatry Conference, Stress, Psychiatry and War.* Paris.

Sedney, M.A., Baker, J.E. & Gross. E. (1994) The story of death: The therapeutic considerations with bereaved families. *Journal of Marital and Family Therapy,* 20(3), 287-296.

Seligman, M.E. (1995) The effectiveness of psychotherapy. The consumers' reports study. *American Psychologist,* 50,965-974.

Selye, H. (1956) *The stress of life.* Great Britain: Lowe & Brydone.

Selye, H. (1974) *Stress without distress.* Philadelphia: Lippincott.

Selye, H. (1976a) *The stress of life.* Revised. New York: McGraw Hill.

Selye, H. (1976b) *Stress in health and disease.* Boston: Butterworth.

Shalev, A. (1994) Debriefing following traumatic exposure. In R.J. Ursano, B.G.McCaughey & C.S.Fullerton (Eds.). *Individual and community responses to trauma and disaster: The structure of human chaos,* 201-219. Cambridge: Cambridge University Press.

Shapiro, D. & Kunkler, J. (1990) *Psychological support for hospital staff initiated by clinical psychologists in the aftermath of the Hillsborough disaster.* Sheffield, England: Sheffield Health Authority Mental Health Services Unit.

Sharp, K. (1998) The case for case studies in nursing research: The problem of generalization. *Journal of Advanced Nursing,* 27, 785-789.

Silverman, D. (1993) *Interpreting qualitative data: Methods for analysing talk, text and interaction.* London: Sage.

Smith, C.L. & de Chesnay, M. (1994) Critical Incident Stress Debriefings for crisis management of Post-Traumatic Stress disorders. *Medicine and Law,* 13, 185-191.

Snelgrove, T. (1998) Debriefing under fire. *Trauma Lines,* 3(2), 11.

Solomon, Z. & Benbenishty, R. (1986) The role of proximity, immediacy and expectancy in the frontline treatment of combat stress reaction among Israelis in the Lebanon war. *American Journal of Psychiatry,* 143, 613-617.

Southwick, M. (1994) Making the Treaty count: A new curriculum for Whitireia Nursing Centre of Learning. *Whitireia Nursing Journal,* 1, 7-16.

Stake, R. (1978) The case study method in social inquiry. *Educational Researcher,* 9(2), 5-9.

Stake, R. (1994) Case study. In N. Denzoin & Y.Lincoln (Eds.). *Handbook of qualitative research (pp.236-247).* Thousand Oaks, California: Sage Publications.

Stake, R.(1995) *The art of case study research.* California: Sage Publications.

Standards for Occupational Health Nursing in New Zealand. (1988). 1st. Ed. Christchurch: N.Z.Occupational Health Nurses' Association:

Stanley, S.R. (1990) When the disaster is over: Helping the healers to mend. *Journal of Psychosocial Nursing and Mental Health Services,* 28(5), 12-16.

Steinmetz, J., Kaplan, R. & Miller, G. (1982) Stress management: An assessment questionnaire for evaluating intervention and comparing groups. *Journal of Occupational Medicine,* 24, 923-937.

Streubert, H. & Carpenter, D. (1995) Qualitative research in nursing: Advancing in humanistic imperative. Philadelphia: J.B.Lippincott.

Stuhlmiller, C.M. (1996) Narrative methodology in disaster studies. Rescuers of Cypress. In Benner, P. (Ed). *Interpretive phenomenology, embodiment, caring and ethics in health and illness.* Thousand Oaks, California: Sage Publications.

Swanson-Kauffman, K. & Schonwald, E. (1988) Phenomenology, In B.Sarter (Ed.). *Pathways to knowledge: Innovative methods for nursing.* New York: National League for Nursing.

Taylor, A.J.W. & Frazer, A. (1982) The stress of post-disaster body handling and victim identification work. *Journal of Human Stress,* 8(4), 4-12.

Taylor. A.J. (1990a) A pattern of disasters and victims. *Disasters,* 14(4), 290-299. *Community Mental Health in New Zealand,* 5(1), 60-68.

Taylor, B. (1994a) *Researching human health through interpretation.* Armidale, Australia: University of New England Press.

Taylor, B. (1994b) *Being Human: Ordinariness in nursing.* Melbourne: Churchill Livingstone.

Taylor, S.E. (1983) Adjusting to threatening events. A theory of cognitive adaptation. *American Psychologist,* 38,1161-1173.

Taylor, S.E. (1991) Asymmetrical effects of positive and negative events: The mobilisation-minimisation hypothesis. *Psychological Bulletin,* 110, 6705.

Treadwell, W.J. (1993) Servimus, June, 3.

Van der Staay, S.L. (1994) Stories of social distress: Applied narrative analysis and public policy for the homeless. *Journal of Social Distress and the Homeless,* 3(4), 299-319.

Van Manen, M. (1990) *Researching lived experience. Human science for an action sensitive pedagogy.* London, Ontario: Althouse Press.

Watson, J. (1988) *Nursing science and human caring.* New York: National League for Nursing.

Watson, J. (1990) The moral failure of the patriachy. *Nursing Outlook,* 38(2), 62-66.

Watts, R. (1994) The efficacy of Critical Incident Stress Debriefing for personnel. *The Bulletin of the Australian Psychological Society,* June/July, 607.

Wee, D.F., Mills, D.M. & Koelher G. (1993) Stress response of emergency medical services personnel following the Los Angeles civil disturbances. In G.Koelher et al. *Medical care for the injured: The emergency medical response to the April, 1992 Los Angeles civil disturbance.* Sacremento, CA: Emergency Medical Authority.

Weisaeth, L. (1989) The stressors and the Post-Traumatic Stress syndrome after an industrial disaster. *Acta Pscyhiatra Scandinavica,* 80(Suppl,355), 25-37.

Whitireia Community Polytechnic (1993). *Bachelor of Nursing Curriculum.*

Wilson, S. (1979) Explorations of the usefulness of case study evaluations. *Evaluation Quarterly,* 3(3), 446-459.

Wiltshire, J. (1995) Telling a story, writing a narrative: Terminology in health care. *Nursing Inquiry,* 2, 75-82.

