PASTORAL CRISIS COUNSELING

INTRODUCTION

In our world today, faith-based Pastoral care is unfortunately underutilized and misunderstood during times of grief, apprehension, violence, disasters and terrorism.

As a post-911 society, there is a tremendous need for pastoral support and care for those affected by traumatic situations throughout the world.

Pastoral care has primarily been associated with church attendance. Many have the misconception that if you don't attend or belong to a specific church, pastoral care is not available. Pastoral care-givers who become part of the survival process far out reach that concept today. Chaplain care-givers potentially provide much needed support in times of crisis and disaster to anyone who needs it, whether they are part of the same faith or not.

Dedicated pastors are often called upon to be an integral part of the healing process after a traumatic event or disaster and, through their love of others and the desire to do God's work, become the spiritual backbone to recovery. The question for pastoral counselors today is how we respond during the post-911 era.

Understanding the need for Pastoral care has become paramount throughout the last 10 years due to so many deadly disaster and crisis associated events. However, the lack of training for pastoral counselors in the area of crisis intervention has put an additional burden on our response.

As part of seminary and religious training, we focus on our beliefs and practices for providing spiritual mental health associated with the "front lines" of grief, helplessness, trauma, violence and disaster and practice an on-going faith-based response.

Research shows that most people would rather receive counseling from the clergy than from of a medical doctor or psychologist and usually respond better because of the pastoral presence-listening techniques used. The present demand for Chaplain care-givers is growing daily.

Over the last several years intense training and education has been offered to Pastoral care givers to help bridge the gap between the victims of the crisis and a complete recovery.

We are very pleased that you have chosen to further your education in chaplaincy by becoming a certified chaplain crisis counselor. Please take your time and do not rush through this material.

Bless you

Dr. Donald Gibson
Dr. Bruce Francis

Course Title: Chaplain Crisis Counseling Total Hours: 20

Mandatory Grade: 80%

Chapter One:

The student will utilize critical thinking skills in assessing the dynamics of the crises
The student will identify the crisis theory when affecting crisis behavior
The student will recognize human nature during crisis intervention.
The student will identify the "crisis of faith" response during trauma

Chapter Two:

The student will be able to recognize the social impact during crisis incidents
The student will be able to recognize signs and symptoms associated with a crisis
The student will acknowledge caution indicators associated with a crisis

Chapter Three:
The student will be able to evaluate a person in a crisis
The student will be able to evaluate the crisis situation
The student will recognize the best approach for assessment.

Chapter Four:
The student will know the difference in CISM debriefings/defusing
The student will identify debriefing and defusing procedures
The student will identify the importance of follow-up procedures

Goal:

To convey the importance of Crisis counseling and Intervention and explain the need for such training, acknowledge prior historical problems associated with Emergency Personnel. To express the importance of Chaplains, Teachers, and emergency response personal understanding the communications necessary during a crisis or disaster incident. To give an explanation of the benefit of Crisis Counseling and Intervention.

Chaplain Crisis Counseling

Goal: To increase awareness and understanding of some basics of Chaplains Counseling during Crisis Intervention.

Crisis Counseling Event: Any event where a chaplain responds to a request for crisis counseling during, or after a critical incident, including but not limited to a life-threatening occurrence, accident, criminal incident or disaster.

Possible Additional Required Responses by:

1. Law Enforcement
2. Fire Service
3. Emergency Medical Service
4. Emergency management Service
5. 911 Communications Personnel
6. Public Informational Services
7. Additional chaplaincy Personnel
8. Public safety chaplain services
9. Church Service Personnel
10. Citizen Response

Suggested Reading:

1. Counseling Survivors of Traumatic Events by Author(s) Andrew J. Weaver, Laura T. Flannelly, John D. Preston

2. Pasturing Children by Author Dick Gruber: All requests for assistance during a traumatic event or disaster must be channeled through the proper authorities as mandated by State, Federal or Local governments.

CRISIS COUNSELING AND INTERVENTION HISTORY

These milestones in the historical development of the field of crisis intervention have served to shape its nature and provide useful insight into its current status. The field of crisis intervention represents an endeavor characterized by the provision of urgent and acute psychological “first aid”. There are many important dates in history that show examples when crisis counseling become necessary

1993: First World Trade Center bombing

1995: Bombing of Murray Federal Building in Oklahoma City clearly shows a need for crisis services for victims and responding personnel.

1996: TWA 800 mass air disaster emphasizes the need for emergency mental health services for families of the victims of traumas and disasters.

1996: OSHA 3148-1996 recommends violence/crisis intervention in healthcare and social service agencies.

1997: Gore Commission recommends crisis services for airline industry. ICISF gains United Nations affiliation in 1997.

1997: AFI-153 mandates establishment of crisis programs for US Air Force bases worldwide.

1998: Spiritual care team established by Red Cross

1998: OSHA 3153-1998 recommends crisis intervention programs for late night retail stores.

1999: COMDINST 1754.3 requires the establishment of a CISM team for US Coast Guard.

1999: Department of Defense Directive 6490.5 establishes policy and responsibilities for developing Combat Stress Control (CSC) programs throughout the US military

1999: Columbine high school shooting leads to a re-examination of youth and school violence issues and an increase in the establishment of school crisis response programs.

2001: World Trade Center over 3000 fatalities caused re-examination of CISM teams available.

2001: Mail based anthrax fatalities emerge

THE CRISIS THEORY

There are many different definitions of crisis. Resource studies find definitions such as:

A crisis is any situation for which a person does not have adequate coping skills. Therefore, crisis is self-defined. What is a crisis for one person may not be a crisis for another person.

Crises may range from seemingly minor situations, such as not being prepared for class, to major life changes, such as death and divorce. Crisis is environment based. What is now a crisis may not have been a crisis before or would not be a crisis in a different setting.

“People are in a state of crisis when they face an obstacle to important life goals and that obstacle is, for a time, insurmountable by the use of customary methods of problem solving.”

“An upset in equilibrium at the failure of one’s traditional problem-solving approach which results in disorganization, hopelessness, sadness, confusion, and panic.”

“Crisis is a perception or experience of an event or situation as an intolerable difficulty that exceeds the person’s current resources and coping mechanisms”.

In mental health terms, a crisis is not necessarily in a traumatic situation or event, but in a person’s reaction to the event. One person might be deeply affected by an event, while another individual suffers little or no ill effects.

The Chinese word for crisis presents a good depiction of the components of a crisis. The Chinese may say it best: crisis in Chinese is formed with the characters for danger and opportunity. A crisis presents an obstacle, trauma or threat, but it also presents an opportunity for either growth or decline.

There are many types of crisis counseling subjects that help assist in facing not only the danger of a crisis but the reaction. The chapter that follows is a listing of just some of the subject that will be covered by the pastoral counselor.

Chaplain Crisis Counseling is performed by a professional faith based counselor who upholds Christian values, beliefs and philosophy.

Clients may see Chaplain Crisis Counseling as a relationship with a caring counselor directed toward increased awareness of themselves, others, the societies and cultures in which they live, and their understanding of the God. It is often focused on solving the individual problems of the person needing crisis counseling services.

Depending on the clinical perspective informing any given Christian counselor's integration, this process may take various avenues and target diverse goals.

Clients may be more comfortable with a Christian counselor, and they may feel such a person's advice is more sensitive to their personal or religious needs. Some clients also wish to use the Bible as a reference for their therapy. For some, prayer enters into the counseling process as well.

A degree in "Christian Counseling" is not required; however, ethical and professional standards suggest that someone holding him or herself out to be a Crisis Counselor would have become competent.

Crisis Counselors can be -- but are not required to be – Chaplains, Ministers, Pastors, Priests, psychologist, psychiatrist, Licensed Mental Health Counselor, Licensed Professional Counselor, Marriage, Family and Child Counselor or a Certified Addictions Therapist.

Christian Chaplain and secular counselors both counsel from a professional standpoint: they adhere to ethical codes, professional standards, often utilize supervision, and consult appropriate diagnostic texts such as the Diagnostic and Statistical Manual of Mental Disorders.

Christian Chaplain counselors are distinguished from other counselors in that they utilize the Christian Bible as a strong source of therapy, as their patients are likely studied in, or at least receptive to, its dictates.

Persons may consider counseling itself as a form of discipleship or ministry by which they serve others in the name of Christ. Although there are differences between secular and Christian counseling, both utilize the same models of therapy (i.e. Cognitive Behavioral Therapy, Gestalt Therapy, etc.).

Chaplain Crisis counseling is a branch of counseling in which ordained chaplains, ministers, rabbis, priests and others provide faith based therapy services. Practitioners in the United States are subject to the standards of the American Association of Pastoral Counseling and many are either licensed as an LPC or LMFT as well.

Most state laws require pastoral counselors to have secular counseling licenses in order to provide mental health services or therapy.

Insurance companies often will not pay for pastoral counseling of counselors without state licensing.

Pastoral care: Pastoral care is the ministry of care and counseling provided by pastors, chaplains and other religious leaders to members of their church, congregation or persons within a faith-based institution.

This ministry can range anywhere from home visitation to formal counseling provided by pastors, chaplains, ministers and priest who are licensed to offer counseling services. This is also frequently referred to as Spiritual Care.

'Pastoral care' is also a term applied where Christians offer help and caring to others in their church or wider community. Pastoral care in this sense can be applied to listening, supporting, encouraging and befriending.

Pastoral care can also be a term generally applied to the practice of looking after the personal and social wellbeing of children under the care of a teacher.

It can encompass a wide variety of issues including health, social and moral education, behavior management and emotional support is often synonymous with pastoral care.

COMMON AREAS OF COUNSELING

1. Emotional conflict
2. Conflict resolution
3. Conflict resolution research
4. Dispute resolution
5. Problem solving
6. Creative problem solving
7. Mediation
8. Reconciliation
9. Dialogue
10. Family therapy
11. Responsibility assumption
12. Transtheoretical Model
13. Multitheoretical Psychotherapy
14. Interpersonal communication
15. Intrapersonal communication
16. Nonverbal communication
17. Nonviolent communication
18. Stress management
19. Experiential education
20. Human Potential Movement
21. Self-help
22. Health psychology
23. Social psychology (sociology)
24. Social psychology (psychology

Emotional conflict: Emotional conflict is the presence in the subconscious of different and opposing emotions relating to a situation that has recently taken place or is in the process of being unfolded, accompanied at times by a physical discomfort and in particular by tension headaches

TRIGGERS: Situations which cause emotional conflicts can be everyday occurrences which might seem at the time unimportant; as in the case of having to decide whether or not to accept an invitation to dinner, where a person we don't like or wish to see is likely to be, but where another family member whom we do wish to see is likely to be as well, or when there is an underlying anger against a friend or a family member that we are unable or afraid to express for fear of hurting their feelings, and therefore repress, or when we are doing something we don't like and resent having to do.

SYMPTOMS: Inner emotional conflicts can sometimes result in physical discomfort or pain, often in the form of tension headaches, the duration of which can range from a few minutes to days and in some cases even months, but would normally be a few hours.

These tension headaches can be episodic or chronic, with episodic normally occurring less than 15 days a month, and chronic occurring 15 day or more a month and sometimes stretching over a few months.

The pain associated with Tension headaches is normally mild to moderate, but can be severe

POSSIBLE REMEDY: Physical discomfort or pain without apparent cause is the way our body is telling us of an underlying emotional turmoil and anxiety.

One way of dealing with such physical manifestations is by becoming aware of the real life conflict that triggered them.

While it is not easy, and at times might even seem impossible, by relaxing, calming down, and trying to find out what recent experience or event could have been the cause of our inner conflict, by bringing these underlying conflict to our awareness, by rationally looking at and dealing with the conflicting desires and needs, a gradual dissipation and relief of the pain is possible.

CONFLICT RESOLUTION: Conflict resolution is the process of attempting to resolve a dispute or a conflict. Successful conflict resolution occurs by listening to and providing opportunities to meet the needs of all parties, and to adequately address interests so that each party is satisfied with the outcome.

Conflict Practitioners talk about finding the win-win outcome for parties involved, vs. the win-lose dynamic found in most conflicts. While 'conflict resolution' engages conflict once it has already started , 'conflict prevention' aims to end conflicts before they start or before they lead to verbal, physical, or legal fighting or violence.

Conflict itself has both positive and negative outcomes. Practitioners in the field of Conflict Resolution aim to find ways to promote the positive outcomes and minimize the negative outcomes.

There is a debate in the field of conflict work as to whether or not all conflicts can be resolved, thus making the term conflict resolution one of contention. Other common terms include Conflict Management, Conflict Transformation and Conflict Intervention.

Conflict management can be the general process in which conflict is managed by the parties toward a conclusion. However it is also referred to as a situation where conflict is a deliberate personal, social and organizational tool, especially used by capable politicians and other social engineers.

Conflict Practitioners work on conflict in many arenas - internationally, domestically, interpersonally and interpersonally.

AMONG GROUPS: Conflict resolution processes can vary. However, group conflict usually involves two or more groups with opposing views regarding specific issues. There is often another group or individual (mediator or facilitator) who is considered to be neutral (or suppressing biases) on the subject.

This last bit though is quite often not entirely demanded if the "outside" group is well respected by all opposing parties. Resolution methods can include conciliation, mediation, arbitration or litigation.

These methods all require third party intervention. A resolution method which is direct between the parties with opposing views is negotiation. Negotiation can be the 'traditional' model of hard bargaining where the interests of a group far outweigh the working relationships concerned.

The 'principled' negotiation model is where both the interests and the working relationships concerned are viewed as important. Often, face saving and other intangible goals play a role in the success of negotiation.

It may be possible to avoid conflict without actually resolving the underlying dispute, by getting the parties to recognize that they disagree but that no further action needs to be taken at that time.

In many cases such as in a democracy, a dialogue may be the preferred process in which it may even be desirable that they disagree, thus exposing the issues to others who need to consider it for themselves: in this case the parties might agree to disagree and agree to continue the dialogs on the issue.

It is also possible to manage a conflict without resolution, in forms other than avoidance. For more, see conflict management.

Conflict management: Conflict management refers to the long-term management of intractable conflicts. It is the label for the variety of ways by which people handle grievances standing up for what they consider to be right and against what they consider to be wrong.

Those ways include such diverse phenomena as gossip, ridicule, lynching, terrorism, warfare, feuding, genocide, law, mediation, and avoidance. Which forms of conflict management will be used in any given situation can be somewhat predicted and explained by the social structure or social geometry of the case.

Conflict management is NOT the same as conflict resolution. Conflict resolution refers to resolving the dispute to the approval of one or both parties, whereas conflict management concerns an ongoing process that may never have a resolution.

For example, gossip and feuds are very common methods of conflict management, but neither entails resolution. Neither is it the same as conflict transformation, which seeks to reframe the positions of the conflict parties.

Conflict is an omnipresent trait of human societies since it is almost impossible to find two parties with entirely overlapping interests, thus a general theory for bargaining and negotiation to address conflict is useful not only in the field of international politics or business management, but also at the personal and intimate level.

FAMILY COUNSELING: Family therapy and counseling, also referred to as couple and family therapy and family systems therapy, is a branch of psychotherapy related to relationship counseling that works with families and couples in intimate relationships to nurture change and development.

It tends to view these in terms of the systems of interaction between family members. It emphasizes family relationships as an important factor in psychological health. As such, family problems have been seen to arise as an emergent property of systemic interactions, rather than to be blamed on individual members.

Family therapists may focus more on how patterns of interaction maintain the problem rather than trying to identify the cause, as this can be experienced as blaming by some families. It assumes that the family as a whole is larger than the sum of its parts.

Family therapy may also be used to draw upon the strengths of a social network to help address a problem that may be completely externally caused rather than created or maintained by the family.

Family therapy practitioners come from a range of professional backgrounds, and some are specifically qualified or licensed/registered in family therapy. Requirements differ from state to state.

Counselors are usually psychologists, nurses, psychotherapists, social workers, or counselors , pastors, chaplains etc, who have done further training in family therapy.

Family therapy has been used effectively where families, and or individuals in those families experience or suffer:

Interactional and transitional crises in a family's life cycle (e.g. conflict, estrangement, divorce, child and adolescent issues).

Serious psychological disorders (e.g. schizophrenia, anxiety, depression, personality disorders, conduct disorders, ADHD, addictions and eating disorders); as a support of other psychotherapies and medication.

It uses a range of counseling and other techniques including:

Communication therapy
Psycho Education
Psychotherapy
Systematic Coaching
Systems Theory

The basic theory of classical systemic family therapy was derived mainly from systems theory and cybernetics, and secondarily from behavioral therapy and cognitive psychotherapy, although most of the founders of the field had psychoanalytic backgrounds.

More recent developments have come from feminist, postmodernist, narrative, psychodynamic and attachment theories.

Important schools of family therapy include structural family therapy, strategic family therapy, a range of cognitive and behavioral approaches, constructivist, solution-focused therapy, psychodynamic, object relations, intergenerational (emotionally focused therapy), and experiential therapy. Multicultural, intercultural, and integrative approaches are being developed.

Most practitioners claim to be "eclectic", using techniques from several areas, depending upon their own inclinations and/or the needs of the client(s).

The number of sessions depends on the situation, but the average is 5-20 sessions. A family therapist usually meets several members of the family at the same time; This has the advantage of making differences between the ways family members perceive mutual relations as well as interaction patterns in the session apparent both for the therapist and the family.

These patterns frequently mirror habitual interaction patterns at home, even though the therapist is now incorporated into the family system.

Therapy interventions usually focus on relationship patterns rather than on analyzing impulses of the unconscious mind or early childhood trauma of individuals as a Freudian therapist would do - although some schools of family therapy, for example psychodynamic and intergenerational, do consider such individual and historical factors, and they may use instruments such as the genogram to help to elucidate the patterns of relationship across generations.

Family therapy is really a way of thinking, an epistemology rather than about how many people sit in the room with the therapist.

Family therapists are relational therapists; they are generally more interested in what goes between people rather than in people.

Depending on circumstances, a therapist may point out to the family interaction patterns that the family might have not noticed; or suggest different ways of responding to other family members.

These changes in the way of responding may then trigger repercussions in the whole system, leading to a more satisfactory systemic state; it should be noted though, that some family therapists - in particular those that identify as psychodynamic, object relations, intergenerational, EFT, or experiential family therapists - tend to be as interested in individuals as in systems. A novel development in the field of couple's therapy in particular, has involved the introduction of insights gained from affective neuroscience and psychopharmacology into clinical practice.

There has been interest in use of the so-called love hormone – oxytocin – during therapy sessions, although this is still largely experimental and somewhat controversial.

VALUES AND ETHICS IN FAMILY THERAPY: Since issues of interpersonal conflict, values, and ethics are often more pronounced in relationship therapy than in individual therapy, there has been debate within the profession about the different values that are implicit in the various theoretical models of therapy and the role of the therapist's own values in the therapeutic process, and how prospective clients should best go about finding a therapist whose values and objectives are most consistent with their own.

Specific issues that have emerged have included an increasing questioning of the longstanding notion of therapeutic neutrality, a concern with questions of justice and self-determination, connectedness and independence, "functioning" versus "authenticity", and questions about the degree of the therapist's "pro-marriage/family" versus "pro-individual" commitment.

Responsibility assumption: Responsibility assumption is a doctrine in the personal growth field holding that each individual has substantial or total responsibility for the events and circumstances that befall them in their life.

While there is little that is notable about the notion that each person has at least some role in shaping their experience, the doctrine of responsibility assumption posits that the individual's mental contribution to his or her own experience is substantially greater than is normally thought.

"I must have wanted this" is the type of catchphrase used by adherents of this doctrine when encountering situations, pleasant or unpleasant, to remind them that their own desires and choices led to the present outcome.

The term responsibility assumption thus has a specialized meaning beyond the general concept of taking responsibility for something, and is not to be confused with the general notion of making an assumption that a concept such as "responsibility" exists.

VARIATIONS IN PERSONAL RESPONSIBILITY POSTULATED: The main variable within various interpretations of the responsibility assumption doctrine is the degree to which the individual is considered the cause of his or her own experience, ranging from partial but substantial, to total.

PARTIAL BUT SUBSTANTIAL RESPONSIBILITY: In its forms positing less than total responsibility, the doctrine appears in nearly all motivational programs, some psychotherapy, and large group awareness training programs.

There is power in positive thinking and it functions as a mechanism to point out that each individual does affect the perceived world by the decisions they make each day and by the choices they made in the past.

These less absolute forms may be expressed within the rubric that we cannot control the situations that befall us, but we can at least control our attitudes toward them.

TOTAL RESPONSIBILITY: In its more absolute form, the doctrine becomes both more pronounced and more controversial. Perhaps the most prominent dividing line of controversy is the threshold of reversed mental causation, where sufficient responsibility is assigned to the individual that their thoughts or mental attitudes are considered the actual cause of external situations or physical occurrences rather than vice-versa, along the lines of the catchphrase, "mind over matter."

In this realm the doctrine can present controversial propositions such as, "you chose to have cancer and can just as easily become well if you choose," or the even more shocking and unpalatable proposition, "this genocide took place because the victims wanted to die."

Despite the extremity of these positions, there are indeed groups and schools of thought subscribing to the doctrine of responsibility assumption that would support these propositions and more.

RELIGIOUS AND PHILOSOPHICAL ROOTS AND USAGE: The doctrine has spiritual roots in the monism of Eastern religious traditions which hold that only one true being exists, and all people are one with each other and with god and hence possess Godlike powers, though they are often unaware of it.

It has been likened to karma, which however tends to suggest later retribution for earlier acts, while responsibility assumption posits more of an immediate link between the experience desired and the outcome received.

