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Crisis Intervention by Social Workers in Fire Departments: An Innovative Role for Social Workers

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This article describes a unique use of social workers as crisis response team (CRT) members in a nontraditional host setting, municipal fire departments in Arizona. The role of modern-day firefighters has changed dramatically and now includes responding to a wide variety of crises and emergencies other than fires, such as motor vehicle accidents, family abuse, suicides, mental health incidents, accidents, and shootings. These traumatic events can lead to compassion fatigue in medically trained first responders who lack training to address the emotional needs of those involved in these crisis situations or to provide follow-up to ensure that their needs are met postemergency. Originally, CRTs were developed in these fire departments to address the needs of firefighters themselves. However, their functions have expanded to address the needs of customers served by the fire department, both at the scene and during the postintervention period. Using principles of crisis intervention and trauma theory, social workers and social work students placed in these agencies are benefiting both firefighters and community members served by the fire department.

KEY WORDS: *crisis intervention; crisis theory; critical incident; first responders; trauma*

Social work has a long tradition of helping people and communities deal with crises, including catastrophic events. In recent years, the role of municipal fire departments has changed dramatically. In addition to responding to calls about fires, fire departments now are called on to respond to a wide range of critical incidents and crises, including motor vehicle accidents, shootings, other types of fatalities, and traumatic deaths. This article reports on an innovative use of social workers by two urban fire departments in the greater Phoenix, Arizona, metropolitan area.

The Phoenix and Glendale Fire Departments both serve large, metropolitan areas in and around Arizona's capital city. Both agencies have diverse infrastructures committed to a range of community services, from water safety education to senior outreach and camping survival, in addition to responding to fire and medical emergencies. Serving as a firefighter can be a challenging and stressful occupation (Fullerton, McCarroll, Ursano, & Wright, 1992). First responders working in law enforcement and firefighters encounter traumatic situations every day. All modern-day firefighters are trained as emergency medical technicians (EMTs)

so that they will be prepared to deal with not only fires, but also domestic violence, car accidents, heart attacks, child abuse, and death. These types of calls pose formidable challenges to professional first responders, requiring special skills in crisis intervention and in dealing with vulnerable populations.

This article reports on an innovative form of social work practice in a nontraditional host setting, municipal fire departments. After reviewing relevant literature on crisis intervention, we describe the changing role of fire departments, the involvement of social workers on crisis response teams (CRTs), and the use of these fire departments as field placements for MSW students. Two case studies are presented to illustrate the types of cases seen as well as essential social work knowledge and skills.

CRISIS INTERVENTION AND SOCIAL WORK

In general, critical events can occur as a result of natural disasters, fatal accidents caused by machinery such as motor vehicles or air transportation, and human-induced disasters (Bell, 1995). Everly and Mitchell (1997) have identified individual tragedies as *critical incidents* in which the intensity of suffering is so severe that an individual experiences helplessness

and is unable to cope. The acute response to a critical incident can be described as a crisis, with the most salient markers being a disruption to homeostatic state, failure to cope, and evidence of despair and subsequent dysfunction (Everly, 2000). Characteristics associated with crisis events include the perception of threat; an inability to respond to the intensity of the crisis, so that coping mechanisms initially fail; increased fear and anxiety; high levels of subjective angst; and moving to a "state of disequilibrium" (Ell, 1996; NASW, 2008; Roberts, 2002).

From working with shell-shocked soldiers during World War I to managing the catastrophic effects of the Great Depression, social workers have a long-standing history of serving others during the crisis impact phase (NASW, 2008). In the mid-20th century, social work journals began publishing articles using the crisis intervention framework and promulgating specialized training for social workers in agencies working with clients in crisis (NASW, 2008). Today, social work professionals are well prepared to work with clients experiencing both acute and chronic stress, and they have been trained to intervene during an immediate crisis and to implement postintervention services. These services include individual, family, and group interventions to help victims achieve "reasonable mastery," caring relationships, and purposefulness after a traumatic event (Flannery, 1999, p. 244). One approach often used in crisis intervention is the ACT intervention model: assessment and appraisal, connecting to support and services and crisis intervention, and trauma and stress management (Roberts, 2002). These actions are congruent with social work education, making social workers uniquely qualified to serve on CRTs (Bell, 1995).