Wollman, D. (1993) Critical Incident Stress Debriefing and crisis groups: A review of the literature. *Group,* 17, 70-83

Yanow, D. (1995) Writing organizational tales: Four authors and their stories about culture. Introduction. *Organization Science,* 6,225-226.

Yin, R. (1994) *Case study research: Design and methods.* (2nd ed.). Newbury Park, California: Sage Publications.

TE TIRITI O WAITANGI

HE KUPU WHAKATAKI Ko Wikitoria te Kuini o Ingarani i tana mahara atawai ki ngā rangatira me nga hapū o Nu Tirani i tana hiahia hoki kia tohungia ki a rātou o rātou rangatiratanga me to rātou wenua a kia mau tonu hoki te rongo ki a rātou me te Atanoho hoki kua wakaaro ia he mea tika kia tukua mai tetahi rangatira hei kai wakarite ki ngā Tangata Māori o Nu Tirani kia wakaaetia e ngā rangatira Māori te Kawanatanga o te Kuini ki ngā wāhikatoa o te wenua nei me ngā motu – nā te mea hoki he tokomaha ke ngā tangata o tona Iwi kua noho ki tenei wenua a e haere mai nei.

Na ko te Kuini e hiahia ana kia wakaritea te Kawanatanga kia kaua ai nga kino e puta mai ki te tangata Māori ki te Pākehā e noho ture kore ana.

Na kua pai te Kuini kia tukua ahau a Wiremu Hopihona he Kapitana i te Roiara Nawi hei Kawana mo ngā wāhi katoa o Nu Tirani i tukua aianei a mua atu ki te Kuini e mea atu ana ia ki ngā rangatira o te wakaminenga o ngā hapū o Nu Tirani me era rangatira atu enei ture ka Kōrerotia nei.

KO TE TUATAHI Ko ngā rangatira o te Wakawinenga me ngā rangatira katoa hoki, kihai i uru ki taua Wakaminenga, ka tuku rawa atu ki te Kuini o Ingarangi ake tonu atu te Kawanatanga katoa o o rātou wenua.

KO TE TUARUA Ko te Kuini o Ingarangi ka wakarite ka wakaae ki ngā rangatira, ki nga hapū, ki ngā tangata katoa o Nu Tirani, te tino rangatiratanga o o rātou wenua o rātou kainga me o rātou taonga katoa. Otiia ko ngā rangatira o te Wakaminenga me ngā rangatira katoa atu, ka tuku ki te Kuini te hokonga o era wāhi wenua e pai ai te tangata nona te wenua, ki te ritenga o te utu e wakaritea ai e rātou ko te kaihoko e meatia nei e te Kuini hei kaihoko mona.

KO TE TUATORU Hei wakaritenga mai hoki tenei mo te wakaaetanga ki te Kawanatanga o te Kuini. Ka tiakina e te Kuini o Ingarangi ngā tangata Māori katoa o Nu Tirani. Ka tukua ki a rātou ngā tikanga katoa rite tahi ki ana mea ki ngā tangata o Ingarangi.

Na, ko matou ko ngā rangatira o te Wakaminenga o ngā hapū o Nu Tirani ka huihui nei ki Waitangi ko matou hoki ko ngā rangatira o Nu Tirani ka kite nei i te ritenga o enei kupu. Ka tangohia ka wakaaetia katoatia e matou. Koia ka tohungia ai o matou ingoa o matou tohu.

Ka meatia tenei ki Waitangi i te ono o ngā ra o Pepueri i te tau kotahi mano, e waru rau e wa te kau o to tatou Ariki.

• TREATY OF WAITANGI: A LITERAL ENGLISH TRANSLATION OF THE MAORI TEXT •

Signed at Waitangi February 1840, and afterwards by about 500 chiefs.

VICTORIA, the Queen of England, in her kind (gracious) thoughtfulness to the Chiefs and Hapus of New Zealand, and her desire to preserve to them their chieftainship and their land, and that peace and quietness may be kept with them, because a great number of the people of her tribe have settled in this country, and (more) will come, has thought it right to send a chief (an officer) as one who will make a statement to (negotiate with) Maori people of New Zealand. Let the Maori chiefs accept the governorship (KAWANATANGA) of the Queen over all parts of this country and the Islands. Now, the Queen desires to arrange the governorship lest evils should come to the Maori people and the Europeans who are living here without law. Now, the Queen has been pleased to send me, William Hobson, a Captain in the Royal Navy to be Governor for all places of New Zealand which are now given up or which shall be given up to the Queen. And she says to the Chiefs of the Confederation of the Hapus of New Zealand and the other chiefs, these are the laws spoken of.

THIS IS THE FIRST

The Chiefs of the Confederation, and all these chiefs who have not joined in that Confederation give up to the Queen of England for ever all the Governorship (KAWANATANGA) of their lands.

THIS IS THE SECOND

The Queen of England agrees and consents (to give) to the Chiefs, hapus, and all the people of New Zealand the full chieftainship (rangatiratanga) of their lands, their villages and all their possessions (taonga: everything that is held precious) but the Chiefs give to the Queen the purchasing of those pieces of land which the owner is willing to sell, subject to the arranging of payment which will be agreed to by them and the purchaser who will be appointed by the Queen for the purpose of buying for her.

THIS IS THE THIRD

This is the arrangement for the consent to the governorship of the Queen. The Queen will protect all the Maori people of New Zealand, and give them all the same rights as those of the people of England.

WILLIAM HOBSON, Consul and Lieutenant-Governor

Now, we the Chiefs of the Confederation of the Hapus of New Zealand, here assembled at Waitangi, and we, the chiefs of New Zealand, see the meaning of these words and accept them, and we agree to all of them. Here we put our names and our marks.

THE FOURTH ARTICLE

Two churchmen, the Catholic Bishop, Pompallier and the Anglican Missionary William Colenso recorded a discussion on what we would call religious freedom and customary law. In answer to a direct question from Pompallier, Hobson agreed to the following statement. It was read to the meeting before any of the chiefs had signed the Treaty.