The doctrine also has associations with the Neo-Platonist notion of an illusory world, which the doctrine's adherents would phrase more precisely as an illusion of external worldly effects on inner mental states. It finds further support in philosophical idealism, which posits thought as the one true substance.

Among historically Christian churches, the Quaker and Unitarian Universalist denominations have belief systems that incorporate doctrinal elements similar to responsibility assumption.

Some doctrine has assigned mental causes to physical ailments, and can be found in a number of New Age and new religious movements. Theologies espouse mental approaches to bodily healing and express precepts such as, "to each, according to his belief."

TRANSTHEORETICAL: The trans-theoretical model of change in health psychology explains or predicts a person's success or failure in achieving a proposed behavior change, such as developing different habits. It attempts to answer why the change "stuck" or alternatively why the change was not made.

The trans-theoretical model of change (TTM) currently, the most popular stage model in health psychology has proven successful with a wide variety of simple and complex health behaviors, including smoking cessation, weight control, sunscreen use, reduction of dietary fat, exercise acquisition, quitting cocaine, mammography screening, and condom use).

Based on more than 15 years of research, the TTM has found that individuals move through a series of five stages (pre-contemplation, contemplation, preparation, action, maintenance) in the adoption of healthy behaviors or cessation of unhealthy ones.

TTM research on a variety of different problem behaviors has also shown that there are certain predictors of progression through the stages of change, including decisional balance, self-efficacy and the processes of change.

The Stages of Change: This explains intentional behavior change along a temporal dimension that utilizes both cognitive and performance-based components.

Based on more than two decades of research, the TTM has found that individuals move through a series of stages—pre-contemplation (PC), contemplation (C), preparation (PR), action (A), and maintenance (M)—in the adoption of healthy behaviors or cessation of unhealthy ones.

Pre-Contemplation: The stage in which an individual has no intent to change behavior in the near future, usually measured as the next 6 months. Pre-contemplators are often characterized as resistant or unmotivated and tend to avoid information, discussion, or thought with regard to the targeted health behavior.

Contemplation stage: Individuals in this stage openly state their intent to change within the next 6 months. They are more aware of the benefits of changing, but remain keenly aware of the costs. Contemplators are often seen as ambivalent to change or as procrastinators.

Preparation: The stage in which individuals intend to take steps to change, usually within the next month. PR is viewed as a transition rather than stable stage, with individuals intending progress to A in the next 30.

Action stage: Is one in which an individual has made overt, perceptible lifestyle modifications for fewer than 6 months

Maintenance: These are workings to prevent relapse and consolidate gains secured during A Maintainers are distinguishable from those in the A stage in that they report the highest levels of self-efficacy and are less frequently tempted to relapse.

The TTM uses the stages of change to integrate cognitive and behavioral processes and principles of change, including the processes of change. Pros and cons, benefits ,costs, confidence in one's ability to change; all of which have demonstrated reliability and consistency in describing and predicting movement through the stages .

SIX STAGES

1. Pre-contemplation: lack of awareness that life can be improved by a change in behavior;

2. Contemplation: Recognition of the problem, initial consideration of behavior change, and information gathering about possible solutions and actions;

3. Preparation: Introspection about the decision, reaffirmation of the need and desire to change behavior, and completion of final pre-action steps;

4. Action: Implementation of the practices needed for successful behavior change (e.g. exercise class attendance);

5. Maintenance: Consolidation of the behaviors initiated during the action stage;

6. Termination: Former problem behaviors are no longer perceived as desirable.

STRESS MANAGEMENT: Stress management encompasses techniques intended to equip a person with effective coping mechanisms for dealing with psychological stress, with stress defined as a person's physiological response to an internal or external stimulus that triggers the fight-or-flight response.

Stress management is effective when a person utilizes strategies to cope with or alter stressful situations.

Models of stress management

Transactional model: stress can be thought of as resulting from an “imbalance between demands and resources” or as occurring when “pressure exceeds one's perceived ability to cope”.

Stress management was developed and premised on the idea that stress is not a direct response to a stressor but rather one's resources and ability to cope mediate the stress response and are amenable to change, thus allowing stress to be controllable.

In order to develop an effective stress management program it is first necessary to identify the factors that are central to a person controlling his/her stress, and to identify the intervention methods which effectively target these factors.

Stress focuses on the transaction between people and their external environment (known as the Transactional Model). The model conceptualizes stress as a result of how a stressor is appraised and how a person appraises his/her resources to cope with the stressor.

The model breaks the stressor-stress link by proposing that if stressors are perceived as positive or challenging rather than a threat, and if the stressed person is confident that he/she possesses adequate rather than deficient coping strategies, stress may not necessarily follow the presence of a potential stressor.

The model proposes that stress can be reduced by helping stressed people change their perceptions of stressors, providing them with strategies to help them cope and improving their confidence in their ability to do so.

HEALTH REALIZATION: The health realization/innate health model of stress is also founded on the idea that stress does not necessarily follow the presence of a potential stressor.

Instead of focusing on the individual's appraisal of so-called stressors in relation to his or her own coping skills (as the transactional model does), the health realization model focuses on the nature of thought, stating that it is ultimately a person's thought processes that determine the response to potentially stressful external circumstances.

In this model, stress results from appraising oneself and one's circumstances through a mental filter of insecurity and negativity, whereas a feeling of well-being results from approaching the world with a "quiet mind," "inner wisdom," and "common sense".
This model proposes that helping stressed individuals understand the nature of thought--especially providing them with the ability to recognize when they are in the grip of insecure thinking, disengage from it, and access natural positive feelings, will reduce their stress.

TECHNIQUES OF STRESS MANAGEMENT: There are several ways of coping with stress. Some techniques of time management may help a person to control stress. In the face of high demands, effective stress management involves learning to set limits and to say "No" to some demands that others make.

Techniques of stress management will vary according to the theoretical paradigm adhered to, but may include some of the following:

AUTOGENIC TRAINING

1. Cognitive therapy
2. Conflict resolution
3. Exercise
4. Meditation
5. Relaxation techniques
6. Fractional relaxation
7. Progressive relaxation
8. Stress balls
9. Time management
10. Listening to certain types of relaxing music

MEASURING STRESS: levels of stress can be measured. Changes in blood pressure and galvanic skin response can also be measured to test stress levels, and changes in stress levels.

A digital thermometer can be used to evaluate changes in skin temperature, which can indicate activation of the fight or flight response drawing blood away from the extremities.

EFFECTIVENESS OF STRESS MANAGEMENT: Positive outcomes are observed using a combination of non-drug interventions:

1. Treatment of anger or hostility,
2. Autogenic Training
3. Talking therapy (around relationship or existential issues)
Biofeedback
4. Cognitive therapy for anxiety or clinical depression

NOTES

SUICIDE INTERVENTION: Suicide intervention or suicide crisis intervention is direct effort to stop or prevent persons attempting or contemplating suicide from killing themselves.

Current medical advice concerning people who are attempting or seriously considering suicide is that they should immediately go or be taken to the nearest emergency room, or emergency services should be called immediately by them or anyone aware of the problem.

Modern medicine treats suicide as a mental health issue. According to medical practice, severe suicidal ideation, that is, serious contemplation or planning of suicide is a medical emergency and that the condition requires immediate emergency medical treatment.

In the United States, individuals who express the intent to harm themselves are automatically determined to lack the present mental capacity to refuse treatment, and can be transported to an emergency department against their will.

An emergency physician there will determine whether or not inpatient care at a mental health care facility is warranted. This is sometimes referred to as being "committed." If the doctor determines involuntary commitment is needed, the patient is hospitalized and kept under observation until a court hearing is held to determine the patient's competence.

Individuals suffering from depression are considered a high-risk group for suicidal behavior. When depression is a major factor, successful treatment of the depression usually leads to the disappearance of suicidal thoughts

However, medical treatment of depression is not always successful, and lifelong depression can contribute to recurring suicide attempts. Medical personnel frequently receive special training to look for suicidal signs in patients.

Suicide hotlines are widely available for people seeking help. However, the negative and often too clinical reception that many suicidal people receive after relating their feelings to health professionals (threats of institutionalization, increased dosages of medication, the social stigma) may cause patients to remain more guarded about their mental health history or suicidal urges and ideation

FIRST AID FOR SUICIDE IDEATION: Medical professionals advise that people who have expressed plans to kill themselves be encouraged to seek medical attention immediately. This is especially relevant if the means (weapons, drugs, or other methods) are available, or if the patient has crafted a detailed plan for executing the suicide.

Mental health professionals suggest that people who know a person whom they suspect to be suicidal can assist him or her by asking directly if the person has contemplated committing suicide and made specific arrangements, has set a date, etc. Posing such a question does not render a previously non-suicidal person suicidal.

According to this advice, the person questioning should seek to be understanding and sympathetic above all else since a suicidal person will often already feel ashamed or guilty about contemplating suicide so care should be taken not to exacerbate that guilt.

Mental health professionals suggest that an affirmative response to these questions should motivate the immediate seeking of medical attention, either from that person's doctor, or, if unavailable, the emergency room of the nearest hospital.

If the prior interventions fail, mental health professionals suggest involving law enforcement officers. While the police do not always have the authority to stop the suicide attempt itself, in some countries including some jurisdictions in the US, killing oneself is illegal.

In most cases law enforcement does have the authority to have people involuntarily committed to mental health wards. Usually a court order is required, but if an officer feels the person is in immediate danger he/she can order an involuntary commitment without waiting for a court order.

Such commitments are for a limited period, such as 72 hours – which is intended to be enough time for a doctor to see the person and make an evaluation. After this initial period, a hearing is held in which a judge can decide to order the person released or can extend the treatment time.

Afterwards, the court is kept informed of the person's condition and can release the person when they feel the time is right to do so. Legal punishment for suicide attempts is extremely rare.

Mental health treatment often including medication, counseling and psychotherapy, is directed at the underlying causes of suicidal thinking. Clinical depression is the most common treatable cause, with alcohol or drug abuse being the next major categories.

Other psychiatric disorders associated with suicidal thinking include bipolar disorder, schizophrenia, Borderline personality disorder, Gender identity disorder and eating disorders.

Suicidal thoughts provoked by crises will generally settle with time and counseling. Severe depression can continue throughout life even with treatment and repetitive suicide attempts or suicidal ideation can be the result.

Methods for disrupting suicidal thinking include having family members or friends tell the person contemplating suicide about who else would be hurt by the loss, citing valuable and productive aspects of the patient's life, and provoking simple curiosity about the victim's own future.

During the acute phase, the safety of the person is one of the prime factors considered by doctors, and this can lead to admission to a psychiatric ward or even involuntary commitment.

Relationship counseling: Relationship counseling is the process of counseling the parties of a relationship in an effort to recognize and to better manage or reconcile troublesome differences and repeating patterns of distress.

The relationship involved may be between members of a family or a couple, employees or employers in a workplace, or between a professional and a client.

HISTORY: Relationship counseling as a discrete, professional service is a recent phenomenon. Until the late 20th century, the work of relationship counseling was informally fulfilled by close friends, family members, or local religious leaders.

Psychiatrists, psychologists, counselors and social workers have historically dealt primarily with individual psychological problems.

In many less technologically advanced cultures around the world today, the institution of family, the village or group elders fulfill the work of relationship counseling. Today marriage mentoring mirrors those cultures.

With increasing modernization or westernization in many parts of the world and the continuous shift towards isolated nuclear families, the old support structures are no longer there and the need for relationship counseling is greater than ever.

In western society the trend is towards trained relationship counselors; these are often volunteers who wish to help others, and are trained by either the Government or social service institutions to help those who are in need of counseling.

Many communities and government departments have their own team of trained voluntary or professional relationship counselors. Similar services are operated by many universities and colleges, often staffed by volunteers from among the student peer group.

Some large companies maintain a full-time professional counseling staff to facilitate smoother interactions between corporate employees, to minimize the negative effects that personal difficulties might have on work performance.

METHODOLOGY: Before the relationships between the individuals can begin to be understood, it is important for all to recognize and acknowledge that everyone involved has a unique personality and background.

Sometimes the individuals in the relationship adhere to different value systems. Institutional and societal variables (like the social, religious, group and other collective factors) which shape a person's nature and behavior must be recognized. A tenet of “relationship counseling” is that:

It is intrinsically beneficial for all the participants to interact with each other and with society at large with the least conflict possible. Occasionally the relationships get ‘strained’, which means that they are not functioning at the optimum extent.

There are many possible reasons for this, including ego, arrogance, jealousy, anger, greed etc. Often it is an interaction between two or more factors, and frequently it is not just one of the people who are involved that exhibits such traits.

Some say the only viable solution to the problem of setting these relationships back on track is to reorient the individuals' perceptions in how one looks at or responds to situations. This implies that they make some fundamental changes in their attitudes - much easier said than done.

The next step is to adopt conscious structural changes to their inter-personal relationships.

The duty and function of a relationship counselor is to listen, understand and facilitate a better understanding between those involved. The basic principles involved are: non-judgment on any of the issues or incidents narrated to them as counselor.

CONFIDENTIALITY: A successful counselor is someone who has a mature and balanced state of mind and disposition, who can place themselves in the shoes of those they are counseling, and the ability to respect their opinions, thoughts, feelings and (more importantly) emotions.

After evaluating the story as it is narrated, a realistic, practical solution can be developed; individually at first if this is beneficial, and then jointly to encourage the participants to give their best efforts at reorienting their relationship with each other.

It has to be remembered that the change in situations like financial state, physical health, and the influence of other family members can have a profound influence on the conduct, responses and actions of the individuals.

GRIEF AND TRAUMA COUNSELING: Anticipating the impact of loss or trauma (to the extent than anyone can), and during and after the events of loss or trauma, each person has unique emotional experiences and ways of coping, of grieving and of reacting or not.

Sudden, violent or unexpected loss or trauma imposes additional strains on coping. When a community is affected such as by disaster both the cost and sometimes the supports are greater.

Weeping, painful feelings of sadness, anger, shock, guilt, helplessness and outrage are not uncommon. These are particular challenging times for children who may have had little experience managing strong affects within themselves or in their family.

These feelings are all part of a natural healing process that draws on the resilience of the person, family and community. Time and the comfort and support of understanding loved ones and once strangers who come to their aid, supports people healing in their own time and their own way.

Research shows that resilience is ordinary rather than extraordinary. The majority of people who survive loss and trauma do not go on to develop PTSD. Some remain overwhelmed.

This article addresses counseling with complex grief and trauma, not only Complex post-traumatic stress disorder but those conditions of traumatic loss and psychological trauma that for a number of reasons are enduring or disabling.

For example: where an adult is periodically immobilized by unwelcome and intrusive recall of the sudden and violent death of a parent in their childhood.

One that they were unable to grieve because they were the strong one who held the family together, or whose feelings of outrage and anger were unacceptable or unmanageable at the time or because the loss of the breadwinner catapulted the family into a precipitous fall losing home, community and means of support.

THE POST-TRAUMA SELF: Because of the interconnectedness of trauma, PTSD, human development, resiliency and the integration of the self, counseling of the complex traumatic aftermath of a violent death in the family, for example, require an integrative approach, using a variety of skills and techniques to best fit the presentation of the problem.

Disruption in the previously supportive bonds of attachment and of the person's ability to manage their own affects challenges traditional, so called 'non-directive' client centered counseling approaches.

The post-traumatic self may not be the same person as before. This can be the source of shame, secondary shocks after the event and of grief for the lost unaltered self, which impacts on family and work. Counseling in these circumstances is designed to maximize safety, trauma processing, and reintegration regardless of the specific treatment approach.

Loss and grief are inevitable at some time in everyone's life and at any age. From pets to close friends and family, from moving countries to changing schools, by death of a loved one or after community disaster. It is present getting married (no longer single) and in divorce (no longer married).

The more significant the loss, the more intense the grief is likely to be. Everyone experiences and expresses grief in their way often shaped by how their culture honors the process or not.

It is not uncommon for a person to withdraw from their friends and family and feel helpless; some might be angry and want to take action. One can expect a wide range of emotion and behavior. In all places and cultures, the grieving person benefits from the support of others.

Where that is lacking, counseling may provide an avenue for healthy resolution. Similarly, where the process of grieving is interrupted for example, by simultaneously having to deal with practical issues of survival or by being the strong one and holding a family together, it can remain unresolved and later resurface as an issue for counseling.

Grief Counseling: Grief counseling becomes necessary when a person is so disabled by their grief, overwhelmed by loss to the extent that their normal coping processes are disabled or shut down.

Grief counseling facilitates: expression of emotion and thought about the loss, including sadness, anxiety, anger, loneliness, guilt, relief, isolation, confusion, or numbness. It includes thinking creatively about the challenges that follow loss, and coping with concurrent changes in their lives.

Often people feel disorganized, tired, have trouble concentrating, sleep poorly and have vivid dreams, change in appetite. These too are addressed in counseling.

Grief counseling facilitates the process of resolution in the natural reactions to loss. It is appropriate for reaction to losses that occurred in the distant or recent past that have overwhelmed a person's coping ability.

Grief counseling may be called upon when a person suffers anticipatory grief, for example an intrusive and frequent worry about loved one's whose death is neither imminent nor likely.

Anticipatory mourning also occurs when a loved one has a terminal illness. This can handicap that person's ability to stay present whilst simultaneously holding onto, letting go of, and drawing closer to the dying relative.

GRIEF THERAPY: There is a distinction between grief counseling and grief therapy. Counseling involves helping people move through uncomplicated, or normal, grief to health and resolution.

Grief therapy involves the use of clinical tools for traumatic or complicated grief reactions. This could occur where the grief reaction is prolonged or manifests itself through some bodily or behavioral symptom, or by a grief response outside the range of cultural or psychiatrically defined normality.

Often shaped by how their culture honors the process or not. It is not uncommon for a person to withdraw from their friends and family and feel helpless; some might be angry and want to take action. One can expect a wide range of emotion and behavior. In all places and cultures, the grieving person benefits from the support of others.

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Transitory Communities: A community may be defined as a group of people with a sense of common history, language, race, mores, values, attitudes, knowledge structures, and purpose. However traumatic events, such as a natural disaster, spawn new “transitory communities” and establish new dynamics that transcend natural communities.

In such transitory communities the blow is not just to the individual psyche, but to the tissues of social life and the bonds that bind these communities together.

Evolution of the Lay Community Counselor in Disasters

The Lay Community Counselor Model for post-disaster crisis intervention was developed in face of the challenging situation faced by the Academy for Disaster Management Education Planning and Training (ADEPT), in the aftermath of the Tsunami.

The 51 Tsunami affected villages in the operational area of Cuddalore District, Tamilnadu, are geographically removed from urbanization. These villages had not been exposed to the effects of Globalization before the Tsunami.

The fishing community, in these villages, is an “ethnocentric community” that does not broach interaction even with neighboring communities except for their trade. Ethnocentricism has been recognized as the single most powerful impediment to trauma counseling.

Ethnocentric communities tend to assume that their experience of the world “is the world”. An influx of the “outside world”, such as in the aftermath of a natural disaster, could, therefore, be an impediment or an advantage.

It could either make the community withdraw into itself, or develop a bond with the outside world that has seen and experienced a similar peril.

According to the National Organization for Victim Assistance (NOVA), Washington, D.C, the likelihood of defensiveness in such communities will be high, based on pre-exposure conditioning. Therefore the biggest obstacle to any kind of crisis intervention was the community’s lack of openness to “outsiders”.

Ethnocentrism is central to understanding help-seeking behavior, what the people in the community define as a "problem," what the individual understands as the causes of psychological difficulties and the unique, subjective experience of traumatic stress symptoms.

While the threats to life associated with psychological trauma are universal, the perception and interpretation of the threats varies across cultures including: the perception of what type of threat is traumatic, the interpretation of the threat's meaning, the nature of the expression (presentation) of symptoms in response to such threats, the cultural context of the responses of traumatized people, as well as the cultural responses by others to those who have been traumatized, and the culturally prescribed paths to recovery from experiencing life-threatening events.

Finally, it is also useful to consider the process by which the exposure of individuals and groups to traumatic events is made useful for the entire culture.

All this is not possible to grasp for new comers who enter the community for the first time in the aftermath of a disaster, and may not be possible even for those who are professionally trained, to understand in the emergency situation.

Another barrier to counseling in the aftermath of a disaster is language. Language differences and patterns among diverse cultures are common and complicated. The national languages, and even the nuances of local dialects spoken, weave into the delicacy of working with local communities, who are little exposed to the world outside.

Languages including regional dialects dictate how one forms ideas, translates sensory perceptions, and interprets the world. The phrasing silences, speed of delivery, and pitch or tone of voice, even when using the same word or phrase, mean different things to different people and form the crux of the counseling skills.

While interpreters can be used, training is needed for speaking through an interpreter. Interpreters or translators contribute to the ambiance of any crisis setting. They become the interpreters not only of the survivor but also of the intervener.

In some cultures it may be appropriate for them to translate with additional flair. In other cultures such interpretation may be offensive. In the counseling situation such differences alter the healing relationships. In any case such training was not possible in the immediate aftermath of a disaster.

In a post disaster setting the counselor, besides meeting the basic needs of the affected individuals, needs to understand the grieving process and psychological trauma, and the needs of the survivors in a culturally appropriate manner.

Also counseling of disaster survivors may require to be undertaken in informal settings. A supportive conversation or a focused problem-solving session during a casual home visit could very well be a counseling session.

LAY COMMUNITY COUNSELORS: Lay counselors are members of the community who are trained to provide a specific service or to perform certain limited activities. The concept of lay / community counselors is not new.