Crisis intervention is strongly person-centered and emphasizes communication, collaboration, and caring, ideals consistent with the social work value of caring for others. Social workers have the knowledge and skills to educate, empower, and assist victims of trauma (Bell, 1995). Recognizing "human beings as a whole," integrating "moral sensitivity, moral awareness, moral reflection, and moral commitment" (Gray, 1996, p. 4), professional social workers have a history of advocating social support for those in need, often using creative intervention strategies such as "nonfamilial sources of support" from within the community (Colorossi & Eccels, 2003). Both the Phoenix and Glendale Fire Departments have CRTs that include social workers

and provide immediate crisis intervention during traumatic incidents.

NEW ROLE FOR FIREFIGHTERS

Once organized around fire suppression activities, as the number of fires and associated injuries and deaths have diminished, fire departments now have different roles as the nature of their calls and activities have changed dramatically (Matarese, Chelst, Straub, & Farezzi, 2008). Because of their modified and expanded roles, most firefighters are now required to be certified as EMTs and may be used to assist with ambulance transport (Matarese et al., 2008). Since September 11, 2001, many firefighters have become engaged in emergency management activities during routine calls (Matarese et al., 2008).

In performing their jobs, firefighters often face stressors that can lead to burnout and emotional problems (Fullerton et al., 1992; Vettor & Kosinski, 2002). Several factors increase the likelihood that firefighters will experience critical incident stress (Lewis, 2002). First responders often empathize with those they help, imagining how it would feel if they were personally affected by the traumatic experience (Fullerton et al., 1992; Stewart, Harris Lord, & Mercer, 2000). They also must often return to work immediately after exposure to a traumatic event and may face scrutiny by the media or investigators regarding how the incident was handled (Lewis, 2002). As a result, sometimes vicarious trauma or compassion fatigue develops, resembling posttraumatic stress symptoms. Compassion fatigue can lead not only to poor job performance, but also to depression, excessive drinking, and flashbacks to the incident (Joslyn, 2002). In nearly 10 percent of cases, compassion fatigue is severe enough that firefighters may develop symptoms (Lahad, 2000).

Compassion fatigue can be relieved through a discussion of the traumatic incident and provision of support (Joslyn, 2002). The critical incident stress management (CISM) model is a highly efficacious strategy that is also a cost-effective approach to community crises, emphasizing precrisis preparation, defusing, organizational consulting, and one-to-one crisis intervention (Everly & Mitchell, 1997). Because of high posttraumatic stress disorder (PTSD) rates in first responders (Marmar et al., 1999; McFarlane & Papay, 1992), formalized CISM initially emerged in emergency medical services to help first responders cope with critical incidents as early as the

1980s. Since then, CRTs have been implemented throughout modern society as a response to traumatic events, such as school-based teams to help children cope with sudden and sometimes violent losses before, during, and after a critical event (Kline, Schonfeld, & Lichtenstein, 1995).

Crisis response programs, such as the one developed by the former Phoenix Fire Department (PFD) Chief Alan Brunacini, began in Phoenix in the early 1990s and despite "initial resistance from city hall" (personal communication with C. Khan, chief, PFD, May 5, 2008) are now recommended in many occupational and community settings. PFD began the program in an effort to "help community members in Phoenix who were going through their worst day ever" (personal communication with A. Brunacini, former chief, PFD, 2006). In other words, this program provides intervention for people during times of personal crises such as accidents, assaults, and even death.

The CRT, thoughtfully planned and well respected, is being replicated in fire departments around the United States from Washington state to Virginia. In the context of the fire department, CRTs moved from a focus on emergency personnel debriefing to psychological crisis management for the public served, both on scene and within hospital settings (Morrow, 2001). The current chief of the PFD says that this is important work in the community, because handling physical crises is often easier than what follows during the emotional aftermath (personal communication with C. Khan, chief, PFD, May 5, 2008). "You don't bounce back without some type of help, and firefighters aren't really trained to handle the emotions of a crisis," according to Khan. The CRTs, he said, "fill in the gap." The PFD's CRT is deployed to residential fires, structure fires, motor vehicle accidents, and all fatalities, including sudden infant and child deaths, drownings, shootings, suicides, and other traumas. Although paramedics work on the patient, the CRT focuses on family members and others who are traumatized on scene (personal communication with C. Khan, May 5, 2008).

