DOCUMENT RESUME

ED 404 055 RC 020 495

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TITLE Psychological Factors in Wilderness Rescue.
INSTITUTION National Outdoor Leadership School, Lander, WY.
PUB DATE 86
NOTE 23p.; Excerpted from a presentation at the Wilderness Medicine Symposium (Jackson, WY, 1986).
AVAILABLE FROM NOLS Staff Library, 288 Main Street, Lander, WY 82520 ($5).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Descriptive (141) -- Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Accidents; *Caregiver Role; Defense Mechanisms; *Emergency Squad Personnel; Emotional Disturbances; Emotional Experience; *Emotional Response; Leadership Qualities; Natural Disasters; *Posttraumatic Stress Disorder; *Psychological Patterns; *Rescue; Training; Wilderness
IDENTIFIERS Outdoor Leadership

ABSTRACT

This presentation provides wilderness rescue workers with an overview of the psychological reactions of victims of accidents and natural disasters and suggested responses for rescuers and caregivers. A personal account of rescue and death in a drowning accident illustrates how the rescuer can also be traumatized by such an incident and may suffer posttraumatic stress syndrome for years afterward. A review of a study of Othello, Washington, after the Mount St. Helen's eruption summarizes social and psychological effects of disaster on personal and family functioning. Typical progressive responses and defense mechanisms during extreme stress are described: the alarm reaction; mobilization of an individual's resources; and four stages of overload and decompensation, ending in terminal response or exhaustion and possible loss of contact with reality. The psychodynamic features of four patterns of decompensation and reintegration are described, which parallel stages in the grieving process. Guidelines are offered to help rescuers and caregivers contribute to the victim's reintegration process while safeguarding their own mental health. The qualities and personality structure of the wilderness leader or rescue crew leader are very important to this process. Education and training time in rescue planning should focus on rehearsals of a broad range of actual rescue situations, and should include the opportunity for rescue team members to explore their feelings and vulnerabilities. (SV)

THE NATIONAL OUTDOOR LEADERSHIP SCHOOL

PSYCHOLOGICAL FACTORS IN WILDERNESS RESCUE

by
Bruce C. Ogilvie, Ph.D.

presented at the
1986 NOLS Wilderness Medicine Symposium

[The following comments are excerpted from notes prepared for an address delivered at the 1986 Wilderness Medicine Symposium held in Jackson, Wyoming and sponsored by the National Outdoor Leadership School]

PSYCHOLOGICAL FACTORS IN WILDERNESS RESCUE

by

Bruce C. Ogilvie, Ph.D.[1]

As a speaker invited to the National Outdoor Leadership School's 1986 Wilderness Medicine Symposium, I prepared myself to offer a brief review of human reactions to a variety of natural disasters, physical injuries and catastrophic accidents. Since this was my first presentation to men and women with wilderness rescue responsibilities, I believed that documenting the extent such traumas contribute to social and psychological problems of a lasting nature would best introduce this timely topic. Before any conclusions could be drawn it seemed necessary to marshal evidence to educate those present that "post-traumatic stress syndromes" were real and required our studied attention. Based upon this evidence it was my intention to touch briefly upon the much neglected concern for the psychosocial traumas of the rescue team members or the caregivers. Historically they have been disregarded because there have been no systematic investigations of the psychological aftereffects upon team members. It was during my discussion sessions with individuals who were experienced in rescue or who had been the victim in a rescue situation that I decided to alter the emphasis of my presentation.

In my eagerness not to take for granted the degree of experience of those here in attendance, I engaged in discussions with several individuals who were experienced in a variety of wilderness rescue situations. I was interested in openly examining those sensitive areas that might be of psychological relevance to the audience. It soon became apparent that

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these individuals shared feelings and experiences which would have been excellent examples of every psychological point I had intended to develop. It was during such a session with Dr. Kip Webb, Jim Ratz, NeNe Wolfe, and Tod Schimelpfenig, that the neglected needs of the rescuer or caregiver became the focus of my attention. I found that there were no exceptions in this group — they had all been traumatized either by their experience as rescuers or in the role of being a victim.