E mea ana te Kawana ko ngā whakapono katoa o Ingarani, o ngā Weteriana, o Roma, me te ritenga Maori hoki e tiakina ngatahilia e ia.

Translation:
The Governor says that the several faiths (beliefs) of England, of the Wesleyans, of Rome, and also Maori custom shall alike be protected by him.

ENGLISH DRAFT

PREAMBLE

Her Majesty, Victoria, Queen of the United Kingdom of Great Britain and Ireland, regarding with her Royal Favour the Native Chiefs and Tribes of New Zealand, and anxious to protect their just Rights and Property, and to secure to them the enjoyment of Peace and Good Order, has deemed it necessary, in consequence of the great number of Her Majesty's Subjects who have already settled in New Zealand, and the rapid extension of Emigration both from Europe and Australia which is still in progress, to constitute and appoint a functionary properly authorised to treat with the Aborigines of New Zealand for the recognition of Her Majesty's Sovereign authority over the whole or any part of these islands. Her Majesty therefore being desirous to establish a settled form of Civil Government with a view to averting the evil consequences which must result from the absence of the necessary Laws and Institutions alike to the Native population and to Her Subjects has been graciously pleased to empower and authorise me William Hobson, a Captain in Her Majesty's Royal Navy, Consul, and Lieutenant-Governor of such parts of New Zealand as may be or hereafter shall be ceded to Her Majesty, to invite the confederated and independent Chiefs of New Zealand to concur in the following Articles and Conditions.

ARTICLE THE FIRST

The chiefs of the Confederation of the United Tribes of New Zealand and the separate and independent Chiefs who have not become members of the Confederation, cede to Her Majesty the Queen of England, absolutely and without reservation, all the rights and powers of Sovereignty which the said Confederation or Individual Chiefs respectively exercise or possess, or may be supposed to exercise or to possess over their respective Territories as the sole Sovereigns thereof.

ARTICLE THE SECOND

Her Majesty the Queen of England confirms and guarantees to the Chiefs and Tribes of New Zealand and to the respective families and individuals thereof, the full exclusive and undisturbed possession of the Lands and Estates, Forests, Fisheries, and other properties which they may collectively or individually possess, so long as it is their wish and desire to maintain the same in their possession; but the Chiefs of the United Tribes and the Individual Chiefs yield to Her Majesty the exclusive right of Pre-emption over such lands as the proprietors thereof may be disposed to alienate, at such prices as may be agreed upon between the respective proprietors and persons appointed by Her Majesty to treat with them in that behalf.

ARTICLE THE THIRD

In consideration thereof, Her Majesty the Queen of England extends to the Natives of New Zealand Her Royal Protection and imparts to them all the Rights and Privileges of British subjects.

W. Hobson, Lieutenant-Governor

Now therefore, We the Chiefs of the Confederation of the United Tribes of New Zealand being assembled in Congress at Victoria, in Waitangi and We the Separate and Independent Chiefs of New Zealand claiming authority over the Tribes and Territories which are specified after our respective names having been made fully to understand the Provision of the foregoing Treaty, accept and enter into the same in the full spirit and meaning thereof. In witness of which, we have attached our signatures or marks at the places and the dates respectively specified.

Done at Waitangi, this sixth day of February in the year of Our Lord, one thousand eight hundred and forty.

AS YOU CAN SEE, THERE ARE TWO TEXTS THE MAORI TREATY. (INCLUDING ITS TRANSLATION INTO ENGLISH), AND THE MAORI ENGLISH DRAFT

WHICH TREATY IS THE REAL ONE?

There are 512 signatures but only 30 are on an English version. The rest are all on the Maori Treaty. The Waitangi Tribunal is instructed to have regard to both Maori and English versions as both have signatures.

IS THE TREATY LEGAL?

Yes, but like other treaties, the Treaty of Waitangi is not directly enforceable by the courts unless Parliament has so directed in an Act of Parliament.

This has happened in some but not all areas of law. Parliament has set up the Waitangi Tribunal to hear and report on claims that the Treaty has been breached.

WHAT HAPPENS WHEN THE TWO TEXTS ARE INTERPRETED DIFFERENTLY?

In International law, in any ambiguity the *contra proferentum* principle applies. This means that a provision should be interpreted against the party who drafts it and that the indigenous language text takes precedence.

FOR MORE INFORMATION CONTACT: PROJECT WAITANGI, P.O. BOX 825 WELLINGTON. PH. 829-300

CHARTER

PURPOSE STATEMENT

Council and staff see the purpose of Whitireia Community Polytechnic is to provide high quality learning opportunities and a sense of belonging for all people in supportive and caring ways which are:

Non-sexist
Non-racist
Sensitive and responsive to the uniqueness of each person's special needs
Responsive to the changing multicultural community
In accordance with the Treaty of Waitangi

VALUES STATEMENT

Council and staff are committed to the following values:

EQUITY

Providing significant learning, power-sharing and success for those who have lacked such opportunities.

IDENTITY

Creating an environment where people feel they belong because their uniqueness is valued and promoted.

RESPONSIVENESS

Being flexible, creative and open to change, to better meet individual and community needs.

MANAAKI

Encouraging the sharing of views, learning and resources, where individual self-esteem (mana) and group harmony result from caring about others.

SUCCESS

Being an effective organisation which leads in its field, demonstrating a clear sense of purpose and striving for excellence.

GOALS

OVER-RIDING STATEMENT

All Goals and Policies developed will be consistent with the Treaty of Waitangi and ensure the opportunity for Maori people to achieve their social and economic potential as an equal party to the Treaty.

GOAL 1

To provide a comprehensive range (introductory to degree level) of high quality, accessible, appropriately recognised, vocational and non-vocational learning opportunities which have been developed by consulting widely with relevant industry, occupational and other constituent groups.

GOAL 2

To provide a learning environment (including high quality teaching and a range of learning services) which enhances the possibility of success for every student - as of right.

GOAL 3
To actively promote equity of educational opportunity particularly for traditionally disadvantaged groups.

GOAL 4
To be accountable for the efficient and effective use of resources allocated.

GOAL 5
To increase available funding resources.

