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Using SAFER-R to Support the Traumatically Bereaved

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CISM's SAFER-R is widely used among first responders, giving them a new lifeline after a critical incident or trauma. For first responders and for those peers and professionals who support them, critical incidents tend to stack up over time; rarely is there a one-and-done critical incident in their lives.

I had one of those rare singular incidents when I was still in my teens and working for the Maryland Department of Natural Resources Police as a summer "part-time officer." I worked weekends for the Marine Police Division on Chesapeake Bay and local river waters without a badge or a weapon, performing go-fer tasks and assisting with handling the boat and radio. I was a shy young woman and, incidentally, the very first female part-time officer for the Maryland DNR, which put many male eyes on me. My first weekend tour was the 3-day Memorial Day holiday. We responded to a drowning and, although my patrol boat officers tried hard to protect me from the site of the deceased man's ghostly white body, I insisted on looking and being a part of the scene. It bothered me, and I've never unseen what happened all those years ago, but it didn't really traumatize me. I was more traumatized the year before by picking up a kitten run over by a car; it died in my arms—that scarred me. Well, it's certain that no one can predict what specifically will hurt one person more than another.

My point here is that I had a trauma but not a wide swath of them. I didn't have to hold onto myself and get back into the work setting daily, pushing away an ever-growing stack of critical incident reminders and traumatic memories. My experience of critical incidents was minimal, just enough to know what trauma is and why CISM works.

Today, as well completing the ICISF CISM Certification of Knowledge exam (CCISM), I'm a certified thanatologist (CT), a specialist in dying, death and bereavement. I serve as a grief trainer and coach who comes across many traumatized people who first responders may never meet or assist; these traumatized people may never talk to a CISM responder for help with their psychological pain. They may never receive crisis intervention for the pain of their loss. I have found that CISM's SAFER-R model for individual crisis intervention is a powerful way into the pain of some people's grief—often rightly called traumatic grief.

To see how CISM's SAFER-R connects with grief, let's begin with a few vocabulary terms. *Trauma* is often defined as an event outside typical life experiences that produces distress, intense fear, or a sense of helplessness; trauma can involve a threat or perceived threat to oneself, one's family, or even a stranger (see DSM-5, 2013; Mitchell, 2017, p. 37). *Grief*, on the other hand, "is an internal sense of loss, typically associated with pain and sadness but that encompasses many other feelings including

anger, guilt, and regret. Grief hits people passively in that they can't choose whether to feel grief, and they can't make it go away by willpower. They just feel it. Grief lasts a lifetime" (Hewett, 2023, p. 43). *Traumatic grief* is grief overlaid with a trauma; for an example, parents whose children die—at any age and from any circumstance—experience traumatic grief (Cacciatore, 2017). Violent, sudden deaths—like murder, accidents, and suicide—nearly always lead to traumatic grief. The process of adapting to grief emotionally and neurologically is *grieving* (O'Connor, 2022, italics in original). Finally, for our purposes here, *mourning* is the "outward expression of loss, which requires an active and often intentional process. If grieving is the process of adapting to loss, then *mourning is how people do the adapting*" (Hewett, 2023, p. 45, italics in original). It's important to note that some non-human losses can lead to traumatic grief, like the sudden loss of a job just when the family has committed to a move, a house fire that consumes everything the family owns, or watching a beloved pet die suddenly from a car accident.

But other deaths can be traumatizing, too, and often these are once-in-a-lifetime events like my encounter with a drowned man. Here is an example of one such case.

When an 80-year-old woman's 83-year-old husband died suddenly on New Year's Eve, and he died in their home, in their bedroom, unclothed, and with no warning that the couple recognized—that was a traumatic death. First responders worked on him for 45 minutes but could not revive him. Unlike my never-to-be-unseen drowning victim or the tiny, writhing, wounded kitten, these two people had a relationship of more than 50 years of marriage. It doesn't matter that the man was in their eighties; to the couple, they weren't old and still had years together ahead of them.