PSYCHOLOGICAL REPERCUSSIONS OF CRISES

Critical events can result in traumatic stress and sometimes persistently severe psychological sequelae, attended by many costs to individuals, families, and society (Ell, 1996; Everly & Mitchell, 1997;

Scaer, 2007). According to the *DSM-IV*, PTSD can occur when critical incidents continue to command the attention of the victim through sensorimotor intrusions, avoidance, and hyperarousal of the autonomic nervous system, lasting longer than a month, while also interfering with a person's ability to function (American Psychiatric Association, 1994). Crisis intervention is intended to stabilize, reduce perceived helplessness and vulnerability, and cocreate new coping skills (Roberts, 2002). Everly (2000) has identified the goals of crisis intervention as well-timed and well-measured strategies that will stabilize the victim, preventing an upsurge of the acute distress; manage and decrease distress; help the person attain functionality; and if the person continues to experience dysfunction, provide a necessary linkage to a higher level of intervention or care.

The types of critical incidents and crises to which fire departments respond involve not only individuals but typically entire families. Families in crisis benefit from person-centered strategies that alleviate vulnerability (Hagenow, 2003). Thus, timely crisis intervention may be effective in preventing a variety of long-term difficulties for both adults and children who have experienced severely traumatic events. The tenets of intervention under the crisis theory model include providing aid quickly; ensuring adequate, immediate, and long-term social support; and facilitating expression of feelings, symptoms, and worries. In sum, CRTs using the principles of crisis intervention practice are intended to short-circuit protracted distress for first responders as well as individuals and families experiencing critical incidents or crises.

SOCIAL WORK'S EMERGING ROLE

Although it is not uncommon to see social workers placed as victim advocates within law enforcement agencies, it is rare to see social workers placed as crisis team members in the fire department. A careful review of the literature found no published books, articles, or chapters that describe the use of social workers for crisis intervention in fire departments. Although Glendale and PFD's CRTs are staffed primarily with volunteers due to limited funding, each CRT employs one full-time MSW who is charged with training volunteers. There are also two paid administrative positions and eight full-time equivalent positions funded half by grant monies and half by the city. They currently have about 14

staff members to fill these part-time positions, about half of whom have a bachelor's degree. All 14 staff members were either volunteers or interns prior to being hired. However, nonpaid staff make up the bulk of the CRTs in both departments, with approximately 80 volunteers in Phoenix and 124 in Glendale. The programs embody the social work values of being person centered and caring, with an emphasis on communication and collaboration.

When critical incidents occur, crisis response vans staffed with volunteers, ideally a social worker and an EMT, are dispatched to a wide range of different types of calls. These types of calls include unexpected deaths of loved ones from natural causes, homicides, suicides, house and apartment fires, motor vehicle accidents in which someone has been seriously injured, child and adult drownings, domestic violence, sexual assaults, bomb threats, and gunshot wounds. These types of calls come at all hours of the day and night. Although there are several categories of calls, once the team arrives on the scene, a call becomes unique because of how it affects those involved.

To respond effectively to these calls, social workers need specific knowledge and skills to perform a variety of roles. They need knowledge of how individuals and families respond when traumatized or in crisis. They also need knowledge of resources in local communities so that they can refer affected individuals after a brief intervention. Other necessary knowledge includes an understanding of emergency medicine and local police department procedures and an awareness of the different cultural and ethnic groups residing in the area served by the fire department. Social workers employed in this capacity also need knowledge of the principles of brief intervention and stress debriefing as well as knowledge of relevant theories and intervention approaches such as solution focused and Gestalt. For example, Gestalt theory can be used to help affected individuals to better understand the gravity of their situations and the actions they need to take to return to normal.

Social workers on the scene of an emergency provide tangible aid as well as comfort and support to individuals in crisis. It is often necessary to advocate for individuals and families during the critical incident, as the nature of the crisis may impede a person's ability to make informed decisions. Social workers also play a mediating role in communicating with the fire and police departments on behalf of those they are assisting.

For example, if the call involves a crime scene or a fire, those affected are not allowed to be near the scene (for safety reasons or to preserve evidence), necessitating communication with first responders to inform family members about what is occurring. Sometimes social workers perform the important role of delivering the sad news to an individual or family that a loved one has died. In some instances, social workers perform debriefings for those who have been affected by a call, such as a suicide. This may consist of acting as a liaison between medical staff and the family; providing accurate, straightforward information to the family in a timely manner; allowing the family to process their thoughts or feelings on the basis of their perceptions of what occurred; ensuring that the family members' medical needs are met; and activating supports for the family. Social workers also educate the family on what needs to happen next and provide resources to make necessary decisions. Using all the kinds of knowledge mentioned, social workers are better able to assist those at the scene by helping them with decision making and in some cases helping them to use the experience as an opportunity for positive change.