THE CURRICULUM PHILOSOPHY

INTRODUCTION

The epistemological beliefs espoused in this curriculum arise from individual and collective critical reflection on past experience. Out of the discourse emerges a renewed commitment to two fundamental principles. Firstly, that health and well-being are an inherent right of all people in our community. Secondly, that through the development of specialised knowledge (research) nurses make a unique contribution to the health of their communities through their nursing practice.

In seeking to embed these principles in our curriculum we have chosen to use the Treaty of Waitangi as a central organising conceptual framework. The justification for using this framework arises out of our belief that the Treaty provides us with a powerful metaphor of PARTNERSHIP by illuminating relational boundedness and the transformative possibilities which occur in the spaces created within this boundedness. The Treaty of Waitangi articulates the nature of the relationship between the founding peoples of New Zealand, by first naming them, and then describing the rights and obligations of each to the other. This is what we refer to as relational boundedness. It is the space between the "one" and the "other" that creates the dialectical tension through which relational possibilities are transformed into action. Even more fundamental than this, we would argue that when "one" and "other" engage in the dialectic each creates both "self" and "other".

Critically reflecting on the historical relationship between the Crown and Maori gives us important insights into how the health and well-being of people within our society has been managed over time, and provides strategies by which barriers to health and well-being may be better addressed in the future. Deep understanding of the relational; that is, recognition of the dialectic between "one" and "other", is a fundamental basis for nursing practice. We believe that an understanding of the relational possibilities illuminates the transformative potential of the teaching/learning relationship, and the nurse/client relationship.

Our beliefs about the significance of the concept of partnership to the teaching/learning, and nurse/client relationship are articulated through the understanding we have of the way the Articles of the Treaty create the possibility of partnership within the New Zealand context.

THE TREATY OF WAITANGI

ARTICLE THE FIRST

KAWANATANGA/GOVERNORSHIP

The first article of the Treaty of Waitangi is the basis for the claim that the Treaty is the cornerstone of New Zealand nationhood. Social existence is dependent on the organisation of mutual relations of human beings and classes of human beings in community. By signing the Treaty, Maori people mandated to the Crown the authority to secure an ordered social system within which Maori people and those represented by the Crown could live together in community. Over time, the authority of the Crown has been transferred to a western liberal parliamentary democratic system of government.

In an uncritical climate this ordered system becomes a dominant ideology by representing itself as the 'natural order', thus "assuming a cultural ascendancy" which enables this world view to reproduce itself overtime. (Fay. 1987. p 138) This process is what Gramsci described as hegemonic oppression in which;

"...those who govern and disproportionably possess its goods are thought to have a right to do so."
(Gramsci. 1971. ps 1 81-182)

The greatest source of a government's power and authority lies in the hegemonic belief held by those who are governed, that governments act in their best interest. It is this process which obscures the real nature of power relations within any social system. What makes the New Zealand context unique is that by using the Treaty of Waitangi as their reference, Maori have consistently challenged this hegemonic process. By their resolve to maintain their mana motuhake, Maori challenge the legitimacy of a social order based on a "single world view" reality. By creating the possibility that "knowledge" may derive

from more than a single world view Maori become an archetypal model for the claim that there may be many ways of knowing.

From the literature, and our own experience of teaching to culturally and socially diverse students we believe that a single world view approach to teaching and learning deriving solely from an empirical/behaviourist paradigm is not only educationally inadequate but also morally indefensible. In acknowledging the possibility of a bicultural world view, we can also extrapolate that there are many world views, many ways of knowing, that inform us. To provide a framework where these different forms of knowing are explicit and open for conscious reflection we have used Habermas' three categories of knowledge-constitutive interests which he argues are integral to human existence. These three categories he identified as "technical", "practical" and "emancipatory". (Habermas, J., 1971).

Each of these knowledge interests articulate essential ways of knowing which is integral to nursing practice.

Technical knowledge interests derive from empirical analytic inquiry and is;..."..typically instrumental knowledge taking the form of scientific explanations. "(Carr & Kemmis. 1986. p 135) These explanations provide nurses with essential

knowledge of the psychobiophysical, as well as an understanding of instrumental methodologies and process which are integral aspects of nursing practice.

Practical knowledge interests derive from the hermeneutic or interpretive paradigm. Typically it takes the form of phenomenological inquiry which explores and articulates the meaning of the lived experience for self and others.

"It is distinguished from technical cognitive interest in that it aims not at comprehension of an objective reality but at the maintenance of the intersubjectivity of mutual understanding." (Habermas, J., 1971. p 176).

It is through the insights gained from the phenomenological paradigm that nurses are able to articulate the core value of caring in nursing practice.

Emancipatory knowledge interest arises from a critical paradigm. Habermas argued that the interpretive paradigm was an insufficient explanation because it ignored the way people's understanding of their lived experience was itself shaped by the social structures and constraints. (Carr & Kemmis ibid.) Emancipatory knowledge is possible when people engage in a discourse which challenges dogma and received wisdoms.

"Discourse helps test the truth claims of opinions (and norms) which the speakers no longer take for granted. In discourse the force of the argument is the only permissible compulsion, whereas cooperative search for truth is the only permissible motive." (Habermas, J., 1971. p 168).

In the context of the relational, when "undistorted" communication occurs people can realise their potential to fully act as autonomous rational decision makers. It is the inclusion of emancipatory knowledge that moves us past the didactic limitations of power and powerlessness, and into a dialectic model of empowerment from which transformative partnership can emerge.

It is this illuminated concept of partnership which links the emancipatory potential of the Treaty of Waitangi with the emancipatory potential of the teaching/learning relationship, and the emancipatory potential of the nurse/client relationship.

TECHNICAL KNOWLEDGE AND NURSING

Critically reflecting on the limitations of positivist science as a 'single world view' enables us to articulate both the relationship of science within the curriculum, and the nature of power relations existing between "teachers" and "learners".