In this case, the woman called me only two weeks from the trauma. At first, she was so hysterical that I could hardly understand her. She claimed suicidal thoughts but denied that she had any plans for ending her life; she said she just didn't see what living could be like without her beloved husband. That's a common belief that we worked to normalize, but I still directed her to call 988 for suicide-specific help or to 911 if she couldn't reach them should she think she might act on those feelings. Then, we chose to meet for a focused session the next day.

When I contacted this woman the next day, she again began with rapid-fire statements that seemed disconnected and often unclear. I decided to begin our grief work with something that I knew would enable focus: SAFER-R.

For *stabilization*, I talked a little bit about myself and my qualifications for coaching her. I told her about my background, on which she honed in, questioning me in a reasonable way and comparing what I could do against what she knew "other counselors" could do. I then eased into talking about basic safety and physical needs: Was she able to navigate her house without her husband's assistance? Since she claimed she was too upset to drive, who was helping to provide her with groceries and trips to her doctor's office? In fact, had she visited her doctor to talk about her husband's death, thereby

setting the scene for her doctor to contextualize any new illness or even upper respiratory infections like colds?

With this attention to stabilizing her focus and attention, I began the *acknowledgement* phase of my session with her. I asked her for information about her husband: his age, what work he did, how long they had been married, whether they had children (No, they preferred dogs. What kind of dogs? Terriers.). Then, I asked her about how her husband died. She told me she might not want to give all the details, which I acknowledged as a wise move because she was only getting to know me. As she talked, her speech began to slow even more, and she gave me a coherent account of his illnesses and sudden death. When I asked how she was handling all the changes that come with death, she was able to remain focused and calm, talking thoughtfully about how much she missed him daily.

To *facilitate understanding* between us, I told her how sorry I am about her loss and shared what I might be able to do with her as a grief coach. I normalized her situation, sharing that most bereaved spouses express feelings like hers and that many of them do so for quite a while. She expressed relief that she wasn't alone in such feelings. I wanted her to understand that two weeks past the traumatic death of her husband of half a century is like no time at all, a bat of an eye, a flicker of a flame. I asked her how distressed she was feeling at that point of the call, and she expressed that she was feeling more able to breathe and handle what she was feeling.

While SAFER-R *encourages effective coping*, in the case of bereavement work, teaching coping skills happens over time and not all at once. That's because typically there will be several follow-on meetings and needs will shift with each meeting. *Restoration of functioning* often occurs with *referral* to continuing care because the adaptation of grief—*grieving*—takes a long time and its needs change over time. In this newly bereaved spouse's case, I was able to assure her that I could continue to work with her and that we would talk more about the signs of grief in our next visit. At that next meeting, I had planned once again to stabilize and acknowledge as needed while eliciting the symptoms of grief that she is having, listening for signals of trauma to address as quickly as possible. I would integrate other elements of grief support that fall outside of SAFER-R. Nonetheless, beginning with this CISM-based approach enabled a more focused, helpful beginning to our work that would engender trust.

In sum, SAFER-R has a lot to offer bereavement counselors who are working with traumatized clients. As indicated in this case description, the next step is to reengage parts of the CISM process in combination with education about grief and loss as well as mourning activities that one can use to assist with adapting to grief. We do some of those mourning activities together as the bereaved often feel lost and alone. We also bring in family and friends as possible. My client's precious dogs can become elements of the mourning work, too.

Not everyone who conducts CISM interventions will be a bereavement specialist. Many first responder peers, psychologists, behavioral therapists, and chaplains won't know as much about how to support the bereaved as a certified thanatologist or bereavement coach. However, they are poised to introduce

critical incident-based, traumatized grief victims to the benefits of a CISM intervention and then to refer them directly to bereavement specialists.

This case study represents one of the approaches recounted in my new book *Duty, Honor, Hope: Strategies for Understanding and Unpacking First Responder Grief* (ICISF), written particularly to help first responders with their own and others' grief that lives underneath and beyond trauma.

References

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