A large number of agencies outside of India, particularly in the United States and United Kingdom depend on the volunteer sector for counseling services. Therefore the strategy adopted by the community based counseling using volunteer lay community counselors who share a significant aspect of their background, culture, language and experience primarily - with the affected community.

Members from affected communities, and others closely interacting with the local population such as teachers, government personnel etc., can be highly effective to reach out as community counselors as they represent the groups they are serving, and can readily gain access to them. This model works by strengthening the existing social support networks.

Experiences have showed that paraprofessional counselors, who would work effectively in their home-community, can be produced with short-term training.

Studies evaluated the effect of the program on the trainees with regard to knowledge and attitudes, the effect of the training upon the trainees with regard to counseling skills acquisition, and the role the trainees played in the community seven months after training.

The results of the study indicated that the trainees did in fact learn the skills taught and did maintain them over a period of time. Peer counselors have been found to be more effective than regular professional care.

Lay community counselors overcome the issues of entry into community, they relate to ethnocentrism, and the shortage of resources, by training members from within affected communities. These same counselors are especially effective as they are involved in the relief and recovery operations after a disaster.

CREATING LAY COMMUNITY COUNSELLORS: Keeping in mind the situational limitations of goals of creating Lay Community Counselors were: To train local volunteer lay community counselors in immediate crisis response and basics of trauma counseling.

To help the community counselors support survivors in their efforts to respond to the effects of a disaster. To assist the counselors plan their activities in the aftermath of the disaster

The participants were trained in the psychological effects of disasters, and simple guidelines with sample techniques to handle them, including vignettes and an assignment to design sample action plans targeting different situations.

Training methodology was short interactive lectures combined with interactive group work and participatory plenary sessions. The entire training is conducted in the vernacular using simple language and avoiding technical terms and jargon.

The design of the program included the preparation of the training module, identification of the target group, planning duration of the training and its methodology and post training professional support. The module was formulated for purposes of exigency and the material adapted from several open source documents.

The training team included a psychiatrist, a psychologist, a trained counselor. The participants of the program were several members associated with the local communities, and grass root level leaders, especially those who have already been providing supportive service to the affected community prior to a disaster.

Self - Help Group members.

1. Teachers
2. Youth Leader
3. Faith Based Leaders
4. Community Leaders
5. Disaster Response Workers
6. To help survivors begin to take control of the events going on around them
7. To assist survivors in handling the practical issues that will face them in the aftermath of the disaster.
8. To identify survivors with severe psychological problems and refer them to qualified experts/professionals.

Training is designed to quickly equip the volunteer community counselors with the basic skills of counseling. Thereafter additional support and hand holding was provided and should be participatory and interactive.

The Community Counselors take the initiative to sit and talk with the survivors, listen to them and be a part of their loss and this was immensely helpful. The survivors need someone to empathize with them and it was not always the monetary part that mattered. The community counselors provide counsel by:

Handling the bereaved through supportive interaction.

Handling the children through play, and interactive and creative activities such as enacting plays, composing poems, singing songs, dancing and music etc. with the themes of “goodness of nature”, “tsunami is transient”, “we shall overcome” etc.

Public education and awareness of the nature of the disaster

Problem solving and supportive activities: Twice monthly a follow up meeting should show that the training produces efficient and expeditious results. The referral pattern is good and it was observed that the community counselors developed culturally appropriate interventions that were effective and methodologically diverse for every group.

These have been documented as case studies. The trained volunteer community counselors helped to provide structure and calm in the midst of the chaos in the aftermath of the disaster.

The methods used among the adult population were case specific, innovative and adaptive such as:

1.Systematic de-sensitization of the fear.
2. Diverting attention from the tragedy by engaging in an activity.
3. The examples of cases referred to professionals were also indicative of the confidence of the community counselors – both in the counseling process and in realizing their own limitations.

The design of the program and the associated advantages of the model were many including:

1.Less dependence on experts
2. Cost effectiveness
3. Ensured local community participation
4. Ready entry points with the additional benefits of shorter time frames, easier
Identification of needs, easy rapport, and effective communication,
5. Enhanced stature of the community counselors in the affected communities due to their continued presence and participation in recovery and reconstruction activities.

EFFECTIVENESS OF LAY COMMUNITY COUNSELORS: Focus group evaluations should be conducted 8 months and 16 months after training o monitor the long-term effects of the training from core groups of community counselors, including the knowledge and attitudes, the effect of the training upon the trainees with regard to counseling skills acquisition, and the role the trainees played in the community immediately after the training and at the time of evaluation.

Many feel that training enhanced their skills in interpersonal relationships and help them to be more insightful in their work. The major points that the majority of participants of the training include the following:

REACHING OUT TO COMMUNITIES: Reaching out to the communities helps guide and help them with:

1.The confidence that they could translate learning into practice.

2. A distinct difference between those who had been trained and those who had not. While those who had been trained coped well with post tsunami daily life crisis, those who had not floundered.

3. Personal benefit as they ventilated during the training, rendering their own healing process much faster.

4. Information produced by engaging the adults in re constructive activities.

5. The acquired ability to train co-workers on psycho-social intervention

6. The benefits of “venting” their feelings and sharing their experience with other community counselors during the post training contact programs, that helped them cope with the stress that came with handling grief stricken survivors.

7. The perceptible sharpening of innate qualities that are a natural part of any individual such as listening skills, use of questions, even reflective silences

The study that those who undergo training are could narrate in depth how they handled subsequent crisis situations. More than half of the trainees felt competent to identify and refer cases they were unable to handle to experts and several who were from the Public health department were aware of the services available and frequently referred them to experts.

INTERVENTION COUNSELING: An intervention is an orchestrated attempt by one, or often many, people (usually family and friends) to get someone to seek professional help with an addiction or some kind of traumatic event or crisis. It can also refer to the act of using a technique within a therapy session

HARMFUL ACTIVITIES AND LESS HARMFUL ACTIVITIES: Interventions have been used to address serious personal problems, including, but not limited to, alcoholism, compulsive gambling, drug abuse, compulsive eating and other eating disorders, self-mutilation, tobacco smoking, "workaholism", and various types of poor personal health care.

Interventions have also been conducted due to personal habits not as frequently considered seriously harmful, such as video game addiction, excessive computer use and excessive television viewing.

DIRECT AND INDIRECT INTERVENTIONS: Interventions are either direct, typically involving a confrontational meeting with the alcohol or other drug dependent person (the most typical type of intervention) or indirect, involving work with a co-dependent family to encourage them to be more effective in helping the addicted individual.

In the same sense, direct interventions tend to be a form of short-term therapy aimed at getting the addicted person into inpatient rehabilitation, whereas indirect interventions are more of a long-term therapy, directed at changing the family system, and therefore promoting healing of addiction.

PLANS FOR DIRECT INTERVENTION: Plans for a direct intervention are typically made by a concerned group of family, friends, and counselor(s), rather than by the addict. Often the addict will not agree that they need the type of help that is proposed during the intervention, usually thought by those performing the intervention to be a result of denial.

One of the primary arguments against interventions is the amount of deception required on the part of the family and counselors. Typically, the addict is surprised by the intervention by friends and family members.

PRIOR PREPARATION: Prior to the intervention itself, the family meets with a counselor (or interventionist). Families prepare speeches in which they share their negative experiences associated with the target's particular addiction-based lifestyle, to convey to the target the amount of pain his or her addiction has caused others.

Also during the intervention rehearsal meeting, each group member is strongly urged to create a list of activities (by the addict) that they will no longer tolerate, finance, or participate in if the addict doesn't agree to check into a rehabilitation center for treatment. These usually involve very serious losses to the addict if s/he refuses.

WHAT THE PERSON MAY LOSE: These items may be as simple as no longer loaning money to the addict, but can be far more alarming. It is common for groups to threaten the addict with permanent rejection (banishment) from the family.

Wives often threaten to leave their husbands during this phase of the intervention, and vice versa. If the addict happens to have any outstanding arrest warrants or other unresolved criminal issues, the threat is usually made that he or she will be turned in to the authorities.

Family and friends present every possible loss that the family can think of to the addict, who then must decide whether to check into the prescribed rehabilitation center, or deal with the promised losses.

SUCCESS OF INTERVENTIONS: Proponents of intervention, including Dr. Drew from the radio show Love line, claim that interventions are 90% to 95% successful at getting the target into and through a treatment plan.

SCHOOL COUNSELING: A school counselor is a counselor and educator who works in schools, and have historically been referred to as "guidance counselors" or "educational counselors," although "Professional School Counselor" is now the preferred term.

Most school counselor occupations or equivalent occupations (e.g. career counselor) are comparable to the U.S. high school counselor in terms of duties and services.

Historically, the need for high school counselors has been emphasized more so than school counselors in lower grades. Many countries vary as to whether school counseling services are provided.

United States

Some elementary school counselors use books and other media to facilitate the counseling process.

In the United States, the school counseling profession began as a vocational guidance movement at the beginning of the 20th century. Jesse B. Davis is considered the first to provide a systematic school guidance program.

In 1907, he became the principal of a high school and encouraged the school English teachers to use compositions and lessons to relate career interests, develop character, and avoid behavioral problems.

From the 1920s to the 1930s, school counseling and guidance grew because of the rise of progressive education in schools. This movement emphasized personal, social, moral development.

Many schools reacted to this movement as anti-educational, saying that schools should teach only the fundamentals of education. This, combined with the economic hardship of the Great Depression, led to a decline in school counseling and guidance.

In the 1940s, the U.S. used psychologists and counselors to select, recruit, and train military personnel. This propelled the counseling movement in schools by providing ways to test students and meet their needs.

Schools accepted these military tests openly. The emphasis was on helping relationships during this time influenced the profession of school counseling. In the 1950s the government established the Guidance and Personnel Services Section in the Division of State and Local School Systems.

Out of concern that the Russians were beating the U.S. in the space race, which had military implications, and that there were not enough scientists and mathematicians, the American government passed the National Defense Education Act, which spurred a huge growth in vocational guidance through large amounts of funding.

Since the 1960s, the profession of school counseling has continued to grow as new legislation and new professional developments were established to refine and further the profession and improve education. On January 1, 2006, Congress officially declared February 6-10 as National School Counseling Week.

Teachers and other personnel also develop (with the student) a plan to address the behavioral issue(s), and then work together (collaboration) to implement the plan. They also help by providing consultation services to family members.

Additionally, professional school counselors may lead classroom guidance on a variety of topics within the three domains such as personal/social issues relative to student needs, or establish groups to address common issues among students, such as divorce or death.

The topics of character education and diversity are usually infused into the guidance curricula. Often counselors will coordinate outside groups that wish to help with student needs such as academics, or coordinate a state program that teaches about child abuse or drugs, through on-stage drama.

Christianity and domestic violence: Because some abusive men have justified their domestic violence as their right as head of the household, some feminists have pointed to traditional Christian conceptions of patriarchy (particularly the idea of men as divinely authorized to exert authority over wives and children) as one of the basic reasons for domestic violence.

This has been disputed by many Christians who cite both the general Christian duty to love others and specific theology on the nature of the relationship between the Christian husband and wife state that violence against women, inside or outside the home, is never justified." There is nothing in Christian teachings that can rightly be used to justify abuse of another person.

"However, there are teachings that can be misused and distorted to suggest that domestic violence may be acceptable or even God's will.

Christian teaching that husbands are to love their wives as Christ loved the church is a challenge to husbands to treat their wives with respect and love, not with violence or control. This teaching can serve as a valuable resource to address and prevent domestic violence.

THEOLOGICAL PATRIARCHY AND CHRISTIANITY: Various passages in the New Testament have been seen as justifications of patriarchy, and some have called patriarchy a cause of domestic violence.

"The concept of male headship first entered the church through the Apostle Paul (1 Cor. 11:3; Eph. 5:23)." St. Paul also states that the husband is head of the wife as God the Father is head of Christ (1 Cor. 11:3).

The New Testament teaching on the subject in a way similar to many other modern Christian theologians in a variety of traditions. John 5:18-24 as repeatedly emphasizing that the relationship between God the Father and God the Son is one of intimate love.

"Abusive men often cite male headship/female submissiveness to justify their abuse. Ultimately, this is based on a perverted assumption of male superiority. Based on John's description of the Father and the Son, human male headship, defined as harsh authoritarian domination of an inferior, is destructive heresy."

Men who abuse often use Ephesians 5:22, taken out of context, to justify their behavior, but the passage (v. 21-33) refers to the mutual submission of husband and wife out of love for Christ. Husbands should love their wives as they love their own body, as Christ loves the Church."

Patriarchy should be replaced rather than reinterpreted: "Following the pattern of Christ means that patterns of domination and submission are being transformed in the mutuality of love, faithful care and sharing of burdens. 'Be subject to one another out of reverence for Christ'(Ephesians 5.21).

Although strong patriarchal tendencies have persisted in Christianity, the example of Christ carries the seeds of their displacement by a more symmetrical and respectful model of male–female relations."

CHRISTIAN THEOLOGY AND COUNSELING ABUSE VICTIMS: Sometimes pastoral counselors are criticized for counseling victims to passively accept abuse in the way that Jesus and the martyrs accepted suffering. Christian pastors or counselors **should not advise victims** to make forgiving the perpetrator the top priority "when the welfare and safety of the person being abused are at stake", the report advises.

PASTORAL RESPONSES TO DOMESTIC VIOLENCE CASES: A 1998 survey of more than 5,000 Protestant pastors indicated that the pastors failed to take the husband's violence seriously and simply encouraged wives to be submissive.

LOWER DOMESTIC VIOLENCE RATES AMONG CHURCHGOERS: At least two studies based on the National Survey of Families and Households in the United States have shown that an adherence by married men to Christianity (particularly more traditional Christian theology, and particularly as measured by church attendance) correlates with lower levels of domestic violence.

A widely reported study of data from three national surveys showed that evangelical Christian men, especially those who attended church frequently, were more involved with their families overall and less likely to commit domestic violence than men who attended less frequently, or were from mainline Protestant religions or who were not believers in religion.

That Christian men espousing religious beliefs that favored patriarchy were combining that belief with a modern practice of more emotionally involved and sensitive manhood.

Family behaviors of evangelical men with different religious practices as shown in three large-scale surveys taken in the early 1990s. "What we find is the lowest rate of reported domestic violence in the early 1990s is among active evangelical husbands active within the church.

The sociologist used data from the National Survey of Families and Households, which indicated 2.8 percent of active evangelical Protestant husbands, commit domestic violence, compared to 7.2 percent of "nominal" evangelical husbands, meaning those who attend church services once or twice a year or not at all.

Analyzed data from three large surveys conducted several times from 1972 to 1999 stated that examined behaviors and attitudes toward family and gender among different religious groups, resulted to greater family involvement and less domestic violence among church going husbands.

The lower levels of domestic violence were part of a larger pattern in which active evangelical fathers spent more time on parenting and working to fulfill the emotional needs of their wives and children than did nominal Christians.

Although the rates of added involvement with wives and children and lower domestic violence were most pronounced with active Christian fathers, domestic violence was still indicated on a small scale in all religions.

"Domestic violence is an important problem in our society", "but we should not confuse the matter by blaming conservative religion. The roots of domestic violence would seem to lie elsewhere."

Evangelical husbands who rarely attend church have "the highest rates of domestic violence of any group in the United States".

According to studies, "religious involvement, specifically church attendance, protects against domestic violence, and this protective effect is stronger for African American men and women and for Hispanic men, groups that, for a variety of reasons, experience elevated risk for this type of violence."

PASTORAL CRISIS CARE AND COUNSELING

TERMS USED

CRITICAL INCIDENT: Any event which has the potential to engender a crisis response. The term is often confused with the crisis response itself.

The inability to communicate during a crisis can inhibit progress. For many reasons:

(1) Counseling may not be offered or available and

(2) Some people in crises have difficulty communicating while in a fragile state of mind.

Pastoral counselors are faced with the difficult task of helping people cope with the suffering brought on by sudden, unpredictable and traumatic events. This module intends to offer a model of crisis dynamics and some useful tips for pastoral counselors.

“As a religious problem, the problem of suffering is, paradoxically, not how to avoid suffering but to suffer, what to make of physical pain, personal worldly defeat, something bearable, supportable, something as we say, sufferable. (Lucien Richard”)

Emotional stages that a person may encounter include pain, loss, anger, depression etc. It is common that the individual in a crisis situation will exhibits an acute cognitive dysfunction.

This phenomenon is often referred to as:

(1) Cognitive distortion
(2) Cortical inhibition syndrome
(3) Numbing down

This is the reason someone suffering a crisis may have no cognitive understanding of any irrational or illogical behavior displayed during the crisis, or any understanding of the consequences of their actions during that time.

Secondary victims such as police, fire, rescue workers, pastors, chaplains, disaster workers, etc, may blame themselves for an adverse outcome when an error occurs and they may take on a sense of faulty self-attribution.

No one is immune from crises. In fact, a crisis it will occur at least one time in everyone's life. Crisis may vary in nature and severity and the impact on a person's physical, mental, and spiritual well-being will vary depending on the nature of the incident.

The emotional stages a person may encounter during recovery from a crisis are based on four stages of the terminally ill (denial, anger, bargaining and acceptance) and have been adapted for pastoral care givers. It is important that a Pastoral care-giver make a correct assessment of the stage the person is in so that the client may emerge with new ways of coping as well as an increased spiritual maturity.

CRISIS COUNSELING: Crisis counseling is short term; usually no more than 1 to 3 months. The focus is on one single event or recurrent feelings or behaviors that are overwhelming to the human psyche. If the crisis is not resolved quickly and properly the experience can lead to lasting psychological, social, behavioral or medical problems.

Crisis counseling provides education, guidance and support. Pastoral counseling is not a substitute for intensive or long term psychiatric care. There are many types of counseling. Many involve work with community and outreach programs. Crisis counseling should not be limited to just one or two office visits.

The Need for Pastoral Counseling :

Between 7% and 35% of people in significant distress after a trauma/disaster, 94% of American's believe in God, 59% likely to seek support from a spiritual counselor.

Hierarchy for Effective Pastoral Crisis Counseling :

1. It is presumed that effective Pastoral Crisis Counseling is based upon a fundamental hierarchy described herein:

2. It is assumed that effective Pastoral Crisis Counseling begins with effective communication practices; verbal and nonverbal.

3. Assessment and screening functions are based upon fundamental training in psychological triage, as well as known observation skills. Basic insight into the components of a crisis oriented mental status examination seems requisite.

4. Assessment functions pertain not only to psychological needs but physical needs as well. In point of fact, meeting physical needs usually takes super ordinance over psychological needs.

5. Once physical needs have been attended to, psychological needs may be addressed.

6. Once all of the aforementioned domains have been addressed, spiritual concerns are assessed.

7. Finally, religious issues may be addressed subsequent to, or in lieu of, more generic spiritual issues.

CRISIS INTERVENTION: Commonly known as "emotional first aid"; the correct definition is "urgent and acute psychological support". There are five stages of urgent and acute support and they are:

1. **Immediacy** – Early intervention.

2. **Proximity** – Intervention done within close physical proximity to the actual incident.

3. **Expectancy**- The person in distress and the counselor have the expectation that the intervention will be acute and directed toward the goal of symptom stabilization and reduction, not cure.

4. **Simplicity-** avoiding complex psychotherapy

5. **Brevity**- a short intervention consisting of no more than three contacts.

Regardless of which description is used or what theory one reads about crisis intervention, there are decisive elements that a counselor can use in the recovery process that will help a person move past a traumatic event.

CRISIS INTERVENTION ELEMENTS: Assessment – To evaluate mental and behavior elements of a person(s) state of psychological crisis with the intent of providing or facilitating access to appropriate support and care.

1. **Psychological Intervention** – basic applicable psychological practices to stabilize acute distress.

2. **Liaison/Advocacy Intervention** – To act as an intermediary advocate for a person in distress.

3. **Spiritual Intervention** – To act on a nondenominational level for all religions or faith; consisting of the ministry of presence and prayer, confession, individual prayer and belief in divine intervention.

4. **Religious Intervention**- Pastoral interventions based upon specific religious doctrine, belief, and scripture.

5. **Observation:** When someone is in crisis they are also in a state of denial. It is difficult for them to realize that the behavior they display, after a crisis not only affects them but everyone around them and that the behavior contributes to the problem.

It is difficult to fix a problem if they do not recognize the extent of the harm they may be doing to themselves and others and that your behavior may be detrimental to those around you.

You must first make a conscious decision that there is a problem and that recovery is necessary. Once the decision has been made, you must make a personal choice to seek recovery.

Understanding the Reaction: It is natural for all of us to have the intention to do the best we can with the amount and type of resources available during a crisis. At this time that we must recognize the true intention here.

We must keep those "best intentions" in mind no matter what we do to keep from over-reacting to the crisis. If our intentions get misguided then normally the reactions become bigger than our intent and could slow us down during the recovery process.

Discovering Potential: During a crisis we often have the opportunity to discover our highest potential for self belief, strength and worth. We often find out during a crisis what our abilities and weaknesses are and where our strength lie. The greatest reward we can have is knowing that we can face any challenge with strength and courage when a crisis occurs.

Encouragement and Support: Support and encouragement are vital during a crisis but support and encouragement may not be all that the person may require for a complete recovery. Often, a person can be supported and given encouragement but may either refuse to act or may not know the proper paths to take for a total recovery.

A person must be encouraged and maybe even required to make needed decisions and actions to improve their life after the recovery process. It may be necessary for a counselor to encourage a person more than once to keep them on the right track.

Depending on the level of emotional trauma, a person may experience one or more set-backs during the recovery process. At this point, self belief and self worth may become an issue. A person may have problems "picking themselves up" and it is the responsibility of the counselor to be consistent with the encouragement and support.