Like most industrially developed countries, New Zealand has gained much from the application of knowledge gained from positivist science. However as Carr and Kemmis (1986) argue;

"Science had become an ideology culturally produced and socially supported unexamined way of seeing the world which shapes and guides social action." (p 1 321)

In developing our curriculum we have recognised that a "single world view" based on an empirical behaviourist approach to teaching and learning is an inadequate

basis to prepare students for nursing practice. There are two major limitations to curricula which rely solely on an empirical approach.

The first serious limitation is that empirical explanations are themselves limited. Again to quote Carr and Kemmis;

"... to claim that the label "Knowledge" can only be ascribed to that which is founded in 'reality' as apprehended by the senses,(is in effect to say) that value judgements, since they cannot be founded on empirical knowledge, cannot be given the status of valid knowledge. (ibid. pp 61-621).

We would argue that one of the important outcomes of this curriculum is in fact to produce beginner nurse practitioners who are able to make sound value judgements in relation to client care. To rely solely on an empirical behaviourist paradigm would be to create a serious paradox between what we teach and what we intended to achieve. Bevis (1989) has lucidly argued that when nursing curricula depend on a behaviourist approach, illegitimate and hidden curricula are employed to circumvent the inadequacies of explanations deriving from this empirical paradigm.

The second limitation to behaviourist curricula is that they become what Friere has described as a "banking" model of education. (Friere, P. 1972) That is to say a model of education in which the teacher has all the 'knowledge' which they 'deposit' in students who are deemed to have no knowledge. It is this model of education which has been challenged by many critics on the grounds that it has become one of the principle mechanisms by which dominant ideology is reproduced by obscuring the nature of the power relations in the teaching/learning context.
(eg Friere, P. 1972, Gramsci, A. 1971, Bourdieu, P. 1973, Apple, M. 1979.)

It is these insights, along with their lived experience which has in recent years caused Maori to question the adequacies of the education system to meet their needs and aspirations. Similarly, authors such as Belenky, M. et al (1986) have challenged this model of education from a feminist perspective. And this same challenge has been raised by nurses who have questioned the adequacies of this model of education to prepare students for nursing practice. (Bevis, E. & Watson, J. 1989, Perry, J & Moss, C. 1989, Clare,J. 1991. Dixon, A. 1991.)

In addressing this limitation we acknowledge our obligations and responsibilities of Kawanatanga in this curriculum. The curriculum describes the "ordered system", and states under what authority actions are taken in order that accountability may be defined.

The boundedness of the concept of Kawanatanga as it relates to the role of the "teacher" in this curriculum, arises from the interpretation of Governorship as authoritative responsibility and obligation to "students" rather than authoritarian privilege. From this stance, Tutors model the way "governance" translates into a social contract of competency for the professional responsibilities and obligations of safe nursing practice.

In this curriculum technical interests are reflected in a strong Bioscience focus and technical nursing skills.

ARTICLE THE SECOND AND FOURTH

TINO RANGATIRATANGA/AUTONOMY

At the very least the second article of the Treaty articulates the right of Maori to maintain their separate identity as Maori. The Crown guaranteed to protect those

institutions, customs and artefacts by which Maori express and know themselves as Maori. We have interpreted Tino Rangatiratanga to mean the right to be self governing and self determining, and use the term "Autonomy" to represent this meaning.

Hoagland (1988) describes the Kantian view of autonomy as the need for people to rise above their nature and through the use of pure reasoning determine what to do and by exercising their will do their duty. Fay (1987) presents the existentialist view of autonomy as defined by Sartre as the freedom from the illusion that our actions are dependent on external forces or other people. According to this view of autonomy we are condemned to freedom. The autonomous person knows that they alone are responsible for the decisions they make from an infinite range of possibilities. (p 201)

A third sense of how the term autonomy has been defined is that suggest by Rousseau. He argued that autonomy represented moral liberty. That is, the autonomous person is one who acts on the basis of ones best judgement as to what one should do. A person is self determining in the sense that who one is and what one does is as a result of ones own voluntary discretion. (Fay. 1987. p 76).

Hoagland challenges the Kantian view of autonomy as freedom from ones emotions, and the radical autonomy of the existentialists, and appears to argue a view of autonomy similar to the Rousseau explanation.

She proposes that autonomy may be defined as the self conscious sense of ourselves as moral agents. She extends the concept of autonomy (self governing) to include the idea of autonomous individuals in community by coining the term "auto koenony", that is self in community. Auto (self) and koenonia (community, or any group whose members have something in common).

"The self in community involves making choices, it involves us having a self conscious sense of ourselves as moral agents in a community of other self conscious moral agents."
(Hoagland. 1988. p 451.)

This idea of self in community is expanded upon by Fay who argues that:

"Collective autonomy involves a group of people determining on the basis of rational reflection the sorts of policies and practices it will follow and then acting in accordance with them." (Fay. 1987. p 77)

In relating these different perspectives back to the Treaty, we argue that autonomy expressed as Tino Rangatiratanga, is the possibility Maori people have to critically reflect on what it is to be Maori within the context of the dialectic tension between Kawanatanga, and Tino Rangatiratanga.

It is in the space between Kawanatanga and Tino Rangatiratanga that all of the relational possibilities can be realised. It is from the Treaty that we take this model of the way "partnership" can emerge from a transformative relationship in which "self' and "other" are mutually constitutive.

In his discussion of Buber's conceptualisation of the I-Thou relational, Geering captures the essence of this potential.

" In the beginning there is neither I nor Thou but the primal relation we may call I-Thou. It is out of such a relation that the I grows to become a self conscious

reality. Moreover, it is only through a Thou that a person develops a clear sense of self identity: and this happens to one as an act of grace."
(Geering. 1983. p 27)

We would argue that the Treaty provides an opportunity for this relational possibility to exist between Maori and non Maori, and to symbolically represent the transformative potential of all relationships.

If it is an act of grace to recognise that the "I" needs the "other" in order to know "self" then it is the act of an autonomous, self conscious moral being to accept responsibility for what they bring to the relational.

Understanding the shared meanings of people's lived experience, and the choices they make, forms the basis for Habermas' claim that this constitutes a practical knowledge interest.

PRACTICAL KNOWLEDGE INTERESTS AND NURSING

If technical knowledge enables us to develop universal laws of probability, then practical knowledge enables us to understand through interpretive theory the meanings people make of their lived experience.