In addition to knowing how to help those in need, CRT social workers need self-knowledge to be aware of how the experience of assisting those who have been traumatized or are in crisis is affecting them. Some calls can "hit close to home" because of personal experiences or losses. Being aware of their own sensitivities around certain issues can help workers maximize effectiveness by getting supervision or support and instituting self-care activities if necessary. Child deaths often incite great angst in crisis team members. For example, when a child dies as a result of a drowning, many team members struggle with their own emotions and personal feelings while trying to provide effective services to family members. CRTs allow for supervision to occur on scene and for debriefings to occur after the teams have finished with the calls. Because social workers are trained to recognize how their personal experiences may affect families during their calls, they may be more likely to contact someone for assistance to decrease issues of secondary or vicarious trauma.

CASE EXAMPLES

An example of a typical call started with a dispatch to a case said to involve difficulty breathing. Upon

arrival, the team was informed by the captain of the engine company that the person who was reportedly having difficulty breathing was actually a 16-year-old female who did not reside at the dispatch address, was not related to anyone at the scene, appeared to be mentally challenged, and stated that she had been sexually assaulted. The team was told that the victim had run to the dispatch address and banged on the door, crying and asking for help. Because she had been running, the adolescent had difficulty trying to tell the people who lived there what had happened to her. The residents called 911 and reported that they had a teenager who was having difficulty breathing. When the teenager stated that she had been raped, the firefighters immediately requested the service of the fire department's CRT van and police. The captain informed the team that the police had been contacted and were en route. Before the police arrived on scene, the CRT asked the teenager where she lived and if she knew her phone number. The teenager stated that she did not know her address or phone number because she was living in a group home from which she had run away the previous night. When the police arrived, they were briefed on what information the firefighters had received from the victim, those who had called 911, and the CRT. The team coordinated with the police regarding what they wanted to do to assist the teenager. The police wanted to talk with the teenager, but she stated that she was unwilling to talk with the police unless the team members were with her, because she was scared of the police. The team explained their concerns for the teenager and willingness to be with her during the police interview, and the police in turn agreed to have the CRT present when they interviewed the adolescent.

One team member stayed with the teenager and police, the other member initiated phone calls to the local agency that specialized in sexual assaults of minors and to Child Protective Services (CPS) to find a caseworker for the adolescent. When the team member told the advocacy center of the situation, she was asked to bring the teenager to their location with the police officers. The CPS caseworker was located and informed about what had happened and what was currently underway with the CRT and police. Prior to arriving at the sexual assault advocacy center, the police wanted to take the victim to the location where she said she had been raped. The team members were allowed to accompany the victim because she did not want

to be left alone with the police. During the drive and walk to the location where the teenager said the rape took place, the teenager started telling the police about what had happened and why she had run away from the group home. After leaving the location of the rape, the CRT drove the victim and one of the police officers to the sexual assault agency so she could talk with detectives and have an examination done to gather evidence. But when the team and police arrived at the agency, they were informed that because the adolescent did not know her attackers, she would have to be taken to a different agency that serves adults who are sexually assaulted.

After arriving at the agency serving adult sexual assault victims, the CRT contacted the CPS caseworker to inform her of their location and the status of situation. From there, the team prepared the victim regarding what was going to happen at this agency—that she was going to have to tell her story again to more police officers and have a sexual assault examination performed by a nurse. At this point, the victim started to cry because she was scared that her classmates would find out what had happened to her and that no one would want to be her friend. The CRT reassured the teenager that no one would know what had happened to her because they were not allowed to tell anyone the details of what she had told them. At that point, the CPS caseworker arrived at the agency and was able to take over the call and provide the teenager with more assistance.

In a second case example, a fire station in Glendale requested the CRT's assistance with a "customer" who was quadriplegic and had cerebral palsy. The customer resided alone in his home, was confined to his bed, and had no social supports. He had a home health care nurse who was at the home 18 hours a day. When the nurse was not there, the customer would call the fire department, who would respond in the middle of the night to nonemergency medical issues that could have been handled by a caregiver. These types of calls were being received three to six times per week. When the CRT met with the customer and completed an assessment, it was found that the customer was connected with another service that could obtain 24-hour home health care for him. The service provider was contacted and advised of the concerns. Because the worker had not been aware of the frequency of the calls, she had not previously felt that 24-hour home health care was

needed. With the assistance of the fire department, the worker had sufficient information to justify a 24-hour home health care nurse. This resulted in the customer's needs being met more effectively, decreasing the frequency of the customer's calls and allowing the firefighters time to respond to more urgent calls.