Structure: Providing structure in crisis intervention is a necessity. It is human nature to react with calm when we are in our "life's routine". Counseling can provide the same structured routine and that will allow us to become active in the recovery process.

Structure allows us to mentally re-examine our abilities and strengths during a crisis. We will often gain the strength and courage necessary to "carry on" in the face of adversities.

Failure to provide needed structure during crisis intervention may hinder the progress made by the person in crisis and/or cause permanent fears and anxieties for them. Some examples of structure are:

1. Discuss our expectations for recovery
2. Discuss the person's expectations for recovery
3. Create a plan
4. Set a schedule and stick with it
5. Provide the person reading material, exercises and resources
6. Provide peer support if available

Irrational Beliefs: During a crisis we are often challenged in what we feel and what we believe. It is not uncommon for us to question our own belief system while in a state of crisis. We may have changes in reactions that we do not understand, while at the same time we may not realize that a change has taken place.

We also assume that others know why we have a "bad reaction" during a situation and not only assume but expect those around us to have a complete understanding of those changes.

Facing Fear: People suffering from a crisis feel fear, sadness and confusion. The reaction to those feelings manifest in many forms, anger, depression, alcohol, drugs, medication, self mutilation, violence, suicide attempts etc.

Whatever the reaction is, it is very real to the person involved and it may be the "darkest" time in his/her life and it may be the only way that, that person knows how to cope with the crisis. It is extremely important during counseling that we don't "down play" a person's feelings.

A person suffering from a crisis may become emotionally blocked from the real world. The most important thing a support system can do is make him/her feel that they are not alone.

Dependencies: Crisis dependencies are usually temporary and can be overcome in a minimum amount of time. However, the lack of a good support team may have long lasting effects. Once counseling has commenced, the person will usually gain enough strength to become less dependent. Examples:

1. Alcohol dependency
2. Drug dependency
3. Prescription medication dependency
4. Becoming overly dependent on others

Dependency Behavior

Alcohol: A chemical dependency despite repeated adverse consequences to self and others. The illness can be determined by genetic, physiological, bio-chemical and emotional vulnerability. Drug/Medication Dependency: Psychological dependency occurs when a drug has been used habitually and the mind has become emotionally reliant on its effects, either to elicit pleasure or relieve pain, and does not feel capable of functioning without it which are often brought on or magnified by stress.

Dependency on others: Individuals with dependent personality disorder often have been socially humiliated by others or experienced violence or a traumatic event(s). They may carry significant doubts about their abilities to perform tasks, take on new responsibilities, and generally function independently of others. They may have feelings of helplessness that elicits care-giving behavior from some people in their lives.

Addictive Behavior: There are many types of addictions; drugs, alcohol, and prescription medications, for example. These addictions are life destroyers and are by far the hardest to treat. Often, an early childhood or teen crisis can be the cause of these addictions.

A person that has experienced vicious cycles of trauma early in life can become dependent on others who support the "victim" role and may develop additive behavior. Example of such causes:

1. Physical abuse
2. Sexual abuse
3. Mental abuse
4. Extreme violence
5. Witnessing violent behavior such as domestic violence

If a person feels like the "victim" they often refuse to deal with the problems and choose instead to escape from the emotional pain. Jails and prisons are crowded with people who have experienced these types of life's crises.

CRISIS or DISASTER: We often have the misconception that a crisis is a sudden unexpected disaster, such as a car accident, natural disaster, or other cataclysmic event. However, crises can range substantially in severity. Sometimes a crisis is a predictable part of the life cycle brought about by progressive changes that occur in human nature.

Examples:

1. A scientific study of progressive changes that occur in human nature.
2. Changes from infancy to aging and how it encompasses the entire life span
3. Changes in motor skills and psycho-physiological processes.
4. Changes in problem solving skills or moral understanding

Situational crises are sudden and unexpected, such as accidents and natural disasters. Existential crises are inner conflicts related to things such as life purpose, direction, and spirituality.

Differences between Disaster and Crisis: A disaster and a crisis are two different events. The two are sometimes used interchangeably. There are manmade disasters that can occur through persons or organizations which result in a crisis and a crisis can happen though terrorism, nature, accidents. The following information will show the difference between the two.

A disaster occurs by misfortune, misadventure, mishap, accident, blow, reverse, adversity, and affliction. DISASTER, CALAMITY, CATASTROPHE, CATACLYSM refers to adverse happenings often occurring suddenly and unexpectedly.

A DISASTER may be caused by carelessness, negligence, bad judgment, or the like, or by natural forces, as a hurricane or flood: a railroad disaster. CALAMITY suggests great affliction, either personal or general; the emphasis is on the grief or sorrow caused: the calamity of losing a child.

CATASTROPHE refers esp. to the tragic outcome of a personal or public situation; the emphasis is on the destruction or irreplaceable loss: the catastrophe of a defeat in battle. CATACLYSM, physically an earth-shaking change, refers to a personal or public upheaval of unparalleled violence: a cataclysm that turned his life in a new direction.

Crisis: A response to an event

1. a stage in a sequence of events at which the trend of all future events is determined: turning point.

2. A condition of instability; as in a social, economic or political event that can lead to a change in behavior.

3. One's usual coping skills have failed. 4) There is evidence of distress and significant functional impairment.

One purpose of crisis counseling is to deal with the current status of the individual in a crisis. The goal is to reduce the intensity of an individual's emotional, mental, physical and behavioral reactions to reduce chronic exposure to stress or trauma that can lead to mental illness.

It is important that counselors have the skills and knowledge to help people cope with stressors and trauma. Crisis counseling offers assistance, support, resources, and stabilization.

Functioning may be improved by eliminating ineffective ways of coping, such as withdrawal, isolation, and substance abuse. In this way, the individual is better equipped to cope with future difficulties.

Through talking about what happened, and the feelings associated with what happened, while developing ways to cope and solve problems, crisis intervention aims to assist the individual in recovering from the crisis and to prevent serious long-term problems from developing.

Research documents positive outcomes for crisis intervention, such as decreased distress and improved problem solving but before assistance can be offered and an attempt at resolution can be sought through intervention, there are things that must be understood about crisis situations.

Purpose for Crisis Intervention: To establish the dimensions of the problem and define it

1. Encourage the expression of emotions
2. Explore and assess past coping attempts
3. Explore alternatives and specific situations

4. Restore normal functioning
5. Follow up and guidance
6. Concept of Crisis

While attempting an analysis of the concept of crisis we cannot ignore that there are many types of crisis. The psychosocial crisis concept as it is used in psychiatry, psychotherapy, social work, etc. has two historic roots. One root lies in the medical-natural-sciences tradition; the other in the dramaturgical i.e. healing tradition, and they both flow together in the concept as commonly used. At present, there are numerous crisis definitions each of which emphasizes a different aspect.

1. Crises occur in individuals at one time or another and are not necessarily related to psychopathology.
2. Crises are precipitated by a specific event.
3. Crises are acute, not chronic and can usually be resolved within a brief period.
4. A crisis situation has the potential for growth or deterioration.

THREE CHARACTERISTICS OF CRISIS:

1. Failure of coping mechanisms: The connection between mind and body and the difference between the thought and operation processes. It is the philosophy of the mind and soul and the lack of communication between the two and the disruption of the body's normal functioning level.

2. Disrupted homeostasis: Homeostasis is essential for normal functioning it is the constant state of internal environment.

3. Evidence of behavioral/mental impairments: Changes in behavior, reactions, temperament, habits, thought processes.

Characteristics of Those in Crisis:

1. Interference with cognitive processing
2. Difficulty making decisions
3. Limited alternatives (tunnel vision)
4. Inability to connect past and present successes
5. Helplessness/hopelessness

Response depends on:

1. The individuals perception of the event or incident
2. The support and willingness by family, and friends
3. The availability of counsel

TYPES OF CRISES

Medical Crisis: While measures can be taken to prevent some particular types of medical crisis there are many that cannot be prevented. Some examples are:

1. Terminal illness
2. Death
3. Childbirth emergencies and deformation
4. Sudden environmental diseases such as Bird Flu

Developmental Phases of Crises:

1. Starts with a precipitating event
2. Anxiety increases when normal problem solving techniques fail
3. Internal and external resources are used to resolve the problem
4. Without resolution, tension mounts beyond the person's control
5. Drastic results may occur when one reaches the breaking point.

Natural Crises: Disasters are known as an environmental phenomenon. A natural crisis is considered unpredictable and is a menace to life and property and is the earliest types of crisis known to man. The danger of a disaster has to be taken into account when thinking in terms of crisis. There are types of crises that you can take measures to avoid; however, there is no way to avoid a natural crisis. Examples are:

1. Tornados
2. Earthquakes
3. Hurricanes
4. Storms
5. Floods
6. Tidal waves
7. Droughts
8. Forest Fires

These types of disasters have caused billions of dollars in damage and loss and hundreds of thousands of deaths over the last decade. A closer examination of these disasters serves as a foundation for the need for crisis intervention.

Technical Crises:

1. Radon
2. Air pollution
3. Water pollution
4. Pesticides
5. Toxic waste
6. Underground storage dumps

The public perception of a technical crisis is that of manmade human manipulation. The public expects that the Government, Environmental Protection Agency, etc, will use caution during technical disasters. However, attitudes toward technical disasters play an important role in public reactions to technical crises.

In less than a year and a half, three momentous technical crises occurred that has challenged the perception between the public and government.

Bhopal Disaster: December 3, 1984: Considered the worst disaster ever. 2,500 people died, 1,000 expected to die, 3,000 remained critical and over 150,000 people we treated.

Chernobyl Nuclear Plant Explosion: April 26, 1983: Considered the ultimate civilian accident. Spread horror of nuclear power gone out of control. The explosion occurred because of human error while testing. Over 140,000 were evacuated and 30,000 to 50,000 people are expected to die of cancers caused by air born radiation.

Spaceship Challenger Explosion: 1986: Millions watched while the spaceship disintegrated over several states killing all 7 aboard. The launching symbolized the United States Technological knowledge and put doubts and horror in the minds of all who watched.

Crises of Malevolence Examples:

1. World Trade Center Explosions, 2001
2. Alfred P. Murrah Building, Oklahoma City, 1995.
3. Pepsi Syringe scare, 1993, syringes were found in cans of Pepsi nation wide

Individuals use criminal means or other tactics for the purpose of expressing hostility to gain from a company, country, or economic system with the aim of destroying persons or property. Other means have been extortion, and Product tampering: i.e. Tainted Tylenol medication.

Traumatic Crises: Traumatic crisis is an extreme stressor involving injury or a threat to life or witnessing an event that involves the death or serious injury of another person. The trauma's impact is determined by its cause and extent. Natural disasters (floods, earthquakes, hurricanes, etc.) or accidents (plane crashes, workplace explosions) are less traumatic than human acts of intentional cruelty or terrorism.

Terrorist-inflicted trauma appears to produce particularly high rates of crisis emergencies in survivors and bystanders.

Although most people define trauma in terms of events such as war, terrorist attacks, and other events that resulting in vast loss of life, the leading cause of stress-related mental disorders in the United States is motor vehicle accidents. Most Americans will be involved in a traffic accident at some point in their lives, and 25% of the population will be involved in accidents resulting in serious injuries.

Examples of traumatic arises are:

1. Motor vehicle/industrial accidents
2. Sudden death
3. Shootings/stabbings
4. Drowning

Misconception: A common reaction to someone in a crisis is that it was caused by an accident. Crises can be caused by many different means. There are many types of crisis situations that require Crisis Intervention these are just naming a few.

The mental psyche of a person in crisis varies depending on the type and nature of the event either involved in or witnessed.

Crisis Overview

1. Occurs in everyone
2. Not necessarily pathological, may encourage growth and change
3. Time limited to brief period
4. A person's perception determines the severity

Developmental (Maturational) Crises: Predicted times of stress in everyone's life which occurs in response to a transition from one stage in the life cycle to another.

Situational Crises: Occur in response to sudden unexpected events in a person's life. The critical life events revolve around experiences of grief and loss.

Adventitious Crises: Are not part of everyday life. They are unplanned and accidental resulting in traumatic experiences, such as:

Natural disasters: hurricanes, flood, fire, earthquake, war, riots, etc.

Crime of violence: Child abuse, rape, assault, bombing in crowded areas.

BALANCING FACTORS

1. Crisis – good outcome
2. Perception of event is realistic
3. Situational support adequate
4. Coping mechanism adequate
5. Equals – No crisis
6. Crisis - bad outcome
7. Perception distorted
8. Support inadequate
9. Inadequate coping mechanism.
10. Equals - Crisis

Signs and Symptoms of Trauma Related Crisis: People who go through traumatic experiences often have certain symptoms and problems afterward. How severe these symptoms are depends on the person, the type of trauma involved, and the emotional support they receive from others. This section is a general listing of possible symptoms, and is not exhaustive.

Reactions to and symptoms of trauma related crisis can be wide and varied, and differ in severity from person to person. A traumatized individual may experience one or several of them.

After a traumatic experience, a person may re-experience the trauma mentally and physically. Because this can be uncomfortable and sometimes painful, survivors tend to avoid reminders of the trauma. They may turn to alcohol and/or drugs to try and escape the feelings.

Re-experiencing symptoms are a sign that the body and mind are actively struggling to cope with the traumatic experience.

Emotional triggers and cues act as reminders of the trauma and can cause anxiety and other associated emotions. Often the person can be completely unaware of what these triggers are.

In many cases this may lead a person suffering from traumatic disorders to engage in disruptive or self-destructive coping mechanisms, often without being fully aware of the nature or causes of their own actions. Panic attacks are an example of a psychosomatic response to such emotional triggers.

Intense feelings of anger may surface frequently, sometimes in very inappropriate or unexpected situations, as danger may always seem to be present. Upsetting memories such as images, thoughts, or flashbacks may haunt the person, and nightmares may be frequent. Insomnia may occur as lurking fears and insecurity keep the person vigilant and on the lookout for danger, both day and night.

In time, emotional exhaustion may set in, leading to distraction, and clear thinking may be difficult. Emotional dissociation or "numbing out", can frequently occur.

Dissociating from the painful emotion includes numbing all emotion, and the person may seem emotionally flat, preoccupied or distant. The person can become confused in ordinary situations and have memory problems.

SIGNS AND SYMPTOMS OF EMOTIONAL TRAUMA/CRISIS: More and more, researchers in the area of trauma are acknowledging the importance of individual resiliency and vulnerability as key determinants of the intensity and duration of trauma-related symptoms while recognizing that the longer a person suffers a crisis due to trauma the harder it is to cure.

Determining the relative influence of individual predictors is important for the further development of theoretical models for understanding trauma responses. Development of crisis intervention strategies that are sensitive to individual differences is the key to success in crisis intervention.

This study explores the influence of individual factors and social support on traumatic reactions for those exposed to tragic events.

Study results indicate that individuals with feelings of insecurity, lack of personal control, and alienation from others are more likely to experience higher levels of depression and posttraumatic stress symptoms subsequent to exposure to traumatic events. There are many different types

There are common effects or conditions that may occur following a traumatic event. Sometimes these responses can be delayed, for months or even years after the event. Often, people do not even initially associate their symptoms with the precipitating trauma. The following are symptoms that may result from a more commonplace, unresolved trauma, especially if there were earlier, overwhelming life experiences:

PHYSICAL

1. Eating disturbances
2. Sleep disturbances
3. Sexual dysfunction
4. Chronic, unexplained pain
5. Headache
6. Back problems
7. Chest pain
8. Difficulty breathing
9. Visual problems
10. Dizziness
11. Profuse sweating

EMOTIONAL

1. Anxiety/guilt/grief
2. Denial
3. Panic attacks
4. Fear/uncertainty
5. Loss of emotional control/crying for no reason
6. Depression/Suicidal thoughts
7. Feeling overwhelmed
8. Intense anger
9. Irritability/agitation
10. Behavioral
11. Withdrawal
12. Emotional outbursts
13. Suspiciousness/paranoia
14. Pacing
15. Erratic movements
16. Anger
17. Alcohol/Drug abuse
18. Cognitive
19. Blaming others
20. Confusion
21. Poor attention
22. Poor decisions

23. Heightened or lowered alertness
24. Poor concentration
25. Memory Problems
26. Hyper-vigilance
27. Increased or decreased awareness of surroundings
28. Poor problem/ abstract thing
29. Loss of time, place or person orientation
30. Nightmares
31. Intrusive images

SPIRITUAL:

1. Anger with God
2. Feeling distant from God
3. Withdrawal from church
4. Uncharacteristic church involvement
5. Sudden turn toward God
6. Familiar faith practice feel empty (prayer, scriptures, hymns)
7. Church rituals seem empty (worship, communion)
8. Belief that God is powerless
9. Loss of meaning and purpose
10. Sense of isolation (from God and church members)
11. Questioning of one's basic beliefs
12. Anger at clergy
13. Believing God is not in control
14. Believing God doesn't care
15. Belief that we have failed God

SIGNS AND SYMPTOMS OF CRISIS RELTATED STRESS: The causes of stress related to a crisis are numerous. Stress may be linked to outside factors such as the state of the world, the environment in which we live or work, or, our family. Stress can also come from your own irresponsible behavior, negative attitudes and feelings, or unrealistic expectations.

Reactions and responses to stress are individual. What we consider stressful depends on many factors, including, your personality, and your general outlook on life, problem-solving abilities, and social support system.

RESPONSES TO CRISIS RELATED STRESS : Crisis related stress affects many parts of the body, mind and behavior patterns. The specific signs and symptoms of stress vary from person to person, but all have the potential to harm your health, emotional well-being, and relationships with others.

It is a normal reaction for a person suffering from crisis to take his anger, resentment, and feelings of confusion out on family, friends and co-workers.

It is not uncommon to take those feelings out on perfect strangers in such instances as road rage, anger with a waitress in a restaurant, or a clerk at the local convenient store etc.

The first response from a stranger is that the person may just be a “jerk” or just “rude”, however, there are all types of crisis situations and it may be crisis related stress at work or from something more serious. It is a known fact that after a disaster the crime rate goes up, such as murders, shootings, stabbings, violent acts as well as the increase of domestic violence.

Some of the examples of symptoms are listed below.

1. Memory problems.
2. Difficulty making decisions.
3. Inability to concentrate.
4. Confusion.
5. Seeing only the negative.
6. Repetitive or racing thoughts.
7. Poor judgment.
8. Loss of objectivity.
9. Desire to escape or run way
10. Moody and hypersensitive.
11. Restlessness and anxiety.
12. Depression.
13. Anger and resentment.
14. Easily irritated and “on edge”.
15. Sense of being overwhelmed.
16. Lack of confidence.
17. Apathy.
18. Urge to laugh or cry at inappropriate times.
19. Headaches.
20. problems.
21. Muscle tension and pain.
22. Digestive Sleep disturbances.
23. Fatigue.
24. Chest pain, irregular heartbeat.
25. High blood pressure.
26. Weight gain or loss.
27. Asthma or shortness of breath.
28. Skin problems.
29. Decreased sex drive
30. Eating more or less.
31. Sleeping too much or too little.
32. Isolating yourself from others.
33. Neglecting your responsibilities.
34. Increasing alcohol and drug use.
35. Nervous habits (e.g. nail biting, pacing).
36. Teeth grinding or jaw clenching.
37. Overdoing activities such as exercising or shopping.
38. Losing your temper.
39. Overreacting to unexpected problems.

Keep in mind that the signs and symptoms of crisis related stress can be caused by other psychological or physical problems, so it's important to consult a doctor to evaluate physical symptoms. Similarly, emotional symptoms such as anxiety or depression can mask conditions other than stress. It's important to find out whether or not they are stress-

Acute stress: Acute stress is the most common and most recognizable form of stress, it is the kind of sudden event or incident in which a person knows why they're stressed, like a car crash. Acute stress occurs during obvious dangers and threats.

Common causes of acute stressors include loud noises, isolation, crowding, and hunger. Normally, the body rests when these types of stressful events cease and life gets back to normal. Because the effects are short-term, acute stress usually doesn't cause severe or permanent damage to the body.

Episodic acute stress: Episodic acute stress is something that happens frequently. These people are recognizable because their lives are frequently chaotic, out of control, and they always seem to be facing multiple stressful situations.

They're always in a rush, taking on too many projects at once, handling too many demands. Unlike people for whom stress is a once-in-a-while spike, these folks are experiencing episodic acute stress.

Those prone to episodic acute stress include driven, hard-charging "Type A" personality types and worrywarts; always anxious about the next disaster they're sure lurks around the corner.

While the Type A tends to seem angry and hostile and the worrier more depressed, both are frequently over-aroused and tense and both are susceptible to the physical manifestations of extended stress, including high blood pressure and heart disease.

Chronic stress: The APA Help Center describes chronic stress as "unrelenting demands and pressures for seemingly interminable periods of time." Chronic stress is stress that wears a person down day after day and year after year, with no visible escape. It grinds away at both mental and physical health, leading to breakdown and even death.

Common causes of chronic stress include:

1. Poverty and financial worries
2. Long-term unemployment
3. Dysfunctional family relationships
4. Caring for a chronically ill family member
5. Feeling trapped in unhealthy relationships or career choices
6. Living in an area besieged by war or violence
7. Bullying or harassment
8. Perfectionism

One of the most dangerous aspects of chronic stress is that because chronic stress is based on long-term, often intractable situations, both the mental and physical symptoms of chronic stress can be difficult to treat.

General Stress: Stress encountered on a daily basis.