"Lived experience is the way people encounter situations in terms of their own personal concerns, background meanings, temporality, habitual, cultural bodies, emotions and reflective thought. "
(Benner & Wrubel. 1989. p 410)

The significance of practical knowledge to nursing practice is that through the use of interpretive methodologies such as phenomenology, nurses are able to surface the central caring value of nursing practice. Patterson & Zderad (1976), Watson (1985), Benner & Wrubel (1989), and Bishop & Scudder (1991) have all provided examples of thick descriptions of the way caring is critically and fundamentally a process involving the relational between nurse and client.

Nursing begins with a moral disposition "to care". Using an ontological interpretation of caring as a fundamental human way of being in the world, Bishop and Scudder (1991) draw a Heidegarrian distinction between caring that creates dependency and "authentic caring".

"... authentic care occurs when the care giver will 'leap ahead' in his existential (sic) potentiality-for-Being, not in order to take away his "care" but rather to give it back to him authentically. Thus, in authentic care the other is helped to care for his or her own being." (Bishop & Scudder. 1991. p 57)

The significance of the distinction between caring which is dependency creating and caring which is authentic, is that dependency creating care inevitably involves a "power-over" relationship. Authentic care is "an act of grace", in that the power in the relational is an enabling power, a "power-to".

We would argue that a prerequisite for understanding the full potential of what it means "to care" is the development of an autonomous self as defined by Hoagland. That is that "authentic caring" can only be undertaken by people who have developed a self conscious sense of themselves as moral agents. It is our

contention that authentic caring for self precedes the possibility of authentic caring for others. Within this curriculum students are guided through a reflective process of exploring their own lived experience, in relation to others. From this platform, students begin the exploration of the meaning of authentic caring for self and others, for the I-Thou within a nursing context, using the knowledge from the interpretive paradigm to inform them.

While knowledge from the interpretive paradigm is a necessary aspect of nursing knowledge, it is no more sufficient an explanation of the complexities of nursing practice than knowledge from the technical paradigm. To argue that the one or the other is a better foundation for nursing practice is to deny ourselves the opportunity to use both kinds of knowledge. The transformative power of the relational is diminished when it is represented as a reductionist argument of either/or. That is to say that neither the knowledge from the technical , nor the interpretive is sufficient to explain the relational.

In relation to the Treaty this point is most aptly put in a submission to the Waitangi Tribunal from the Manakau claim:

".. As things are, the local tribes have no status. Continually they feel it to be pressed upon them that they have only two options- to capitulate to Western ways, which they refuse to do, or cling to past ways in the belief that they contain fixed and uncompromising truths freed from the challenge of change. We believe there is a better option." (Cited by William Renwick. 1990. p 42).

In relation to an educational curriculum, Bawden argues that this reductionist logic has become a

".. conflict around the relative importance of knowing versus doing. It has indeed become an issue of competitive exclusion- Knowing has become divorced from doing and vice versa, and indeed has been placed in opposition to it. (Bawden. 1993. p 1)

Within Nursing this same argument takes the form of the a debate between "theory" versus "practice", and between the "ethic of efficiency" and the "ethic of caring".

What is required to move beyond this sterile binary trap is a way of conceptualising the relationship between Kawanatanga and Tino Rangatiratanga, between knowing and doing, and between theory and practice.

We believe the third article of the Treaty moves us beyond the binary trap of either/or, and enables us to explore the "other options", the other potentialities.

In this curriculum practical interests are reflected in the emphases on personal growth and communication skills, and an acknowledgment of the significance of the meaning that individuals have of their own lived experience.

ARTICLE THE THIRD

KIA RITE TAHI/EMPOWERMENT

The third article brings the concept of Kawanatanga into relationship with Tino Rangatiratanga. It articulates two obligations of the Crown to Maori, and by inference suggests the responsibility of Maori to the Crown. The first obligation was that the Crown would protect Maori people. We interpret this obligation from a deontological perspective of non maleficence, that is an obligation to do no harm. The second obligation was that the Crown would invest Maori people with the same

rights of citizenship as all other people within the Crowns jurisdiction. This second obligation we interpret as a right of inclusion.
The significance of defining protection and inclusion is that it places some boundaries on the nature of the relationship formed by the two parties to the Treaty. The notions of protection and inclusion oblige the Crown to remain in the partnership with Maori. At the same time it may be argued that by accepting the rights of citizenship, Maori also accept the responsibility to participate,and thereby setting some limits to their autonomy.

The three articles of the Treaty of Waitangi create the possibility of a partnership between the founding peoples of New Zealand. Our understanding of the partnership between Maori and non Maori acknowledges past power relations of dominance and subordination, and the effects that this history has had on the way we express ourselves as New Zealanders. In the past we would argue that the denial of the significance of the Treaty by Tau Iwi has led to injustices and social inequities for the Tangata Whenua. A relationship built on hegemonic privilege is oppressive to all in the relationship because it limits human potential.

When we begin to understand through critical reflection that the Treaty enables both 'partners' to define themselves in relation to the other, then the whole concept of partnership becomes one of emancipatory potential. This potential occurs when people are able to engage in what Habermas defined as the undistorted communication of discourse. When discourse occurs all of the dialectical possibilities are attendant in a relational in which authentic self engages with authentic other to act. Empowerment is achieved when this emancipatory potential is realised.

EMANCIPATORY KNOWLEDGE INTERESTS AND NURSING

Bawden argues that the reductionist trap can be avoided through the realisation that the relationship is triangular not binary. In his formulation the triangle is defined at each apex by 'theory", "practice" and "praxis".

"As a Trinity (these concepts) reflect a set of interrelated processes where no one element is prime, but each contributes to, and indeed participates in the others in affecting their very essences and creating a dynamic learning system." (Bawden. 1993. p 2.)

Similarly, Bishop and Scudder reconceptualise Buber's I-Thou, I-It from a binary dialogue to a "triadic dialogue", by including the "It" world into the relational between the "I and Thou".