These cases illustrate the breadth of types of cases to which CRTs in the fire departments are called on to respond. Modern-day firefighters receive training that enables them to respond to medical emergencies. However, they are not qualified to provide crisis intervention services or address the diverse needs of individuals and families experiencing a mental health crisis, the death of a child or other family member, suicide, child abuse or elder abuse, domestic violence, or other types of emergencies to which first responders are called. They are also not prepared to perform the follow-up that is often necessary to ensure that "customers" (clients) are linked with appropriate services after the emergency has passed. As CRT leaders, social workers use their knowledge of human development and practice skills to quickly connect with customers, assess their needs, provide crisis intervention services, and determine whether follow-up or referrals are needed.

USE OF THE FIRE DEPARTMENT'S CRT AS A FIELD PLACEMENT

Field education is an integral part of social work education, and students in both BSW and MSW programs are required to apply in real-world settings what they have learned in their classes, including principles, values and ethical behaviors, and the scientific basis for practice. The social work program located in the College of Public Programs on the West campus at Arizona State University offers a generalist social work education at both the bachelor's and master's levels. In the bachelor's-level program, social work students learn the basics of case management; in the master's-level program, students acquire the advanced generalist skills that allow them to practice at both the micro and macro levels, advocate for clients, and become exemplary leaders in their communities. Under skilled field instructors who are trained to supervise students, BSW and MSW students apply their practical knowledge and skills while clients of the human service organizations benefit from professional services that might not otherwise be available due to limited resources.

We began to place students at the Glendale Fire Department in 2005, beginning with a BSW student who contributed 380 hours to the community. By the 2007–08 academic year we had placed seven BSW and MSW students, who contributed a total of 2,040 hours of service. Starting in 2008–09, two additional municipal fire departments have requested social work students to be placed in their CRTs. Over the past four years, more than 25 social work students have contributed a total of 10,280 hours of service to help the citizens of the Phoenix metropolitan area who found themselves in the most critical and traumatic situations. The crisis intervention mode of services provided by the CRTs of both the Glendale and PFDs has not only allowed social work students to help those who experience immediate trauma, but also created an excellent environment for the students to apply what they are learning in the social work program. Performing intake and assessment, finding appropriate resources, counseling individuals who are in crisis, and advocating on behalf of trauma victims are examples of skills that students have been able to apply and enhance in their field placements.

The field placement begins by having students attend an extensive training program of over 100 hours of classroom and practical training that covers a wide range of topics, including crisis intervention, substance abuse, domestic violence, sexual assault, grief, stress management, and cultural diversity. The training also includes "ride-alongs" in which the volunteers (and social work students in field placement) observe CRT members in action before they are permitted to function as team members. Working as part of a team with the fire department staff provides a unique opportunity to not only learn about community resources, but also (more important) be a part of a team of helping professionals working together for the benefit of members of the Phoenix community. Because crises occur during evenings and weekends as well as during normal business hours, students can work flexible shifts that accommodate their work and family schedules. Over the years, the internship within the CRTs at the fire departments has become one of the most desired field placements. Upon graduating with their social work degree, some graduates are hired by the fire department. For them, being a part of this unique program and service to the community become their professional work. Other former social work students continue to contribute their skills and knowledge

by working as volunteers for the CRTs with both fire departments.

Another unique dimension of the field education experience for master's-level students is the Applied Project, in which students carry out a hands-on research project in their field setting. For example, a recent student conducted a quantitative study of compassion fatigue and burnout among CRT members at the Glendale Fire Department. She surveyed team members regarding burnout and compassion fatigue and how they coped with their experiences as team members. Most reported that their experience as a CRT member was rewarding, and few reported burnout or secondary trauma (Kay, n.d.).

CONCLUSION

The fire service has dramatically changed in recent years, focusing more on emergencies other than fires, such as motor vehicle accidents, family abuse, suicides, mental health incidents, accidents, and shootings. The increase in loss of life related to these traumatic events can elicit long-term psychological consequences for first responders. Originally, CRTs were developed within fire departments to address the psychological needs of firefighters and to avert posttraumatic stress symptoms. However, in metropolitan Phoenix and other selected areas, the role of the CRTs has expanded to meet the needs of customers served by fire departments. Using principles of crisis intervention and trauma theory, social workers, as well as social work students, are being placed in these departments to benefit both civil servants and community members served by the fire department during a traumatic incident. We hope that the fire department-based CRT programs described here will be expanded to other fire departments across the country so that other communities can benefit from the services of social workers. For a relatively small investment of resources, fire departments in other communities can replicate the model described here using professionally trained social workers and volunteers to address the needs of both first responders and community members experiencing crises and traumatic events. **SW**

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