1. Children/home
2. Job related stress
3. Financial Problems
4. Marital Problems
5. Holidays

Cumulative Stress: Stress brought on when additional, more serious stresses are added to everyday stressors. Some examples of these are:

1. Carpal tunnel syndrome
2. Tendonitis
3. Bursitis
4. Tennis elbow
5. Long-term Stress

The stress response of the body is meant to protect and support us. When faced with a threat, whether it is to our physical safety or emotional equilibrium, the body's defenses kick into high gear in a process known as the "fight or flight" response.

The sympathetic nervous system pumps out adrenaline, preparing us for emergency action. Our heart rate and blood flow to the large muscles increase, the blood vessels under the skin constrict to prevent blood loss in case of injury, the pupils dilate so we can see better, and our blood sugar ramps up, giving us an energy boost.

Physical and Mental Signs of Long-term Stress: Long-term stress or stress that is occurring over long periods of time can have an even greater effect on your body and mind. Long-term stress can affect your body by:

1. Changing your appetite
2. Changing your sleep habits
3. Encouraging 'nervous' behavior such as twitching, talking too much, nail biting, teeth grinding, pacing, and other repetitive habits
4. Causing you to catch colds or the flu more often and causing other illnesses such as asthma, headaches, stomach problems, skin problems, and other aches and pains
5. Affecting your sex life and performance

Making you feel constantly tired and worn out: Long-term stress can also have serious effects on your mental health and behavior. If you are under stress for long periods of time, you may find that you have difficulty thinking clearly, dealing with problems, or even handling day-to-day situations as simple as shaving, picking up clothes or arriving somewhere on time. Some mental signs of long-term stress include:

1. Worrying and feeling anxious (which can sometimes lead to anxiety disorder and panic attacks)

2. Feeling out of control, overwhelmed, confused, and/or unable to make decisions

3. Experiencing mood changes such as depression, frustration, anger, helplessness, irritability, defensiveness, irrationality, overreaction, or impatience and restlessness

4. Increasing dependence on food, cigarettes, alcohol, or drugs

5. Neglecting important things in life such as work, school, and even personal appearance

6. Developing irrational fears of things such as physical illnesses, natural disasters like thunderstorms and earthquakes, and even being terrified of ordinary situations like heights or small spaces

While occasionally experiencing one or two of the above symptoms may not be cause for concern (everyone has a few nervous habits and difficulties in their lives!), having a number of these symptoms may mean you are under more stress than you think. But realizing you are under stress is the first step in learning to deal with stress.

Health Problems Linked to Stress

1. Heart attack
2. Hypertension
3. Stroke
4. Cancer
5. Diabetes
6. Depression
7. Obesity
8. Eating disorders
9. Substance abuse
10. Ulcers
11. Irritable bowel syndrome
12. Memory loss
13. Autoimmune diseases (e.g. lupus)
14. Insomnia
15. Thyroid problems
16. Infertility

Physical and Mental Signs of Short-term Stress: Often occurring in quick 'bursts' in reaction to something in your environment, short-term stress can affect your body in many ways. Some examples include:

1. Making your heartbeat and breath faster
2. Making you sweat more
3. Leaving you with cold hands, feet, or skin
4. Making you feel sick to your stomach or giving you 'butterflies'
5. Tightening your muscles or making you feel tense
6. Leaving your mouth dry
7. Making you have to go to the bathroom frequently
8. Increasing muscle spasms, headaches, fatigue, and shortness of breath

While this burst of energy may help you in physical situations where your body needs to react quickly, it can have bad effects on your mind and performance if there is no outlet or reason for your stress. These effects may include:

1. Interfering with your judgment and causing you to make bad decisions
2. Making you see difficult situations as threatening
3. Reducing your enjoyment and making you feel bad
4. Making it difficult for you to concentrate or to deal with distraction
5. Leaving you anxious, frustrated or mad
6. Making you feel rejected, unable to laugh, afraid of free time, unable to work, and not willing to discuss your problems with others

Psychological Responses to Stress: Stress can be defined as the sum of physical and mental responses to an unacceptable disparity between real or imagined personal experience and personal expectations. By this definition, stress is a response which includes both physical and mental components.

Mental responses to stress include adaptive (good) stress, anxiety, and depression. Where stress enhances function (physical or mental) it may be considered good stress. However, if stress persists and is of excessive degree, it eventually leads to a need for resolution, which may lead either to anxious (escape) or depressive (withdrawal) behavior.

One may further appreciate from that definition that stress may derive from imagined experiences that are frightening. Further, the fulcrum of stress response is the presence of disparity between experience (real or imagined) and personal expectations.

A person living in a fashion consistent with personally-accepted expectations has no stress even if the conditions might be interpreted as adverse from some outside perspective — rural people may live in comparative poverty, and yet be unstressed if there is a sufficiency according to their expectations.

Finally, when there is chronic disparity between experience and expectations, stress may be relieved by acceptance. However, since acceptance is rarely complete except in children, stress resolution by this approach is also rarely complete.

It has been said that stress is often a reaction to a crisis of predictability, that the mind is solely an instrument of prediction, and that the body may be divided into a vegetative process and an integrative process.

Psychological Responses to Trauma: Psychological trauma is a type of damage to the psyche that occurs as a result of a traumatic event. A traumatic event involves a singular experience or enduring event or series of events that completely overwhelms the individual's ability to cope or to integrate the ideas and emotions involved with that experience.

Trauma can be caused by a wide variety of events, but there are a few common aspects. It usually involves a complete feeling of helplessness in the face of a real or subjective threat to life, bodily integrity, or sanity.

There is frequently a violation of the person's familiar ideas about the world; putting the person in a state of extreme confusion or insecurity. This is often seen when people or institutions depended on for survival violate or betray the person in some unforeseen way.

Psychological trauma may accompany physical trauma or exist independently of it. Typical causes of psychological trauma or abuse, violence, the threat of either, or the witnessing of either, particularly in catastrophic events such as earthquakes and volcanic eruptions, war or other mass violence can also cause psychological trauma.

Long-term exposure to situations such as extreme poverty or milder forms of abuse, such as verbal abuse, can be traumatic (though verbal abuse can also potentially be traumatic as a single event).

In some cases, even a person's own actions, such as committing rape, can be traumatic for the offender as well as the victim, especially if the offender feels helpless to control the urge to commit such crimes.

However, different people will react differently to similar events. One person may perceive an event to be traumatic that another may not, and not all people who experience a traumatic event will become psychologically traumatized.

When assessing a person, it is extremely important that they are assessed correctly. To anticipate a complete and successful recovery depends on the correct assessment and treatment of the crisis.

Understanding Psychological Trauma: Human beings require, and therefore they create, assumptive explanatory worldviews. These assumptions about the world serve to bring order to chaos and safety to a dangerous environment. These worldviews are essential aspects of human development because they serve as substitutes for actual means of protection and understanding.

They are most operational in childhood, but are essential through all aspects of human development. A traumatic stress response arises when an essential assumption about the world is violated. We believe that there are but a finite set of operative assumptive worldviews and they appear to pertain to:

1. The belief in a fair a just world
2. The need to trust others
3. A positive self-identity
4. The need for safety

Some form of faith or religion that serves to bring meaning to even the most complex or ambiguous events. Thus, we believe that psychological Traumatization is a direct result of:

1. A violated sense of fairness or justice
2. Treachery or betrayal
3. A violation of one’s sense of self

4. A catastrophic revelation of mortality or vulnerability.
5. The violation or contradiction to one's score religious or faith based belief system.

While the Pastoral Crisis Counseling can have a positive effect upon any of the violated assumptions, the Pastoral Crisis Counseling may be uniquely prepared to address the trauma of a violated religious tenet.

Some people suffering from trauma feel mentally damaged when they realize that the symptoms don't go away and they don't believe their situation will improve.

This can lead to feelings of despair loss of self-esteem and frequent depression. If they feel that their world or belief system has been violated, the person may call their own identity into question.

These symptoms can lead to stress or anxiety disorders or even post traumatic stress disorder where the person experiences flashbacks and re-experiences the emotion of the trauma as if it is actually happening.

Once a condition has been diagnosed as an anxiety disorder the feeling of despair may increase especially if the person feels that the situation will not improve.

Situational Trauma: Trauma is well-known in war, accidents and crime situations. It is almost always seen in military actions, victims of crime, and violent situations. It also occurs in natural and man-made disasters, catastrophic mishaps, and medical emergencies.

Here treatment for trauma is often either not sought, or is not available. Trauma is common, but less often identified in situations of domestic violence, pedophilia, and incest.

It also occurs in victims of child or elder abuse. Victims in situations of pedophilia, domestic violence, and neglect are often not identified by caregivers and so are unlikely to receive proper treatment for ongoing trauma.

Trauma is often defined as the lack of coping skills to a particular event and a consequence of overwhelming situations. However, as an individual's sense of being "overwhelmed" is subjective, the occurrence of trauma is also subjective.

There is evidence to suggest that how people cope with extremely stressful situations is associated with the amount of trauma suffered from such events.

It is not necessary that physical damage occurs for experiences to have a traumatizing effect. Regardless of the source of the trauma, the experience has three common traits: it was unexpected, the person was unprepared and there was nothing the person could do to prevent it from happening. It is not the event that determines whether trauma occurs, but the subjective experience of the person involved.

In many incidences a person may even be surprised by their own reaction to the situation and often will not realize the extent of the effect that the traumatic event had on them until they have an adverse reaction to a seemingly simple, minor situation.

By the time an adverse reaction occurs those suffering from a crisis may be well on their way to suffering long term effects.

RESPONSES TO PSCHOLOGICAL TRAUMA: There are common behavioral responses to stressors; Some of those responses may include:

Proactive response: The attempt to correct a stressor before it becomes an effect on a lifestyle

Reactive response: Occurs after a trauma has occurred: aimed at correcting the damage of the event.

Passive response: The emotional numbness or ignorance of a stressor.

Those who are able to be proactive can often overcome stressors and are more likely to be able to cope well with unexpected situations. On the other hand, those who are more reactive will often experience more noticeable effects from an unexpected stressor.

In the case of those who are passive, victims of a stressful event are more likely to suffer from long term traumatic effects and often enact no intentional coping actions. These observations may suggest that the level of trauma associated with a victim is related to such independent coping abilities.

There is also a distinction between trauma induced by recent situations and long-term trauma which may have been buried in the subconscious from past situations such as childhood abuse. Trauma is often overcome by recreating the origin of the trauma.

TRAUMA AND STRESS DISORDERS: In times of war, psychological trauma has been known as shell shock or combat stress. Psychological trauma may cause acute stress disorder (ASD) which may lead on to post-traumatic stress disorder (PTSD).

PTSD can also develop without an antecedent ASD and may come on months or years after the trauma. Both ASD and PTSD are specific disorders in which the traumatized individual may experience nightmares, avoidance of certain situations and places, depression, and symptoms of hyperactivity.

PTSD emerged as the label for this condition after the Vietnam War when many veterans returned to their respective countries demoralized, and sometimes addicted to drugs.

Psychological trauma is treated with therapy and, if needed, medications. Recent studies try to show the effect of traumatic events on human memory. This kind of study is useful when someone has witnessed or been involved in a violent criminal act.

Therapies used in the treatment of psychological trauma include: Cognitive therapy (CBT): Using cognitive therapy in persons suffering acute psychosis has shown a significant impact on the recovery rate of positive symptoms.

Brief therapy: Brief therapy is defined in contrast to "long-term" therapy in that the focus of treatment is on specific, measurable, short term goals. The length of treatment is dependent upon the client's

achievement of these goals. The philosophy of Brief Therapy is to not spend great amounts of time in therapy.

The therapist's commitment is that a client's outside life is more important than therapy and that therapy is not "timeless". There is a conscious and conscientious use of time and a frequent review of progress.

New solutions are targeted if previous solutions are found to be ineffective. Brief therapy may occur episodically over years with challenging problems such as severe abuse or trauma.

Psychodynamic Psychotherapy - Psychodynamic psychotherapy is a type of psychotherapy, usually meeting about once or twice a week. It is different from other systems of psychotherapy, for instance psychoanalysis or cognitive therapy, in that it uses a range of different techniques applied to the client considering his or her needs.

Traumatic Incident Reduction (TIR) – TIR, or Traumatic Incident Reduction is a systematic method of locating, reviewing and resolving traumatic events.

TIR has proven useful in relieving a wide range of fears, limiting beliefs, suffering due to losses (including unresolved grief and mourning), depression, and other PTSD symptoms.

The TIR technique, though directive, can be traced to roots in psychoanalytic theory and desensitization methods; however, it is carried out in a thoroughly person-centered, non-judgmental and non-evaluative.

Eye Movement Desensitization and Reprocessing (EMDR). Also known by its abbreviation EMDR. This treatment claims to relieve the symptoms of Post Traumatic Stress Disorder (PTSD) and other mental health problems using only movements of the eyes similar to those which occur naturally in REM sleep.

Dialectical Behavioral Therapy (DBT): Dialectical behavior therapy (DBT) is a psychosocial treatment developed by Marsha M. Linehan specifically to treat individuals with borderline personality disorder. While DBT was designed for individuals with borderline personality disorder, it is used for patients with other diagnoses as well.

Once a person has been requested therapy and he/she has been assessed, the correct type of therapy may be applied by a counselor. A counselor who has been requested by a person involved in a traumatic incident should consider each of these therapies carefully to make sure the correct treatment will be administered.

Persons involved in traumatic events need assistance as soon afterwards as possible. This practice may not alone, gather the positive results needed to recover psychologically from a traumatic event.

Victims of traumatic occurrences who were debriefed immediately after the event in general do better than others who received therapy at a later date. Yet, there is one indication that forcing immediate debriefing may distort the natural psychological healing process.

If someone is not ready and prepared to have counseling they may show extreme resentment therefore, the idea of getting treatment should be theirs.

Growth aspects of trauma: Though trauma is most frequently thought of in negative terms, it often has positive aspects. Many people have overcome traumas and moved on to become inspirational figures.

This growth, can involve changes in how people think of themselves, changes in relationships with others. (Including all of humanity) and profound philosophical, spiritual, or religious changes.

Trauma experiences can lead to growth. Though this is not inevitable, they have found that "reports of growth experiences in the aftermath of traumatic events far outnumber reports of psychiatric disorders." They state that these changes can include.

1. Improved relationships
2. New possibilities for one's life,
3. Greater appreciation for life,

Greater sense of personal strength and spiritual development: There appears to be a basic paradox experienced by trauma survivors who report these aspects of posttraumatic growth: Their losses have produced valuable gains.

They also may find themselves becoming more comfortable with intimacy and having a greater sense of compassion for others who experience life difficulties. Still, they add, "posttraumatic growth does not necessarily yield less emotional distress."

Posttraumatic growth occurs in the context of suffering and significant psychological struggle, and a focus on this growth should not come at the expense of empathy for the pain and suffering of trauma survivors.

For most trauma survivors, posttraumatic growth and distress will coexist, and the growth emerges from the struggle with coping, not from the trauma itself.

They point out that "there are also a significant number of people who experience little or no growth in their struggle with trauma."

A traumatic stress response arises when one feels that they have been violated. When our belief system has been challenged in such areas as:

1. A just and fair world
2. Trust in others
3. Positive self belief and image
4. The need for safety
5. Faith or religion

Psychological Traumatization is the direct result of:

1. Fairness and Justice has been violated
2. Betrayal
3. Violation to one's self
4. Vulnerability during a catastrophe
5. Contradiction to one's core religious, faith or belief system
6. Crisis of Faith

Definition: A critical period in the person's life when they are confused about their beliefs. As a Christian they are uncertain about what they are to believe. As a result, they are insecure and bewildered and there lies the crisis. It is a confused state of mind when their mental attitude towards the most sacred mysteries, become distorted.

Many psychologists and theologians have contributed to research and publications concerning the fields of coping with crisis on the one hand, and religious belief on the other. Very few, however have tried to clarify the relationship between the two.

The purpose of this is to clarify the meaning of crisis experiences in the development of belief and unbelief. In order to do so our very first task will be to define the concepts we use. This is all the more necessary because there appears to be a wide range of meanings attributed to these terms.

CHALLENGED BELIEF AND UNBELIEF: We often take belief and unbelief as religious attitudes while attempting to distinguish between religion, faith and belief. Religion is the cumulative tradition of expression of faith. Belief is seen as the adherence to certain (religious) convictions or ideologies, and faith is described as the attitude of an individual's heart and will a sense of loyalty and trust.

It might be safe to say that religion is the more formal and social dimension, belief the cognitive dimension, and faith the affective and relational dimension. This relational dimension should include the relationship with God.

In Object-relation-psychology some have integrated the religious and social dimensions. It is an object of the psychology of religion to investigate the interaction of these dimensions.

Belief is the cognitive dimension of a religious attitude in which human life is interpreted within a religious frame of reference; a central story line that says: "God has something to do with it".

Unbelief however is in the same way, a religious attitude. Unbelief means that human life is interpreted within a religious frame of reference; a central story line that says "God has nothing to do with it". The belief and unbelief are processes of adherence to traditionally defined doctrines on one hand and experiences of reality on the other.

Belief and unbelief are central story lines that express an interpretation of the facts of life and give an answer to the questions concerning the relationship between God and our lives. Both attitudes address an ultimate concern and ultimate meaning of life, and thereby are fundamentally religious.

Reactions by a person during a traumatic event or tragedy may on the surface appear to be a theological expression of trauma such as “If there was a God, he wouldn’t do this” or “How could God let this happen” However, the purpose of this reaction needs to be heard. The person is using theological language to express an extreme sense of being overwhelmingly helpless, shocked, and traumatized with the reality of the tragedy.

A Pastoral Crisis Counselor should avoid the temptation to enter into a theological dialogue in the defense of God. Instead, the focus needs to be on the sense of helplessness and violation with respect to one’s own view and their relationship with God.

1. Crisis of Faith Symptoms
2. Anger at God
3. Feeling betrayed and abandoned by God
4. Disbelief and helplessness
5. Inability to pray or attend to bible study or church
6. Violations of Belief
7. Belief that we live in a just and fair world
8. Believe that we can trust people
9. Believe in self worth and self esteem
10. Require sense of safety
11. Believe in order, faith and religion
12. The Theoretical Model

The subject under discussion is the interaction of crisis experiences and the development of belief or unbelief. Using the concepts as described above, we can formulate a narrative theory of crisis, belief and unbelief.

The question to be answered is how the attitudes of belief and unbelief develop and what the influence of crisis experience can be. Studies and clinical pastoral experience show that crisis experience can strengthen both belief and unbelief. A further question therefore is why crisis experiences in some cases support the development of belief and in others the development of unbelief.

When we take belief and unbelief as interpretations within a religious frame of reference, and a crisis experience as the failure of the personal frame of reference to give adequate meaning to the facts of life, then the basic features of this narrative theory emerge.

The individual is constantly interpreting his or her own world, writing the personal narrative in which these fundamentally religious questions are to be answered.

This means that identity as it becomes clear in the personal narrative and belief are very closely linked. Both belief and identity are dimensions of the personal narrative and contribute to the interpretations we make. Crisis is the rupture of this personal narrative, asking for a re-writing and the attribution of a new meaning to the same facts.

Through crisis experiences we come to a new interpretation, a central story line that may be quite different from before. In the new personal narrative the interpretations concerning the place of God in

our lives may significantly change. It is possible that new interpretations of belief represent old interpretations pertaining to unbelief.

A second possibility is the situation where interpretations of belief are substituted in crisis experiences by interpretations of unbelief. We might call these situations conversions too, because the religious dimension of the personal narrative or frame of interpretation in these cases is also thoroughly changed.

We therefore call this type a negative conversion. The third possible outcome is a change in interpretations where the fundamental narrative of belief or unbelief is not substituted by its counterpart. In this case we speak of stable belief or stable unbelief.

That belief and unbelief may change in crisis experiences is not too hard to explain in a narrative theory. More important, however, and more difficult is the question why it changes the way it does.

What are the factors involved that make crisis experiences change the belief / unbelief-attitudes? Detailed conclusions are not yet available, but some comments can be made, based on preliminary results, and on research done by others.

NOTES

TERMINOLOGY

Definitions:

1. Precipitating Event: The traumatic event that occurred to cause the crisis: occurrence brought about prematurely, hastily or suddenly: exceedingly sudden or abrupt.

2, Resources: Supply, support or aid: Capability in dealing with a situation or in meeting difficulties.

3. Internal Stressors: Internal stress

4. Crisis of Erosion: Crisis triggered by accumulation of small stressors

5. Resolution: to resolve or determine

6. CISM: Critical Incident Stress Management

7. PCI: Pastoral Crisis Intervention

8. Intervention: To act or fact of intervening

9. Pastoral: pertaining to or counseling of shepherds by pastor, minister or chaplain

10. Counselor: A person who counsels or advises

11. Trauma: The condition resulting from an injury or startling experience

12. Stress: The action on a body or any system of balanced forces whereby strain or deformation result.

13. Faith: Confidence or trust in a person or thing or a system of religious belief.

PASTORAL ROLE IN CRISIS COUNSELING: Member's of the clergy represent a large resource in times of trauma related crisis. They possess a very unique accumulation of characteristics that make them valuable amidst the turmoil of a psychological crisis.

In critical incidents such as mass disasters, violence, death of family etc, and any event where human actions result in injury, destruction, and/or death, the pastoral community possess powerful restorative attributes.

Unfortunately, there has existed no generally recognized and accepted manner in which the healing factors inherent in pastoral care have been functionally integrated with the well-formulated principles of crisis intervention.

This information represents an initial effort to elucidate how the principles of pastoral care may be functionally integrated with those of crisis intervention. The amalgam shall heretofore be referred to as "Pastoral Crisis Counseling.