"Triadic dialogue is constituted by the relationship of two partners to the events in the world, as well as their relationship to each other." (Bishop & Scudder. 1991. p 83)

We would argue then that emancipatory knowledge within the curriculum enables tutors and students to engage in dialogue which surfaces the contradictions between "theory" and "practice", by reflecting on their own understanding and experience in such a way that new questions and therefore possibilities emerge. According to Perry and Moss (1989) this becomes a transformative process because "ideal-real" dichotomies are able to be made explicit and therefore open to critique. It is this transformative potential which Friere (1972) calls praxis and which we derive from the Treaty partnership as empowerment.

It is this transformative potential of the relational which we take from the Treaty and embed in our curriculum to illuminate the teaching/learning partnership, and the nurse/client relationship in nursing practice.

In this curriculum emancipatory interests are reflected in the strong emphasis on critiquing Maori access to health, and sociological concepts relating to disadvantage, which create structural barriers to full and equitable access to health care.

REFERENCES

Apple, M. W. (1979). Ideology and curriculum. Routledge and Kegan Paul.

Bawden, R. (1993). Praxis: The essence of systems for being. In Alison R. Viskovic, (Ed.), Research and development in higher education (pp 1-7). HERDSA (Inc).

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). Women's ways of knowing: The development of self, voice, and mind. NY: Basic Books.

Benner, P. & Wrubel, J. (1989). The primacy of caring: stress and coping in health and illness. California: Addison-Wesley.

Bevis, E. (1988). New directions for a new age. Curriculum revolution: mandate for change. N.Y.: National League for Nursing.

Bevis, E. & Watson, J. (1989). Towards a caring curriculum: A new pedagogy for nursing. N.Y: National League for Nursing.

Bishop, A., & Scudder, J. (1991). Nursing: The practice of caring. N.Y.: National League for Nursing.

Bourdieu, P. (1973). Cultural Reproduction and Social Reproduction. In Richard Brown (Ed.), Knowledge, education and cultural change. Tavistock.

Buber, M. (1970). I and thou, Trans. W.Kaufmann, T & T Clark, Edinburgh.

Carr, W., & Kemmis, S. (1986). Becoming critical: Education, knowledge and action research. Victoria, Australia: Deakin University Press.

Clare, J. (1991). Transforming health care: Does nursing theory have anything to offer? Nursing Praxis in New Zealand. 6 (2):5-9.

Dixon, A. (1991). Bachelor of Nursing and Midwifery curriculum. Otago Polytechnic.

Fay, B. (1987). Critical social science. Oxford: Polity Press.

Friere, P. (1972). The pedagogy of the oppressed. N.Y.: The Seabury Press.

Geering, L. (1983). The world of the relation: An introduction to Martin Buber's I and Thou. Victoria University Press.

Gramsci, A. (1971). Selections from the prison notebooks. Q. Hoare and Geoffrey Nowell-Smith (Eds.). N.Y.: International Publishers.

Habermas, J. (1971). Knowledge and human interest. (Trans. J. Shapiro). Boston: Beacon Press.

Hoagland, S. L. (1988). Lesbian ethics: Towards new value. Institute of Lesbian Studies. Palo Alto, California.

Paterson, J. G., & Zderad, L. T. (1976). Humanistic nursing. N.Y.: Wiley.

Perry, J., & Moss, C. (1989). Generating alternatives in nursing: Turning curriculum into a living process. The Australia Journal of Advanced Nursing. 6 (2):33-40.

Renwick, W. (1990). The Treaty Now. Government Print Publications.

Watson, J. (1985). The moral failure of the patriarchy. Nursing Outlook. 38 (2):62-66.

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APPENDIX 111
INFORMATION SHEET

TO EXPLORE THE EXPERIENCE OF CRITICAL INCIDENT STRESS-DEBRIEFING ON FIREFIGHTERS WITHIN A REGION OF THE NEW ZEALND FIRE SERVICE.

Researcher: Julie Maher, Programme Manager,
Level 3 Bachelor of Nursing Programme,
Whitireia Community Polytechnic, Porirua.
Telephone 237.3103 ext.3738.

I am asking you to consider being part of a research project I am doing for my thesis for a MA in Nursing at Victoria University. This information sheet gives you information about the project to help you decide whether you wish to be involved.

I am interested in finding out more about the experience of participating in a Critical Incident Stress Debriefing (C.I.S.D.) for firefighters. No studies have been carried out within the New Zealand culture and ever changing workplace of the New Zealand Fire Service. By talking with firefighters like yourself it will be an ideal opportunity of gaining further information and understanding of the concept.

This study forms the basis of a MA Thesis to be conducted by myself, Julie Maher, through the Department of Nursing and Midwifery, Victoria University of Wellington. My supervisor is Margi Martin, Senior Lecturer from the Department. I am a Registered General and Obstetric Nurse and was employed in the No.4.Region of the New Zealand Fire Service from 1988 - 1993. I am currently employed as a Nursing Lecturer in the Bachelor of Nursing Degree programme at Whitireia Community Polytechnic. I have been and remain an active member of the C.I.S.D.Peer Support Team for the last 8 years.

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2/. (Information sheet continu'd).

If you choose to be a participant in the research project your position within the New Zealand Fire Servie will not be adversely affected.

It is important that you are willing to openly and honestly talk about your experience of debriefing. You have the right to refuse to answer any particular questions. If during the course of the study you no longer wish to participate, you have the right to withdraw at any time.

Confidentiality will be maintained at all times throughout the process and anonymity will be adhered to in the final draft of the Thesis and any publications or conference presentations arising from this. You will be allocated a pseudonym to which only you and I will have access to. The transcripts will be typed by a third person who will sign a confidentiality agreement.

The aim of this study is to assist the researcher in understanding the experience of being a participant in a C.I.S.D. The researcher would like to interview 3 - 6 firefighters who have participated in a C.I.S.D. Knowledge gained from the study may benefit the health and welfare of firefighters and may also assist the C.I.S.D.Peer Support Teams provide a more effective programme.