The term "Pastoral Crisis Counseling" has been defined as the functional integration of faith-based resources with traditional crisis intervention assessment and intervention technologies.

Pastoral Crisis Counseling has been differentiated from ministry and the provision of chaplaincy services. This information provides a public health model for integrating Pastoral Crisis Counseling services within the larger domain of community disaster response, crisis intervention, and emergency mental health. Pastoral Crisis Counseling is a combination of faith-based and traditional techniques of crisis intervention.

Pastoral counselors are trained to provide services to individuals in crisis. These workers can assist an individual or group in crisis by providing direct intervention, by identifying alternative coping skills or by consulting with others.

A pastor's primary role in a crisis is to identify, assess and intervene and to return the individual to his/her normal level of functioning as quickly as possible and to lessen any negative impact on future mental health. Sometimes during this process, new skills and coping skills are acquired in the process.

Pastoral crises intervention is not the same as pastoral counseling or pastoral psychotherapy. This by way of summarial parallelism, as crisis intervention is to counseling and psychotherapy so Pastoral Crisis Counseling is to pastoral counseling and pastoral psychotherapy.

IDENTIFICATION: Identification recognizes that a problem exists and it focuses on the event's significance in the person's environment and the person's current functioning level. The event or crisis may be categorized as either developmental or situational

Developmental crisis result from predictable change and are due to normal growth or development such as the onset of adolescence. Situational crises are either predictable, arising from certain events such as divorce or failing a grade or are unpredictable such as an accident death or natural disaster. Both types involve a change in circumstances, usually accompanied by a loss, which can precipitate a crisis reaction in an individual.

Therapists and counselors must promptly identify a person in crisis as well as assess the degree to which his/her functioning level has been impaired. In addition to psychological disequilibrium other signs and symptoms may indicate a problem for those experiencing a crisis.

The goals of Pastoral Crisis Counseling as defined, are fundamentally the same as those of non-Pastoral Crisis Counseling.

The reduction of human stress: To overcome the event that caused a crisis of faith. Pastoral Crisis Counseling brings with it a value added over and above the traditional non-pastoral approach to crisis intervention. The corpus of value added ingredients has been enumerated above as mechanisms of action or agents of change and appears to be unique to the pastoral perspective as it employs religious, spiritual and theological resources in an effort to "shepherd" an individual from distress and dysfunction to restoration.

As a result of these unique strengths some form of Pastoral Crisis Counseling options should be integrated within all critical incident stress management teams, community crisis response efforts and other crisis intervention systems.

PHASES OF CRISIS COUNSELING: Immediate crisis intervention or "psychological first aid" involves.

1. Establishing a rapport with the victim
2. Gathering information for short-term assessment
3. Service delivery
4. Averting a potential state of crisis

Many victims may be resistant to crisis intervention due to fear or anxiety. Resistance is one form of the victim's response to a crisis situation. The immediacy of the response is critical to ensure the safety of the victim and his or her family.

Time may be extremely important because of impending danger to the victim or the family. Victims should not wait hours or days to see a crisis intervention counselor to assist in their time of need.

Immediate crisis intervention also includes:

1. Caring for the medical, physical, mental health of the person
2. Meeting personal needs of the victim
3. Providing local resource information to the victim
4. Providing information about shelter facilities
5. Providing home security information
6. Providing crime victim information

The second phase of crisis intervention involves an assessment of:

1. Personal needs to determine the services and resources required
2. Provide emotional support to the victim.

The purpose of this phase is to determine how the crisis affects the victim's life so that a plan for recovery can be developed, allowing the victim to begin moving towards the future

The third phase: Recovery intervention helps victims re-stabilize their lives and become healthy again. It also involves helping the victim prevent further victimization from the criminal justice system or other agencies the victim may come into contact with in the aftermath of victimization.

This is the initial period of recovery for the victim, and may require considerable time, effort and resources before the victim resolves long-term issues associated with the victimization.

THE ASSESSMENT PHASE: Before proper assessment can be started, there are specific elements that must be discussed. There are elements such as proper listening skills, establishing trust etc. There are effective elements and certain obstacles that must be overcome before a complete assessment can be done.

ESTABLISING RAPPORT: The first step is to gain trust. Sometimes that is a difficult task depending on the mental condition of the person after a crisis and depending on the crisis situation itself. The more devastating the trauma the more difficulty one may have gaining that trust.

There are specific techniques that can be used to gain the trust needed to begin the assessment.
Examples Are

1. Call them by their first name
2. Let them know it's okay to be afraid
3. Let them know that you want to be there and you want to help
4. Never talk down to them
5. Never show disrespect for their race, gender or realign
6. Never yell or get impatient with them
7. Never prejudge their situation
8. Let them talk without interruption
9. Listen, don't give advice
10. Ask or use feeling questions or statements

LISTENING TECHNIQUES: The most important thing a pastoral counselor does is to listen carefully to the person in crisis. There are techniques used to gather as much information as possible for a complete and successful assessment.

1. Use active listening
2. Pay attention to non-verbal communication
3. Attempt to grasp what is being said and don't ignore the message
4. Identify coping patterns
5. Ask open ended questions
6. Use eye contact
7. Listen with empathy not sympathy
8. Paraphrase when necessary
9.b Watch body language and mannerisms

What Not to Say

1. I know how you feel
2. Time heals all wounds (it doesn't)
3. You will get over this
4. You must go on
5. He didn't know what hit him
6. There is always someone worse off than you
7. Just remember the good memories

8. It was God's will or it was their time to go
9. Someday you will understand
10. God never gives us more then we can handle
11. Only the good die young
12. You can have another child
13. Be brave, Don't cry

Never burden someone with these platitudes:

1. You need to stay strong
2. You've got to get a hold of yourself

What To Say:

1. I'm so sorry, I care how you feel
2. Your reaction is normal
3. It's okay to cry
4. Talk to me, tell me how you feel, help me to understand
5. I will be here if you want to talk

Obstacles to Effective Listening

1. Prejudging the relevancy of the problem
2. Rehearsing a response
3. Failing to hear what is being said
4. Focusing your attention on the delivery and not the content

An essential part of this assessment is an evaluation of the person's current safety. Any risk to his/her own current stress level and emotional affect such as hopelessness and helplessness should be identified and through effective listening a complete recovery can be anticipated.

After identifying a crisis situation and a person in crisis, a counselor must assess the crisis's impact on the individual. This assessment usually takes a form of an interview at which time the counselor must convey an atmosphere of:

1. Acceptance
2. Support
3. Calm confidence about the future.

Communication with the person experiencing a crisis is vital. This involves establishing eye and sometimes, physical contact. Questions addressed to the individual may include his/her perception of the problem. Some of these questions are:

1. The sequence of events
2. The frequency of feelings
3. A history of attempts to deal with the problem
4. Specific feelings about the precipitating event

LISTENING SKILLS: Often, a person does not feel comfortable talking with a supervisor, friend or family about problems they are experiencing. They do not want to take the problem home to the spouse or parents as they do not want to alarm them. Where do they go?

The pastor must have good listening skills to be able to listen with empathy and compassion and then calmly offer assistance when such assistance is appropriate.

On call 24 hours a day a pastor stands ready to respond. Pastoral Counselors know they need to be with people whenever and wherever their service is needed.

Ministry is no place for a person who does not like to have his sleep interrupted. It is not a vocation or avocation for the person who is in need and wishes only to be used on "state occasions." The ministry must be filled by a person whose primary desire is to be of help to those in need.

ACTIVE LISTENING: Listening makes the person you are speaking to feel worthy, appreciated, interesting, and respected. Ordinary conversations emerge on a deeper level, as do our relationships. When we listen, we foster the skill in others by acting as a model for positive and effective communication and it helps them feel that we understand what they are saying.

Whenever counseling, greater communication brings greater understanding. Pastors listen and it helps build self-esteem.

In the business world, listening saves time and money by preventing misunderstandings. And we always learn more when we listen than when we talk.

Listening skills fuel our social, emotional and professional success, and studies prove that listening is a skill we can learn.

The Technique: Active listening is really an extension of the Golden Rule. To know how to listen to someone else, think about how you would want to be listened to.

While the ideas are largely intuitive, it might take some practice to develop (or re-develop) the skills. Here's what good listeners know -- and you should, too:

Face the speaker. Sit up straight to show your attentiveness through body language.

Maintain eye contact, to the degree that you all remain comfortable.

Minimize external distractions. Turn off the TV. Put down your book or magazine, and ask the speaker and other listeners to do the same.

Respond appropriately to show that you understand. Murmur ("uh-huh" and "um-hmm") and nod. Raise your eyebrows. Say words such as "Really," "Interesting," as well as more direct prompts: "What did you do then?" and "What did she say?"

Focus solely on what the speaker is saying. Try not to think about what you are going to say next. The conversation will follow a logical flow after the speaker makes her point.

Minimize internal distractions. If your own thoughts keep horning in, simply let them go and continuously re-focus your attention on the speaker, much as you would during meditation.

Keep an open mind. Wait until the speaker is finished before deciding that you disagree. Try not to make assumptions about what the speaker is thinking.

Avoid letting the speaker know how you handled a similar situation. Unless they specifically ask for advice, assume they just need to talk it out. Remember, it's not about you, it's about them and what the problem is.

Engage yourself. Ask questions for clarification, but, once again, wait until the speaker has finished. That way, you won't interrupt their train of thought. After you ask questions, paraphrase their point to make sure you didn't misunderstand. Start with: "So you're saying…"

Even if the speaker is launching a complaint against you, wait until they finish to defend yourself. The speaker will feel as though their point had been made. They won't feel the need to repeat it, and you'll know the whole argument before you respond. Research shows that, on average, we can hear four times faster than we can talk, so we have the ability to sort ideas as they come in…and be ready for more.

As you work on developing your listening skills, you may feel a bit panicky when there is a natural pause in the conversation. What should you say next? Learn to settle into the silence and use it to better understand all points of view. Ironically, as your listening skills improve, so will your aptitude for conversation.

Active listening

A FOUNDATION of effective Communication: Active listening intentionally focuses on who you are listening to, whether in a group or one-on-one, in order to understand what he or she is saying. As the listener, you should then be able to repeat back in your own words what they have said to their satisfaction. This does not mean you agree with, but rather understand, what they are saying.

Before responding or questioning, give the speaker time and space to rest after talking, then express appreciation and interest in the topic.

1. Briefly restate the key points to show you are interested and understand what the speaker intended.
2. If you have a question, ask it in a positive, non-judgmental manner.
3. Maintain eye contact
4. Don't argue with the topic or purpose of the communication
5. Prepare with a Positive, Engaged Attitude
6. Focus your attention on the subject
7. Stop all non-relevant activities beforehand to orient yourself to the speaker or the topic

8. Review mentally what you already know about the subject
9. Organize in advance relevant material in order to develop it further
(previous counseling, newspaper articles, prior real life experience, etc.)
10. Avoid distractions
11. Seat yourself appropriately close to the speaker
12. Avoid distractions (a window, noise, etc.)
13. Acknowledge any emotional state
14. Suspend emotions until later, or
15. Passively participate unless you can control your emotions
16. Set aside your prejudices, your opinions
17. You are present to learn what the speaker has to say.
18. Be other-directed; focus on the person communicating
19. Follow and understand the speaker as if you were walking in their shoes
20. Listen with your ears but also with your eyes and other senses
21. Be aware: non-verbally acknowledge points in the speech
22. Let the argument or presentation run its course
23. Don't agree or disagree, but encourage the train of thought
24. Be involved:
25. Actively respond to questions and directions
26. Use your body position (e.g. lean forward) and attention to encourage the speaker and signal your interest

Active Listening is a very successful set of listening skills and techniques which enable the listener to accurately construe what the speaker is intending to say. In turn, the speaker feels heard, and understood.

Soon the communication between the speaker and listener flows smoothly, free of messy misunderstandings. Consequently, the people in communication stand a far greater chance at solving problems, resolving conflicts, fostering deeper intimacy, and creating a

closer and more trusting relationship.

Active Listening skills and techniques include the following

Using your body language effectively

Incorporating Reflective Listening and Paraphrasing techniques

Ask "Clarifying Questions" to make sure he/she accurately hears what the speaker is trying to communicate

Making astute "Content to Process shifts, “which enables the listener to hear the many layers of thoughts and feelings that lie beneath the surface of what is being said out loud.

BODY LANGUAGE and ACTIVE LISTENING: When communicating with others our body language can reveal how we feel about what the speaker is saying.

For example:

1. Rolling eyes
2. Yawning
3. Closing eyes
4. Slouching shoulders
5. Drooping head
6. Moving your hands restlessly
7. Clenching your jaw or Puffing out your chest
8. Breathing shallowly
9. Avoiding eye contact

In order to use your body effectively when listening to someone, do your best to breathe deeply, and offer the person good eye contact. Meaning, soften your eyes, so they appear receptive to what the person is saying, and non-threatening. Do your best to make sure that your body appears relaxed, so that you appear open to what the person is saying to you.
Be still if you can, so that you don't appear distracted or preoccupied by other things going on around you.

Finally, nod your head from time to time, so that the person talking knows that you are following what he or she is saying. There are, of course, many other non-verbal ways to communicate to the person speaking that you are open and receptive to what is being said.

When you make a conscious effort to use your body language in these ways, you will likely find that your verbal exchanges with others become more fluid, more respectful, and more productive as well.

Reflective Listening: Reflective listening is a technique that encourages the listener to repeat back to the speaker exactly what he or she has said, in their own words. For example, take the following exchange: A man appears exasperated because he believes his wife rarely hears what he is saying. So he tells her, "I'm sick and tired of her not listening to me, and not caring enough to understand my feelings!!

Clearly this man rarely feels that his wife gets the gist of what he is saying. But one way for his wife to diffuse his anger and frustration would be to reflect back to him precisely what he has said.

Using the reflective listening technique, she would say: "I hear you saying that you are sick and tired of me not listening to you. Moreover, you think that I don't care enough to understand your feelings.

Often time's two very intelligent people don't accurately hear what one another is saying. The listener may simply hear what he wants to hear, and disregard the rest. Or he may make an inaccurate interpretation of what has just been said.

Or intense feelings that are aroused in our interactions with others make it difficult for us to hear much of anything at all!! One way to lower the margin for error and significantly increase the likelihood that a speaker is heard involves mirroring back precisely what he or she has said, word for word.

Paraphrasing: Paraphrasing is an active listening technique that challenges the listener to accurately capture and paraphrase back the essence of what has been communicated to him or her.

In this instance, he must do so in his own words. Doing so demonstrates that he truly gets the overall gist of what has been said. In turn, the person sharing his thoughts and feelings feels heard, and sufficiently understood.

Take the aforementioned example with regards to the officer and his wife: Remember, the officer has said the following: "I'm sick and tired of your not listening to me, and not caring enough to understand my feelings!!

In this instance, the wife might paraphrase back to him the following: “Honey, you're angry with me because you don't think that I care enough to listen to you, and that I don’t even bother to understand your feelings. I get that you feel adamantly about the situation.

In this instance, the wife has communicated to the husband what she has heard him say, but in her own words. In her communication to him, she uses her intuition and insight as well, and shares with him her own sense of what he is likely feeling. For example, she speculates that he is feeling angry with her.

When she reads between the lines and names what he is feeling, his anger will likely dissipate, and his tone of voice will likely soften, for he will feel accurately seen and heard by her. When she lets him know that she understands that he feels adamantly about this issue, he will once again feel as though she gets how important this matter is to him.

Clarifying Questions: Clarifying Questions are asked in order to gain a deeper and more accurate understanding for what has been said. Such questions lessen the chances that a listener will walk away from a conversation feeling unsure of what the speaker has said.

Therapists, for example, often ask clarifying questions, for they do not want to make assumptions about what their client is thinking and/or feeling. Instead they want to accurately distill what the client is saying, and they want to learn more about their clients’ thoughts and feelings as well.

Take, **for example**, the following exchange. Jack and Jill are boyfriend and girlfriend, and they are taking a walk along the ocean on a cold, wintry day. Jack owns a beautiful cashmere sweater, and he happens to be wearing it. Noticing that Jill appears cold, he offers her his sweater. As he hands it to her, he says," Just remember to give it back to me when you’re done using it.”

Suddenly Jill appears sour, and glum, and begins to tear up. She wraps the sweater up in her hand, and defiantly tries to give it back to Jack. In turn, Jack feels confused, and hurt. He doesn't understand what in the world has upset Jill. In his mind, all he is guilty of is lovingly and selflessly offering his girlfriend his cashmere sweater, as she appeared cold to him.

In his confusion, Jack could choose to respond to her strange reaction with anger: He could say, "What is wrong with you!! You're such a brat!! Why do you act like such a baby for no reason? I try to be nice to you, and what do I get in return? I get frowns, and scowls, and bad looks....You're nuts!!"

Concentrating on the feelings that a person has concerning a particular situation does not mean we don't need additional information for a deeper understanding of the dynamic of the emotions of the crisis. It just means that for a person to feel understood, the listener must first come through with a response (verbal or nonverbal) that indicates an awareness of the feeling. The facts of a situation are seldom as important as we feel about the situation.

Levels of Listening:

Level One: The receiver's expressions are clearly unrelated to what the sender is feeling at the moment. The receiver tends to respond to the content of the discussion and either does not attend to the feelings being expressed or avoids them.

Level Two: While the receiver does respond to the expressed feelings of the sender, he does so in a very surface or minimal way. The sender is likely to respond with, no, that's not what I was feeling.

Level Three: The verbal or behavioral expressions of the receiver are essentially interchangeable with the sender, in that they express essentially the same affect and meaning. The sender responds "Right that's how I feel.

Level Four: The response of the receiver adds noticeably to the expressions of the sender in such a way that he continues to explore his feelings at a deeper level.

Level Five: The receiver responds to the sender in such a way as to add significantly to the feelings and meaning the sender is trying to express. Not only does the sender feel that you are with him, he feels you deeply understand both his feelings and behavior.

Interpretive: Diagnosing, psychoanalyzing, reading-in, offering insights (what you need is, what's wrong with you is…) Your problem is, or I know what you need.

Probing: Questioning, cross examining, prying, interrogating i.e.: Who, what, where, when and why.

Understanding: This response revolves around the notion that when an individual expresses a message and that message is paraphrased in fresh words, with no charge to the essential meaning, the sender will expand upon or further explore the idea, feeling and attitude contained in the message

Active listeners should be able to see through anger and frustration, and understand that more than likely what is being said. If the pastor in this instance has the presence of mind to address sadness, insecurity, self-doubts, and anxiety, the sender in turn might feel attended to, heard, and cared for.

Active Listening skills play help people solve problems, resolve conflicts, foster deeper intimacy, and create more loving, harmonious relationships. These skills also help people to have more empathy for whoever is speaking, for they are better able to get into the other person's shoes, and listen to their perspective on things, and understand how reasonable it might be for him or her to feel and/or think the way they do.

Active listening skills also enable a listener to show that while they may not agree with the other person; they value his or her own unique point of view. People feel seen and heard, understood, and cared for. Needless tensions fall by the way side, and a sense of harmony and mutual respect between people take their place.

Active listening is like learning another language." Most people are far more interested in what they themselves have to say rather than what others are saying to them.

"The opposite of listening," "is waiting." Instead of listening carefully, many people subconsciously send the message "I want you to hurry up and shut up so I can talk."And while waiting for their turn to speak, people often don't pay attention to what others are saying. "They're too busy organizing what they're going to say.

Proponents of active listening say it can improve all sorts of relationships. Husbands and wives, parents and children, students and teachers, doctors and patients, and employees and bosses (and fellow employees) all can benefit from paying closer attention to what each other says as well as from using active listening as a means of showing respect to one another.

Why listening isn't always easy: Learning to listen well can be challenging, "The listener may struggle at first because so many of us have spent years focusing on getting our own messages across rather than on fully understanding someone else. Active listening also "requires that the individual do something with what he/she hears.

It begins with attention to the speaker and extends to comprehension, interpretation and evaluation of the message. "Remembering what is heard and responding appropriately are also included in the active listening process."

Active listening basics: In most instances, active listening consists of a few deceptively simple techniques:

1. Offering encouragement by nodding or saying "uh-huh" or "I see"

2. Restating the basic ideas, using terms such as "If I understand you correctly, ..." or "So what you're saying is ..."

3. Reflecting on the feelings that the speaker is trying to convey: "Seems like that bothered you a lot ..."

4. Summarizing the speaker's key ideas

A structured approach serves several purposes. "It allows the speaker to hear the message as interpreted by the listener and to adjust it if it has been misunderstood or is incomplete. It also prevents the listener from becoming judgmental, so that the speaker is free to express him/herself without becoming defensive."

"The active listening response encourages the speaker to continue speaking." This type of listening is empowering because the speaker's thoughts and feelings are reflected and reaffirmed, providing a safe and supportive context."

At first, active listening techniques can seem stilted and artificial. But with practice, experts agree that you can learn to incorporate active listening skills seamlessly into your everyday conversations. "Active listening is a learned behavior, but it's something anyone can learn."

Additional tips for becoming a proactive listener:

1. Shut up. Stop talking:

2. Cheat. Pick up a pencil and paper and take notes.

3. Sit down with the person. Say, "Let's sit down and talk." This shows that what the person is saying is important.

4. Be aware of your body language and facial expressions. If you keep looking over the speaker's shoulder to see who else is in the room, the speaker won't think that you're listening.

5. Ask open-ended questions — and ask questions that will elicit the information you want to know.

6. Ask for clarification. It's OK to say you're not sure what the speaker has said and to ask him to repeat himself.

7. Paraphrase. Repeat the main ideas back to the speaker. But don't interrupt — wait until the speaker's finished her thought. Then say something like: "It sounds as though you could use some help with that project."