The study has been approved by the Central Regional Health Authority Wellington Ethics Committee, Victoria University of Wellington Ethics Committee, the National Office, the National Firefighter's Union, the United Fire Brigade's Association and the C.I.S.D.Peer Support Team in the Central Region.

STUDY PROCEDURE

If you choose to participate in this study I would meet with you on three separate occasions over a period of 6 - 8 weeks. Each meeting is expected to last up to an hour.

Within the next 24-48 hours I will telephone you to ask if you are willing to participate in the study and address any questions you may like to ask. If you are unwilling or unable to participate then I thank you sincerely for considering my request and for taking the time to read this information sheet.

If you are willing and able to participate in the study I will arrange a time and place suitable to yourself for the first interview within 7-10 days.

3/. (Information sheet continu'd).

At the first interview I will discuss the aims and objectives of the study, what your involvement entails and address any questions or concerns you may have. Following this you will be asked to sign a consent form. After this, the first interview will begin. Each interview will be audio-taped, with your permission, and the transcript, written conversation, will be given to you to verify that the statements are an accurate reflection of what you wanted to say.

A second interview will be arranged approximately 3-4 weeks later at a time and place suitable to yourself. The audio-tapes and transcripts will be made available for you to view, verify or change. Further questions will be asked which will hāve been generated from the analysis of the first interview.

A third and final interview will follow approximately 2 weeks from the last interview. The audio-tapes and transcripts will be made available for you once again to view, verify or modify the information. This will be a time for you to ask any questions, concerns or queries you may have, not dissimilar to a debriefing. At the completion of the study your tapes and transcripts will be returned to you or destroyed, whatever you indicate.

Thank you for taking the time to read this information sheet and for considering my request. Please do not hesitate to contact me by telephoning me on 4738.064(H) or 237.3103ext.3738(W).

If you have any concerns about this study you may contact the Chairperson, Central Regional Health Authortiy, Wellington Ethics Committee, Wellington Hospital, Private Bag 7902, telephone 3855.999 ext.5185 or by Fax 385.5840.

If you wish to contact my supervisor regarding this research please telephone Margi Martin, Department of Nursing and Midwifery, Victoria University tele.4721.00.

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APPENDIX IV

CONSENT TO PARTICIPATE IN THE STUDY.

TO EXPLORE THE EXPERIENCE OF CRITICAL INCIDENT STRESS DEBRIEFING ON FIREFIGHTERS WITHIN A REGION OF THE NEW ZEALAND FIRE SERVICE.

PRINCIPAL RESEARCHER/INTERVIEWER: Julie Maher (M.A.student, Department of Nursing and Midwifery, Victoria University of Wellington).

RESEARCH SUPERVISOR: Margi Martin, Senior Lecturer, Department of Nursing and Midwifery, Victoria University of Wellington.

TIME AND PLACE OF INTERVIEWS: As convenient to the participant.

AIMS AND PURPOSE OF THE RESEARCH:
This study aims to gain meaning and understanding of the experiences of firefighters who have participated in a Critical Incident Stress Debriefing. Potential benefits of this research is to gain a better understanding of the process and its value or lack of value in order to sustain, reshape or remove the present model. Not only will it benefit firefighters but benefit other occupational groups especially in the emergency and health areas.

PARTICIPANTS' COMMITMENTS IN PARTICIPATING IN THE STUDY:
You are asked to meet with the researcher on three occasions in which the interviews will be audio-taped and later transcribed by a transcriber. The audio-tapes and transcriptions will be locked away when not in use and will be destroyed at the end of the study. You may withdraw from the study at any time if you so wish.

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2/. (Consent form continu'd).

ANONYMITY ASSURANCE:
Anonymity will be adhered to so that a pseudonym will be used on any audio-tapes or transcripts, which only yourself and the researcher will be able to identify. Field notes and transcripts will be kept in a safe and secure place where access will be restricted to the researcher, transcriber, supervisor and examiners. All information will be kept confidential at all times and on no account will any information be given to any personnel within the New Zealand Fire Service. Your participation in the study will have no detrimental effect on your employment within the Service. If during the course of the study it becomes evident that you are suffering any ill effects by your participation, with your permission you be supported to seek assistance from a health professional and your participation in the study will be terminated. The experience of ill effects, will in the first instance be determined by yourself, and I will make time before each interview to allow for discussion as to your general health and wellbeing.

INFORMATION DISSEMINATION:
All interviews will be audio-taped, transcribed and presented to verify, modify or withdraw any information you do not wish to remain. The final draft will be reported in an anonymous manner. The final draft will be held in the library at Victoria University of Wellington. A copy of the Thesis will be given to your when it is written.

STATEMENT BY PARTICIPANT:

"I have read the information sheet and have all the details of the study explained to me by Julie Maher. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time."

"If I agree to participate I have the right to withdraw from the study at any time and to decline to answer any particular questions."

"I agree to provide information to the researcher on the understanding that my name will not be used without my permission. (The information will be used only for this research and publications/presentations arising from this study)."

I AGREE TO TAKE PART IN THIS STUDY

Signature of participant ..... Date.....

Witness name: ..... Date.....

3/. (Consent form continu'd).

Researcher declaration

I have discussed with .....(participant's name) the aims and procedures involved in the study.

Signature of researcher ..... Date.....

Three copies required: 1 retained by participant; 1 retained by the researcher; 1 for records.

APPENDIX V

TRANSCRIBER CONFIDENTIALITY AGREEMENT

TO EXPLORE THE EXPERIENCE OF CRITICAL INCIDENT STRESS DEBRIEFING ON FIREFIGHTERS WITHIN A REGION OF THE NEW ZEALAND FIRE SERVICE

This is to certify that I,

NAME .....

ADDRESS .....

.....

.....

TELEPHONE NUMBER .....

"I am the transcriber for the above-mentioned research study.

I understand that the information contained in the study audio-tapes I am to transcribe is to be kept confidential.

I agree to maintain confidentiality by not disclosing any aspects of the audio-tapes or typed transcripts with any other persons at all times other than with the researcher.

Audio-tapes, transcripts and computer discs will be returned to the researcher as soon as they are finished with".

DATE: .....**of**.....**1998.**

SIGNATURE: .....

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