COMMUNICATION SKILLS: It is not surprising that good communication leads to rewarding personal relationships and career success. It encourages the resolution of difficult issues, identifies common goals and desires, and fosters feedback that opens relationships.

Boosting communication skills can enhance all aspects of your life since the way you express and assert yourself can be key to building strong relationships. After taking a good look at your current relationships both in business and at home, determine whether you might benefit from boosting communication skills in your life.

Communication skills simply do not refer to the way in which we communicate with another person. It encompasses many other things - the way in which we respond to the person we are speaking, body gestures including the facial ones, pitch and tone of our voice and a lot of other things.

The importance of communication skills is not just limited to the professional world, since effective communication skills are now required in each and every aspect of our life. However, we will discuss the importance of communication skills in two areas namely business and relationships.

Good Communication skills develop good relationships and healthy lifestyles and a good relationship can only be maintained by maintaining healthy communications. They are the ones we stay with on a regular basis. They are also the ones who see us at our best as well as our worst.

Good communication skills help relationships to develop along good lines, and ensure that arguments and disagreements are kept to a minimum. Good communication will avoid arguments and insults.

Another important part of communication in relationships is taking the initiative yourself. Do not wait for the person to call you after a long break. Instead take the phone and also take initiative to start the conversation.

Often people have this problem while communicating, which comes from fear. They always think a thousand times whether to approach a person or not. But a person with good communication skills is always the first to start a conversation.

Given the importance of communication skills in both the personal and the corporate world, any individual who want to make progress with their life should develop this important skill.

Good communication skills can help you in both your personal and professional life. While verbal and written communication skills are important, research has shown that nonverbal behaviors make up a large percentage of our daily interpersonal communication.

How can you improve your nonverbal communication skills? The following top ten tips for nonverbal communication can help you learn to read the nonverbal signals of other people and enhance your own ability to communicate effectively.

Nonverbal Communication Signals: People can communicate information in numerous ways; so pay attention to things like eye contact, gestures, posture, body movements, and tone of voice. All of these signals can convey important information that isn't put into words.

By paying closer attention to other people's nonverbal behaviors, you will improve your own ability to communicate nonverbally.

Look for Incongruent Behaviors: If someone's words do not match their nonverbal behaviors, you should pay careful attention. For example, someone might tell you they are happy while frowning and staring at the ground. Research has shown that when words fail to match up with nonverbal signals, people tend to ignore what has been said and focus instead on nonverbal expressions of moods, thoughts, and emotions.

1. Concentrate on Your Tone of Voice When Speaking

Your tone of voice can convey a wealth of information, ranging from enthusiasm to disinterest to anger. Start noticing how your tone of voice affects how others respond to you and try using tone of voice to emphasize ideas that you want to communicate. For example, if you want to show genuine interest in something, express your enthusiasm by using an animated tone of voice.

2. Use Good Eye Contact: When people fail to look others in the eye, it can seem as if they are evading or trying to hide something. On the other hand, too much eye contact can seem confrontational or intimidating. While eye contact is an important part of communication, it's important to remember that good eye contact does not mean staring fixedly into someone's eyes. How can you tell how much eye contact is correct? Some communication experts recommend intervals of eye contact lasting four to five seconds.

3. Ask Questions about Nonverbal Signals: If you are confused about another person's nonverbal signals, don't be afraid to ask questions. A good idea is to repeat back your interpretation of what has been said and ask for clarification. An example of this might be, "So what you are saying is that..."

4. Use Signals to Make Communication More Effective and Meaningful: Remember that verbal and nonverbal communication work together to convey a message. You can improve your spoken communication by using nonverbal signals and gestures that reinforce and support what you are saying. This can be especially useful when making presentations or when speaking to a large group of people.

5. Look at Signals as a Group: A single gesture can mean any number of things, or maybe even nothing at all. The key to accurately reading nonverbal behavior is to look for groups of signals that reinforce a common point. If you place too much emphasis on just one signal out of many, you might come to an inaccurate conclusion about what a person is trying to communicate.

8. Consider Context: When you are communicating with others, always consider the situation and the context in which the communication occurs. Some situations require more formal behaviors that might be interpreted very differently in any other setting. Consider whether or not nonverbal behaviors are appropriate for the context. If you are trying to improve your own nonverbal communication, concentrate on ways to make your signals match the level of formality necessitated by the situation.

9. Be Aware That Signals Can be Misread: According to some, a firm handshake indicates a strong personality while a weak handshake is taken as a lack of fortitude. This example illustrates an important point about the possibility of misreading nonverbal signals.

A limp handshake might actually indicate something else entirely, such as arthritis. Always remember to look for groups of behavior. A person's overall demeanor is far more telling than a single gesture viewed in isolation.

10. Practice, Practice, Practice: Some people just seem to have a knack for using nonverbal communication effectively and correctly interpreting signals from others. These people are often described as being able to "read people."

In reality, you can build this skill by paying careful attention to nonverbal behavior and practicing different types of nonverbal communication with others. By noticing nonverbal behavior and practicing your own skills, you can dramatically improve your communication abilities.

The Chaplain's purpose is to serve and assist in helping to meet the spiritual needs of the personnel, families, and the community. The Chaplain offers spiritual guidance and assistance to persons in crisis situations. He also serves as a link in the communication between personnel in crisis and their own spiritual advisors.

Each day, depending on the profession people are faced with potentially dangerous situations. They must make split-second decisions that are just and right. Many times, persons need to express their frustrations and problems to one who fully understands the circumstances surrounding their duties and obligations.

People at times, to discuss their problems with someone who understands, yet is detached enough not to become emotionally involved and the only way they can do this is through good communication.

The clergy person or religious advisor, although trained in the ministry, is not necessarily abreast of the particular problems of a particular profession. In such cases, the pastor could listen with empathy, advise calmly and offer assistance when appropriate.

Normally, on call 24 hours a day, Pastors/clergy stand ready to respond. A key word is "service" and most pastors/clergy pride themselves that they respond when an emergency arises or some other incident occurs where their presence is needed and requested.

It also provides an added dimension to their ministry work in making immediately available to people in crisis situations a trained and caring professional who can assist in times of loss, confusion, depression or grief. These calls are often as appropriate for a pastor/clergy as well as the police officer.

A ministry of presence can also provide a means for the churches in the community to reach out to those in need by having experienced and trained persons available to care for people through communication verbal and non-verbal.

From the officer behind the wheel of a patrol car to the victim of domestic violence, or the church member with marriage problems, the pastor must learn to "relate" to the needs that encompass each situation. Through effective communications, help can be offered without delay.

For the Chaplain who is a good communicator, success for the program can be guaranteed through caring, empathy, compassion and good communications. Once the member or citizen learn that the Pastor will be there to listen when they are needed a good relationship will develop.

A healthy relationship is one in which there is open communication. Certainly, it's not going to be free of all conflict because conflict is really a part of intimacy. But, having a healthy relationship means you find healthy ways of dealing with that conflict and trauma.

"All of life happens in relationships that have good communications. "Maintaining unhealthy relationships can be detrimental over time. It deteriorates your capacity to be successful in the profession of a Pastor. So, if someone is dealing with a bad relationship or job stress, the Pastor must identify the need and then offer help.

The Chaplain must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with officers, their families, and professional associates.

Understanding your communication style: Good communication skills require a high level of self awareness. Understanding your personal style of communicating will go a long way toward helping you to create good and lasting impressions on others.

By becoming more aware of how others perceive you, you can adapt more readily to their styles of communicating. This does not mean you have to be a chameleon, changing with every personality you meet. Instead, you can make another person more comfortable with you by selecting and emphasizing certain behaviors that fit within your personality and resonate with another.

There are three basic communication styles:

1. Aggressive
2. Passive
3. Assertive

ELEMENTS OF THE AGGRESSIVE STYLE

1. Mottos and Beliefs
2. "Everyone should be like me."
3. "I am never wrong."
4. "I've got rights, but you don't."
5. Communication Style
6. Close minded
7. Poor listener
8. Has difficulty seeing the other person's point of view
9. Interrupts
10. Monopolizing

Characteristics

1. Achieves goals, often at others' expense
2. Domineering, bullying
3. Patronizing
4. Condescending, sarcastic

Behavior

1. Puts others down
2. Doesn't ever think they are wrong
3. Bossy
4. Moves into people's space, overpowers

5. Jumps on others, pushes people around
6. Know-it-all attitude
7. Doesn't show appreciation

Nonverbal Cues

1. Points, shakes finger
2. Frowns
3. Squints eyes critically
4. Glares
5. Stares
6. Rigid posture
7. Critical, loud, yelling tone of voice
8. Fast, clipped speech

Verbal Cues

1. "You must (should, ought better)."
2. "Don't ask why. Just do it."
3. Verbal abuse
4. Confrontation and Problem Solving
5. Must win arguments, threatens, attacks
6. Operates from win/lose position
7. Feelings Felt
8. Anger
9. Hostility
10. Frustration
11. Impatience

Effects

1. Provokes counter aggression, alienation from others, ill health
2. Wastes time and energy over supervising others
3. Pays high price in human relationships
4. Fosters resistance, defiance, sabotaging, striking back, forming alliances, lying, covering up
5. Forces compliance with resentment

ELEMENTS OF THE PASSIVE STYLE

1. Mottoes and Beliefs
2. "Don't express your true feelings."
3. "Don't make waves."
4. "Don't disagree."
5. "Others have more rights than I do."

Communication Style

1. Indirect
2. Always agrees
3. Doesn't speak up
4. Hesitant

Characteristics

1. Apologetic, self-conscious
2. Trusts others, but not self
3. Doesn't express own wants and feelings
4. Allows others to make decisions for self
5. Doesn't get what he or she wants

Behaviors

1. Sighs a lot
2. Tries to sit on both sides of the fence to avoid conflict
3. Clams up when feeling treated unfairly
4. Asks permission unnecessarily
5. Complains instead of taking action
6. Lets others make choices
7. Has difficulty implementing plans
8. Self-effacing

Nonverbal Cues

1. Fidgets
2. Nods head often; comes across as pleading
3. Lack of facial animation
4. Smiles and nods in agreement
5. Downcast eyes
6. Slumped posture
7. Low volume, meek

Up talk

1. Fast, when anxious; slow, hesitant, when doubtful

Verbal Cues

1. "You should do it."
2. "You have more experience than I do."
3. "I can't....."
4. "This is probably wrong, but..."
5. "I'll try..."
6. Monotone, low energy

Confrontation and Problem Solving

1. Avoids, ignores, leaves, postpones
2. Withdraws, is sullen and silent
3. Agrees externally, while disagreeing internally
4. Expends energy to avoid conflicts that are anxiety provoking
5. Spends too much time asking for advice, supervision
6. Agrees too often

Feelings Felt

1. Powerlessness
2. Wonders why doesn't receive credit for good work
3. Feels a lack of recognition for others' inabilities

Effects
1. Gives up being him or herself
2. Builds dependency relationships
3. Doesn't know where he or she stands
4. Slowly loses self esteem
5. Promotes others' causes
6. Is not well-liked

ELEMENTS OF THE ASSERTIVE STYLE

1. Mottoes and Beliefs
2. Believes self and others are valuable
3. Knowing that assertiveness doesn't mean you always win, but that you handled the situation as effectively as possible
4. "I have rights and so do others."
5. Communication Style
6. Effective, active listener
7. States limits, expectations
8. States observations, no labels or judgments
9. Expresses self directly, honestly, and as soon as possible about feelings and wants
10. Checks on others feelings

Characteristics
1. Non-judgmental
2. Observes behavior rather than labeling it
3. Trusts self and others
4. Confident
5. Self-aware
6. Open, flexible, versatile
7. Playful, sense of humor
8. Decisive
9. Proactive, initiating

Behavior
1. Operates from choice
2. Knows what it is needed and develops a plan to get it
3. Action-oriented
4. Firm
5. Realistic in her expectations
6. Fair, just
7. Consistent
8. Takes appropriate action toward getting what she wants without denying rights of others

Nonverbal Cues
1. Open, natural gestures
2. Attentive, interested facial expression
3. Direct eye contact
4. Confident or relaxed posture
5. Vocal volume appropriate, expressive
6. Varied rate of speech

Verbal Cues
1. "I choose to..."
2. "What are my options?"
3. "What alternatives do we have?"
4. Confrontation and Problem Solving
5. Negotiates, bargains, trades off, compromises
6. Confronts problems at the time they happen
7. Doesn't let negative feelings build up

Feelings Felt
1. Enthusiasm
2. Well being
3. Even tempered

Effects
1. Increased self-esteem and self-confidence
2. Increased self-esteem of others
3. Feels motivated and understood
4. Others know where they stand
5. Clearly, the assertive style is the one to strive for. Keep in mind that very few people are all one or another style. In fact, the aggressive style is essential at certain times such as:
6. When a decision has to be made quickly; During emergencies;
7. When you know you're right and that fact is crucial;
8. Stimulating creativity by designing competitions destined for use in training or to increase productivity.

Passiveness also has its critical applications:

1. When an issue is minor;
2. When the problems caused by the conflict are greater than the conflict itself;
3. When emotions are running high and it makes sense to take a break in order to calm down and regain perspective;
4. When your power is much lower than the other party's;
5. When the other's position is impossible to change for all practical purposes (i.e., government policies, etc.).

Remaining aware of your own communication style and fine-tuning it as time goes by gives you the best chance of success in the Chaplaincy Crisis Counseling profession.

People often have problems when they communicate with each other. The communication process is very complex and there are many opportunities for breakdowns to occur. As a result, people can become frustrated, instructions are not carried out correctly, people get offended, and conflict can occur. You can minimize these problems and increase the odds that others will understand you by following these simple steps:

1. Take responsibility for the communication: When we communicate with others it is very tempting to blame them for not understanding us. Surely we with our outstanding oratory skills cannot possible be at fault. The problem with this attitude is that it does not achieve our outcome of getting the other person to comprehend what we are trying to say. When we take responsibility for getting a message across to others it frees us to do whatever it takes to achieve that result.

2. Check non-verbal feedback : When you speak to someone don't assume that you are making yourself clear to the other person. Check for non-verbal feedback. People give us many clues as to whether or not they understand us. Do they look confused? Are they unusually quiet? When asked if they have any questions, do they answer with a hesitant no? These are all subtle signs that the individual is not sure of what you just said. Continue communicating until you see signs that your message has gotten through.

3. Be flexible: When communicating with others, he/she who has the most flexibility wins. If you speak to someone and you can tell by the non-verbal cues that he has no idea what you are talking about, change the way you are communicating with a particular person.

Recognize that people understand information in different ways – People do not understand things in the same way. Some people understand things better when they see them, others when they hear them and others when they do or get a feeling about them. Use non-verbal cues to determine if the person understands you.

4. Don't Make People Wrong: When we communicate with others the chances are very good that we will have to change strategies along the way. Don't make people wrong because their communication style is different from yours. If you do, you will not only have to deal with communication problems but also conflict and negative feelings. Instead recognize that each person's uniqueness adds color to the mosaic of life and do whatever you need to do to get your message across correctly.

While it isn't possible to completely eliminate communication problems, by following these steps you can minimize misunderstandings, reduce frustrations, and achieve better outcomes.

How to Develop Good Communication Skills: Make eye contact. Whether you are speaking or being spoken to, looking into the eyes of the person you are in conversation with can make the experience much more successful. Eye contact conveys interest, and encourages your partner to be interested in you in return. In less intimate settings, when giving a speech or when in front of several people, holding the eyes of different members of your audience can personalize what you are saying and maintain attention.

Be aware of what your body is saying. Body language can say so much more than a mouthful of words. An open stance with arms easily to your side tells anyone you are talking to that you are approachable and open to hearing what they have to say. Arms crossed and shoulders hunched, on the other hand, suggest disinterest in conversation or unwillingness to communicate. Often, communication can be stopped before it starts by body language that tells people you do not want to talk. Good posture and an approachable stance can make even difficult conversations flow more smoothly.

Have courage to say what you think! Communication skills begin with simple communication. Take time each day to be aware of your opinions and feelings. When you are aware of what you believe on a certain issue, you can better convey those thoughts to others. Individuals who are hesitant to speak because they do not feel they have worthwhile opinions need not fear: what is important or worthwhile to one person may not be to another and may be more so to someone else. In a world so very big, someone is bound to agree with you, or to open your eyes to an even deeper perspective. The courage to say what you think can afford you the opportunity to learn more than you did before.

Speak loudly enough to be heard. When you are saying what you think, have the confidence to say it so as to be heard. An appropriate volume can inform listeners that you mean what you say, you have thought about what you are saying, and what you are saying is worth hearing. An appropriate tone and volume ensure your listeners hear exactly what you are saying, and decreases room for misunderstanding.

Practice: Communication skills can be practiced every day in settings that range from the more social to the more professional. While some people feel the need to take a special college course on communications, or to attend community lectures on giving speeches, you might find that these simple behavior tips can open up new communication opportunities to you. New skills take time to refine, but each time you use your communication skills you open yourself to opportunities and future friendships.

EFFECTIVE COMMUNICATOR SKILLS

"Asking questions" is an excellent way to initiate communication because it shows other people that you‘re paying attention and interested in their response.

1. Ask focused questions that aren‘t too broad
2. Ask open ended questions
3. Ask for additional details, examples, impressions

Giving Feedback: Several types of feedback--praise, paraphrasing, perception-checking, describing behavior, and "I-messages"--are discussed in the paragraphs that follow.

When giving feedback, it is useful to describe observed behaviors, as well as the reactions they caused. They offer these guidelines: the receiver should be ready to receive feedback; comments should describe, rather than interpret; feedback should focus on recent events or actions that can be changed, but should not be used to try to force people to change.

One especially important kind of feedback for administrators is letting staff members know how well they are doing their jobs. Effective leaders give plenty of timely positive feedback. They give negative feedback privately, without anger or personal attack, and they accept criticism without becoming defensive.

Perception Checking: Perception checking is an effort to understand the feelings behind the words. One method is simply to describe your impressions of another person‘s feelings at a given time, avoiding any expression of approval or disapproval.

Describing Behavior: Useful behavior description, specific body language, observable actions without value judgments, and without making accusations or generalizations about motives, attitudes, or personality traits. "You‘ve disagreed with almost everything he‘s said" is preferable to "You‘re being stubborn."

NONTHREATENING METHOD OF REQUESTING BEHAVIOR CHANGE: "I"-messages reflect one‘s own views and rely on description rather than criticism, blame, or prescription. The message is less likely to prompt defensive reactions and more likely to be heard by the recipient. One form of "I"-message includes three elements:

(1) The problem or situation,
(2) Your feelings about the issue, and
(3) The reason for the concern.

For expressing feelings, You can refer directly to feelings ("I‘m angry"), use similes, ("I feel like a fish out of water"), or describe what you‘d like to do ("I‘d like to leave the room now").

HOW CAN INDIVIDUALS IMPROVE THE NONVERBAL COMPONENTS OF THEIR COMMUNICATION?

Whether you‘re communicating with one person or a group, nonverbal messages play an important role. Study found 93 percent of a message is sent non-verbally, and only 7 percent through what is said.

Body orientation: To indicate you like and respect people, face them when interacting.

Posture: Good posture is associated with confidence and enthusiasm. It indicates our degree of tenseness or relaxation. Observing the posture of others provides clues to their feelings.

Facial expression: Notice facial expressions. Some people mask emotions by not using facial expression; others exaggerate facial expression to belie their real feelings. If you sense contradictions in verbal and nonverbal messages, gently probe deeper.

Eye contact: Frequent eye contact communicates interest and confidence. Avoidance communicates the opposite.

Communication has been part of our civilization for so long that it's hard to fathom why some people still fail to understand each other. Every day, people continue to make mistakes because of

misunderstanding. Every day, people fight and argue because they misinterpreted what the other person was saying. Messages get garbled because people lack effective communication skills.

Effective communication skills, unlike what some people might claim, don't come inherently to each of us. Effective communication skills are not fixed from birth.

Sure, some people may be born with disabilities that prevent them from communicating in the way others do, but the effectiveness of the way they communicate can be nurtured through different ways.

If people with disabilities can develop effective communication skills, why can't you? Here are a few tips that you can use to develop effective communication skills:

1. Understand the power of perception: The way you perceive a message to be may not necessarily be shared by others. You need to see the message you are trying to send the way others would perceive it. Here is an example:

Opening a gift: In America, people like to open their presents in front of the person who gave it. This way, they can show their appreciation for that gift. In other countries, however, they wait for the guest to leave, then open the presents.

This isn't a show of disrespect, but it's to prevent people from seeing the disappointment on the receiver's face if he/she doesn't get what he/she wants. The way we interpret the actions of other people vary greatly from person to person. This means that generalization is the last thing you want to do. Developing effective communication skills demands understanding.

2. Pay attention to details: In order to develop effective communication skills, you need to understand the importance of details. Small details can sometimes change a whole message. One example of this is the comma. It's a little detail in a whole sentence, but when used in terms of finance, one mistakenly placed comma can cost you a lot of money.

This is also true in terms of non-verbal communication. Gestures like handshakes have little details from which a person can judge its sincerity. If you don't want to be misunderstood, make sure you pay attention to the details.

3. Know before you speak: People pay little attention to the meaning of words. This is the main reason why language continues to deteriorate today. In order to have effective communication skills, you need to learn the meaning of a word before you use it. This doesn't mean just looking it up in a dictionary, you need to learn if a word has different meanings based on context.

This is also true for non-verbal communication. In order to develop effective non-verbal communication skills, you need to learn the meanings of symbols before you start sending them out. This means you have to watch what you wear, the gestures

ROAD BLOCKS TO COMMUNICATIONS

1. Directing
2. Ordering
3. Commanding
4. Warning
5. Threatening
6. Moralizing
7. Preaching
8. Persuading
9. Providing solutions
10. Judging
11. Negatively
12. Criticizing
13. Blaming
14. Name Calling
15. Ridiculing
16. Shaming
17. Patronizing
18. Psychoanalyzing
19. Diverting
20. Avoiding
21. Kidding
22. Teasing
23. Sarcasm
24. Comparing

It is essential that the Pastoral Counselor possess the ability to communicate clearly and non-threatening to those people who come to him for help. How we relate with the persons we are sworn to protect and defend, as well as to fellow employees, speaks volumes about who we are as well as our belief in what is right and wrong.

Elements of Assessing

1. Determine severity of the crisis (cognitive, affective, psychomotor)
2. Assess potential lethality or physical harm to the person
3. Identify coping patterns, strengths and resources
4. Assess mental status and functioning
5. Assess emotional status (acute or chronic)
6. Identify support systems and resources

Personal Assessing Techniques

1. Determine if the person is suicidal, homicidal or both
2. Determine the extent of interruption to their daily lives
3. Determine if the level of tension has distorted their perception
4. Determine coping skills for anxiety, tension or depression

5. Find out what coping methods have been used
6. Find out if the families social resources are positive or negative
7. Determine if support systems exist.
8. Examine available alternatives
9. Remove distracters and stressors
10. Avoid impulsive action
11. Model calmness
12. Be prepared

Developing an Action Plan: During the development of an action plan it must be kept simple and manageable if it is expected to work.

These are steps that you can use to help guide your plan.

1. Select and use appropriate plans of action
2. Negotiate a contract or commitment
3. Select appropriate referral resources
4. Plan for immediate action
5. Use a non-directive approach
6. Work together on a joint plan
7. Be directive if necessary
8. Keep action plan short term, 24 hours to three days
9. Keep the action plan achievable
10. Keep it focused
11. Plan for follow-up sessions

Functional Assessment:

1. Assess medical/physical/environmental needs
2. Assess behavior status
3. Status of prescription medication, if any
4. Assess for impairment
5. Assess Degree of Impairment
6. Threat to self
7. Threat to others
8. General ability to function

Crisis-Oriented Elements of Mental Status:

1. Cognitive
2. Orientation (person, place, time)
3. Presence of cause & effect thinking

Rule Out

1. Hallucinations
2. Delusions (paranoia, grandeur)
3. Obsessions
4. Violent/Homicidal/suicidal thoughts

5. Dissociation
6. Disabling guilt
7. Psychogenic amnesia
8. Helpless/hopelessness

Behavioral:

1. Impulsiveness
2. Sleep disturbance
3. Hyper-vigilance

Rule Out

1. Violent acts
2. Self-medication
3. Antisocial acts
4. 1000 yard stare
5. Interpersonal abuse

Emotional:

1. Acute anxiety
2. Acute depression
3. Anger
4. Fear, Phobia, phobic avoidance

Rule Out

1. Panic attacks
2. Immobilizing emotions
3. Regressive emotions in adults
4. PTSD

Spiritual/ Religious

1. Crisis of faith
2. Obsessive thoughts
3. Compulsive acts

Potential Mechanisms Unique to Pastoral Crisis COUNSELING

1. Spiritual Education, Insight, Reinterpretation
2. Individual and Conjoint Prayer
3. Belief in Intercessory Prayer
4. Unifying and Explanatory Worldviews
5. Ventilative Confession
6. Faith-based Social Support Systems
7. Rituals and Sacraments

8. Belief in Divine Intervention/forgiveness
9. Belief in a Life after Death
10. Unique Ethos of the Pastoral Crisis Counseling ist
11. Uniquely Confidential/Privileged Communications

Physical

1. Tachycardia
2. Hyperventilation
3. Muscle spasms
4. Indigestion

Rule Out

1. Chest pain/ irregular heart beats
2. Seizure, persistent vertigo
3. Blood in vomit, urine, stool, sputum
4. Collapse/exhaustion

Pastoral Crisis Counseling Elements Defined

1. Assessment – Evaluate mental/behavioral status
2. Psychological – Use of basic, generic Psychological principles to mitigate crisis
3. Liaison / Advocacy – Serve as intermediary, advocate
4. Spiritual – Use of pastoral interventions generically applicable across religions/faiths
5. Religious – Use of pastoral interventions based upon specific religious doctrine/belief/scripture

Elements of Psychological Interventions

1. Cathartic ventilation
2. Social support
3. Information
4. Stress management
5. Advocacy
6. Problem solving
7. Cognitive reframing
8. Liaison / Advocacy

Facilitation of communications

1. Psychological buffering, insulation
2. Advocacy
3. Helping where needed

Spiritual Interventions

1. Unique ethos of pastoral person
2. Ministry of presence
3. Unique communications

4. Ventilative confession
5. Individual and/or conjoint prayer
6. Belief in Divine Order or Divine Intervention

Religious Interventions

1. Scriptural education, insight, interpretation
2. Rituals, sacraments
3. Rituals of forgiveness, atonement

Most Common Mistakes

1. Unwelcome Preaching
2. Poorly Timed Religion
3. Trying to “Cure” the problem
4. Entitlement vs. Privilege

When a counselor attempts to handle persons or situations in a careless manner, permanent damage can occur and severe repercussions can be great and due to liability reasons, caution should be taken.

Normally when dealing with a person in crises, a counselor will only get one chance to help the victim and if counseling is not handled properly by a trained professional then permanent damage can be done.

It is imperative when counseling a victim that the counselor is trained in the field of the particular crisis and never hesitate to refer the victim to someone who has been trained in the particular field.

One of the biggest problems in crisis counseling today is that pastors and counselors feel that they are supposed to be able to handle any crisis regardless of the training they have received.

If a victim is in the care of an untrained professional and help is not received and the victim ever stops counseling, the chances are that they may never attempt to again, get help.

NOTES

CRITICAL INCIDENT STRESS MANAGEMENT (CISM): Critical Incident Stress Management is a short term intervention process that focuses mainly on identifying the problem to enable the individual(s) affected to return to their daily routine(s) more quickly and with a lessened likelihood of experiencing long term crisis related stress.

The purpose of crisis intervention is to determine the severity of the traumatic event and what stage of crisis the person in is and offer immediate help if necessary. Once a determination has been made, a defusing or a debriefing can be offered at that time.

Critical Incident Stress Defusing - Defusing are normally offered to individuals with a direct involvement to the incident and are often done informally within 8 hours of the incident, sometimes at the scene if necessary.

Post Traumatic Stress Disorder (PTSD) frequently results from not talking about or being able to put into perspective a critical incident. Once PTSD develops, the impairment the long-term emotional response to the trauma causes is harder to heal. Prevention is preferred. Any CISM member can defuse. The processes objectives are:

Steps to Defusing:

1. Introduction: establishment of guidelines
2. Details of event: Given for individual perspectives
3. Emotional responses: Given subjectively
4. Personal reactions and actions:

Symptoms: Exhibited since the event

Instruction Phase: Where individuals are returned to normal tasks

Follow-Up: always done after intervention Rapid reduction in the intense reactions to a traumatic event re-establishing the group's social network so people do not isolate themselves from each other.

Critical Incident Stress Debriefing (CISD): This is a group meeting or process using both intervention and education to mitigate or resolve the psychological distress associated with a critical incident. To maximize effectiveness; a debriefing should occur 24 to 72 hours after an event. CISD usually uses all team members:

A mental health professional – as leader or co-leader

1. Pastor/Chaplain
2. Peers

It is not therapy even though mental health professional(s) are part of the team; the process's objectives are to mitigate the critical incident's impact on:

Primary victims: those directly traumatized by the incident

Secondary victims: emergency services personnel who witnessed or managed the critical incident; and

Tertiary victims: dependent family members

Accelerate recover processes in people experiencing normal stress reactions to the critical incident

Core Interventions of CISM:

1. Pre-incident education and preparation
2. One on one crisis intervention
3. Demobilization (public safety disaster response personnel)
4. Crisis management briefings (large group of primary victims)
5. Defusing
6. Critical Incident Stress Debriefing (CISD)
7. Significant other/Family support
8. Organizational/Community consultations
9. Chaplain/Pastoral Crisis Counseling
10. Follow up services and/or referrals

CISM is an integrated system of interventions designed to prevent and/or mitigate the adverse psychological reactions often accompanying disaster, traumatic or crisis related events. CISM is not therapy. Its goal is to return the affected person or group to a normal functioning level.

CISM concentrates on mitigating post-traumatic stress reactions. CISM has proved to be a means to assist persons in dealing with the symptoms of Critical Incident Stress.

The intervention process involves peers with oversight from experienced mental health professionals with advanced training.

All interventions are strictly confidential unless the interventionist determines that the person being helped is a danger to themselves or to others. The emphasis is always on keeping people safe and returning them quickly to more normal levels of functioning.

Examples Are:

1. Death or serious injury
2. Suicide, attempted suicide
3. Natural disaster
4. Acts of terrorism or extreme violence

CISM TEAMS:

Ref: Critical Incident Stress Debriefing: An Operations Manual for the Prevention of Traumatic Stress Among Emergency Services & Disaster Workers,

Training Requirements: CISM teams must be certified by an accredited training source to provide training and responding to critical incidents.

Composition: CISM teams should consist of:

1. Team Coordinator. This position should be held by a qualified person who has obtained extensive training in basic and advanced CISM techniques.

2. Mental Health Professional: This team member should be a psychiatrist, psychologist, social worker, or other license mental health professional who has attended either the basic or advanced courses for CISM.

3. Chaplain/Pastor: This person shall appropriately bring to bear a moral or spiritual perspective in the proceedings. This person should, at the conclusion, particularly note

resources and activities, which are apt to enhance wholeness following the debriefings, similar to referrals made to mental health and physical resources and activities. Chaplains and pastors shall take the Basic ICISF course for CISM, plus other ICISF courses identified that will enhance their participation as team members.

4. Peers: These are volunteers who have been recommended to the CISM team. If possible, peers should be drawn from locations throughout the area and should have had training in peer support or ICISF certified courses. Selection criteria for peers are:

1. Emotionally mature
2. Good communication and interpersonal skills
3. Ability to transcend the scope of gender, rates and pay grades
4. Have attended ICISF basic and advanced courses.

Contingency Plan: CISM teams shall have a plan that includes these elements:

1. Risk assessment program: to identify high risk persons or groups
2. A survey of CISM resources
3. Response plan

Coordination: CISM teams shall coordinate their interventions with other ongoing activities with other affected areas, which may include Police, Fire, EMS, etc.

Pre-Incident Preparation Training: Pre-incident training helps individuals prepare to cope with traumatic events. People forewarned about traumatic stress generally are able to manage it better and tend to recognize its signs earlier. It is useful for everyone facing exposure to a traumatic event and promotes optimal performance.

Training Objectives:

1. Teach effective approaches to stress
2. Help avoid ineffective approaches
3. Emphasize the normalcy of feeling stress in abnormal situations

Critical Incident Reporting: When a critical incident occurs, CISM officers in charge shall notify the chain of command by the most expedient means to request CISM services. Officers in charge should notify the person in charge with necessary information which should include:

1. Contact person's name, phone number and location
2. Whether there is an immediate need (within 24 hours) to have a CISM team on scene.
3. Whether the incident is completed or ongoing

Officer Responsibilities:

1. Establish, train and support at least one CISM team to meet the needs of each group.
2. Provide rapid means of communication by which to be notified of critical incidents
3. Provide support for teams and conduct pre-incident preparation training
4. Report CISM activity to command chain
5. Coordinate establishing CISM teams
6. Ensure personnel selected as peer support personnel are trained in ICISF interventions.
7. Maintain a roster of trained peer support personnel

Approve peer support personnel for interventions. CISM team members personally affected by an incident will not participate in its intervention.

Coordinate training for all personnel.

Determine intervention level. If trained in the ICISF Mitchell Model, the Chaplain may serve as a listener and guide during interventions.

Ensure CISM confidentiality and effectiveness. No team member shall make any written notes during or about a CISM intervention. An after action report may be used by team members only to discuss at team meetings as to lessons learned about the intervention process. The after action report shall be very generic and shall not include names or any specifics about the intervention.

Respond as necessary and/or coordinate with chaplains or pastors or other specialists to support others within the group. Coordinate and monitor non-member teams responding to critical incidents.

Officers in Charge shall:

1. Report as soon as possible a critical incident to their peers.
2. Conduct pre-incident preparation training.
3. Solicit volunteers to serve as CISM team members.

CISM Activity Measures: To monitor CISM effectiveness, the Director shall compile a report of the measures to be kept on file.

1. Number of CISM pre-incident training sessions and number of operational teams.

2. Number of critical incidents due to:
A. Mishaps
B. Emergency response or law enforcement
C. Workplace violence, terrorism or suicide; and
Other.

Responsiveness: (the average time in hours of all incidents)

1. Time between when incident occurred and notice to CISM teams
2. Time between notice and CISM team's arrival on scene

On-Scene Support Service: Services provided under "on-scene" conditions are brief, practical crisis intervention functions to limit the level of distress member's encounter. On scene support does not interfere with operations.

These service providers usually are peers, with chaplains, pastors or mental health professionals called only of needed. The process objectives are:

1. Stabilize the situation and protect from additional stress
2. Mobilize a wide range of resources to assist distressed persons
3. Normalize the experience and reduce the feelings of uniqueness and abnormality
4. Restore to function as quickly as possible.

Demobilization: Demobilizations are generally used during a disaster or in a large-scale catastrophic critical incident. A primary stress prevention and intervention technique, it is applied immediately after personnel are released from the scene and before they return to normal duties. It is two segments: first, a 10 to 15 minute lecture on understanding and managing stress reactions and, second, a 20 minute rest session.

The process objectives are:

1. Providing a transition from the traumatic event to normal routines
2. Reducing the intensity of immediate stress reactions
3. Assessing preliminary group needs for additional support services
4. Forewarning participants about potential reactions
5. Providing information about the incident and members' reactions
6. Providing practical information for managing stress and establishing linkages for additional support
7. Establishing positive expectations about outcome

Follow-up Services: If CISM provides initial services post-incident, follow-up services are mandatory. The staff is responsible for ensuring follow-up services are provided or accessible. Peers may be used if they have added training and experience in such services as individual crisis intervention; family debriefings; unit training; and/or referral to other mental health services. Follow up procedures are an extremely important part of Crisis counseling.

SELF CARE

One of the leading problems that we face today in the area of crisis counseling is compassion fatigue. Compassion fatigue, also known as "vicarious trauma" or 'secondary traumatic stress", affects people who are exposed to the traumatic suffering of others such as:

1. Pastoral Counselors
2. Emergency workers (police, fire, paramedics)
3. Mental health workers
4. Medical professionals
5. Volunteers
6. Human resource workers
7. Chaplains
8. Teachers/counselors

Compassion fatigue is a state of tension and preoccupation with the individual or cumulative trauma that can manifest in many ways. Signs of compassion fatigue are:

1. Difficulty sleeping
2. Irritability
3. Anxiety
4. Withdrawal
5. Avoidance
6. Isolation
7. Feelings of helplessness
8. Feeling of inadequacy
9. Re-experiencing the event
10. Poor job performance
11. Low self esteem
12. Marital problems
13. Depression

Everyone who is involved in counseling, whether paid of volunteer, is susceptible to compassion fatigue at one time or another and depending on what area of specialty a person is in, it could be considered a "high risk".

The emotional demands placed on the pastoral crisis counselor have never been more intense. Pastoral counselors are expected to provide absorbency for every human emotion imaginable without suffering anxiety, fatigue or burnout.

However, eventually the stress of a case or a culmination of cases can become too great to with-stand.
Examples of these cases are:

1. Counseling traumatized victims
2. Performing funerals
3. Assisting in funeral arrangement
4. Death notifications
5. Counseling children (sexual, physical, mental abuse)
6. Catastrophic disasters with mass casualties
7. Compassion Fatigue is a concept that has been around for awhile, but seems to be more accepted and recognized as a valid danger for people who work in the helping professions.

Some may be more familiar with other terms such as Vicarious Trauma, Grief Overload or Secondary Traumatic Stress Disorder. The definition for Secondary Traumatic Stress Disorder is "the state of tension and preoccupation with the individual or cumulative trauma of clients as manifested in one or more ways including re-experiencing the traumatic event, avoidance/numbing of reminders of the event, and persistent arousal."

Even people who aren't in the helping professions can fall prey to Vicarious Trauma through the daily intrusions of the media regarding violent crimes and traumatic events. By being constantly subjected to these images, it can create a persistent arousal state within us and we may not even be aware that it is happening.

The symptoms of compassion fatigue can be found in these seven areas, Cognitive, Emotional, Behavioral, Spiritual, Personal, Physical and Professional.

Cognitive: We may begin to feel apathetic about our work or patients. We may become preoccupied with the disease process, illness or trauma.

Emotional: Anxiety, depression or being overly sensitive. We may become guilty because we feel we should have or could have done more for our client/patient. We may become shut down where our patients and their families can no longer elicit emotional responses from us.

Behavioral: Irritability or sleep disturbances.

Spiritual: We can start questioning the meaning of life and our religious beliefs.

Personal: We can become withdrawn from our loved ones. This may be done in an effort to not become emotionally available to anyone, or we have given so much of ourselves through work that we have no more to give to our family. We may become intolerant of others

Physical: We may have a lowered immune system because of the stressors we encounter on a daily basis, and much like Caregivers, people in the helping profession usually sacrifice their own needs for the needs of others.

Professional: Our work may suffer because we have low morale, low motivation, staff conflicts, unusual or high absenteeism, fatigue and irritability.

It's easy to see how mundane some of these symptoms can be, so it's particularly important for us to pay attention to these symptoms, especially if they are compounded. One way to keep track of how we are doing in our work is by doing check-ins with ourselves.

The Compassion Fatigue Self Test - can be found at www.ace-network.com/cftest.htm. It's a simple, ten minute test that will rate your level of Compassion Fatigue and your risk for Burn-out.

The Compassion Satisfaction and Fatigue Test - can be found at www.isu.edu/~bhstamm. Even though this test has been simplified, it will not only rate your level of Compassion Fatigue and Burnout, but also assess your current satisfaction with continuing in the helping profession.

The Caregiver Strain Index can be found at www.medscape.com/viewarticle/488917. This is a simple test that is used by Caregiver's but it has the same principles for knowing your level of Compassion Fatigue. I call it the quick and dirty test to do an occasional check-in.

Now the next thing is for you to know if you are in at risk category. You know the symptoms you may have, you know how to evaluate yourself to see if you are heading into trouble, but what can you do prevent it?

The first lesson is to practice saying "no." People in the helping profession have a very difficult time with this. You may find it easier to start practicing saying "no" on family members or friends.

You also have to find what is meaningful to you. Develop your own self-care plan. What will your plan contain? You have to develop the same coping strategies that you would if you were suffering the loss of a loved one. One of the main tenets for coping strategies in grief is the value of the support system. If you are in the helping profession, what about your work environment or agency - use them as your supports. Who will better understand the pressures you are under at work, than a peer or supervisor?

KEY FACTERS:L Know your own triggers and areas of vulnerability. Learn how to avoid them and diffuse them. Ask yourself what the alternatives are in dealing with this and preserving yourself? Can another professional handle the case? Summon a strong support system if necessary to help you through the case? It's important to explore and discuss your options. You don't have to tackle this alone.

Allow yourself to grieve: People in the helping profession are expected to respond to the human loss, emotion and tragedy that surrounds them every day as part of their work, but they are not expected to react as a human. The fact is there will be people you become attached to, there will be people you lose, and there will be people that you grieve their loss.

Set boundaries for yourself: Boundaries are in place as protective measures. It is very common to have the boundary line blurred from time to time when you are working in the helping profession, that is only natural, but learn to recognize when you are getting ready to cross the line and why - this will help you keep those boundaries in place in future situations.

Alter irrational beliefs: There are many different reasons why people are drawn to the helping professions. A lot of us are perfectionists and don't want to be judged. We need to know that we can't do it all and we don't have all the answers. Replace your irrational beliefs with affirmations, such as "I am capable," "I am competent," or "I am good."

Unfortunately compassion fatigue is the cost for caring for others and we have to combat the issues that surround it.

Examples Are:

1. Discuss the problem with peers
2. Maintain a good diet and exercise daily
3. Use humor
4. Keep a journal
5. Take time off if needed
6. Spend time with family and friends
7. Spend time doing what you love to do (reading, fishing, crafts etc)
8. Don't be afraid to say no

Establish a support system

If you don't have a good support system, make arrangements to get one. Everyone needs a support system that will allow them to talk about work related stressors and the chance to blow off steam.

If you are a part of a group of counselors, arrange to have regular closed door meetings, breakfast gatherings or one on one session with another counselor to be able to blow off steam necessary to continue to keep perspective. Discuss the possibility of rotating people during difficult assignments for a period of time.

If you are not part of a large group contact other counselors, pastors, psychologists, or mental health workers in your area to see if there is someone who would be willing to meet with you on a regular basis.

Encourage Self Help

Group members should encourage self help. They should encourage one another to talk to each other after traumatic events, funerals or any crisis related event. It is a fact that when people are able to talk about their feelings they do better work and stay focused on their job. Group leaders and officers should always monitor the mental status of counselors and make self help defusing mandatory if necessary.

RESOURCE

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