I had a personal interest in how those of you who had participated in wilderness rescue missions had gone about working through your own personal feelings with regard to your role. What were your innermost feelings as you attempted to be effective in the crisis situation? I wanted to pose so many questions. Did the physical requirements stretch you to your physiological limits? Were you in immediate physical danger? Could the rescue have cost you your life? How did you handle your feelings when the victim suffered catastrophic injuries? If you lost the victim what were the residual feelings and how did you deal with them? The questions for me are endless and I wish I could pose them to all of you for in your answers we would find the soundest data for training others.

These questions take on a personal meaning for me as I recall my actual personal experiences in the role of rescuer. It is important that I qualify my experience because my efforts were exclusively surf rescue attempts and occurred between 1937 and 1943. What my discussion with others opened up for me was the realization that I had never openly described the mixture of confused feeling with which I had been left.

After waking up early this morning I decided to risk sharing the memory of one particularly traumatic rescue attempt as it had occurred in the surf at a San Francisco beach. My greatest concern was the extent to which I could be totally honest in my recall after 40 plus years, and also the possible effect this attempt at honesty might have upon select members of the audience. As we teach young clinicians in training, "don't let more snakes out the basket than you can handle in one session." But base upon my discussions with rescue team members and three victims, I felt that I should release some emotional snakes. Intuitively, I was

convinced that each person here would be strong enough to put their own lid back on their own basket. The following is the best I can dredge up out of a distant memory which for me was an extremely traumatic rescue. I can assure you that it was the one that time has never been able to erase.

It is important that you realize that I went through a severe internal emotional struggle with regard to the wisdom and appropriateness of this personal disclosure. I woke up at about three a.m. this morning and struggled with my own doubts and uncertainties. By eight o'clock, I decided that my greatest contribution to this wilderness audience would be to expose, as completely as possible, every feeling that I could articulate in the presence of people I did not know. Sensing that I was still fearful and uncertain and provided I could remain sufficiently open with my feelings, I gave myself permission to back out when I came face to face with my audience. I felt, however, if I could screw up my courage and open with this form of honesty, I could move into the more formal material I have prepared and greatly enhance its relevance to you all. I recognize now that it has been the models of honesty of those I have visited with that enables me to take, what for me, is a considerable risk.

I will try to relate this traumatic incident as accurately as my power of recall will permit. As I think now about the experience my mind is a camera and every visual element is still stored on film. Yet as those of you who have lived through such traumas know, these are not the kind of human experiences which we can stand back from and relate in a non-emotional way. For me the emotions from over forty years ago are so real and so overpowering that my controls are unsteady. Still I want to avoid emotionally overloading those present. If I am able to retain my composure, it is the trained psychotherapist in me that shouts, "don't behave in a way that will open up the hurts or pains in others".

It was a windy, slightly overcast summer day. Diane, now my bride of 44 years, and I were holding hands while walking down an embankment, moving toward the edge of the ocean. It is important that you know that we were in the earliest stages of a deep mutual love commitment. We had been bonded in this emotional commitment for only about six months.

As I looked up from the edge of the embankment I saw the silhouettes of two young people as they were being rolled in an unusually dangerous surf. I shouted to Diane that they were going to get in trouble because they were already moving out to the third wave set. I started to run towards the surf while unbuttoning my shirt and kicking off my shoes. As I ran into the water, Diane grabbed me by the arm and would not let go. She was pleading with me not to enter the surf. I do not have total recall but she was shouting that if I went after them she would follow me.

I knew at that moment this was simply her way of trying to stop me because she has an inordinate fear of the surf. I pulled her back to the edge of the water and started out again. Once more Diane ran out to her waist and grabbed me. I pulled away and shouted something profane and headed back in the direction of the couple who were now tumbling uncontrollably in the third wave set.

As I struggled to get through the surf I had to make my decision which struggling form to attempt to reach first. Weighing the distance odds, I turned to the body on the left and struck out for what turned out to be the woman of the couple. By the time I reached her I was nearly physically spent, and yet I had to somehow fight my way through a receding surf. I now only remember how helpless I felt because I wasn't making any headway. I was so weak that I could not keep her head above water; the waves just rolled and tossed us about. I prayed a sandbar would appear beneath my exhausted legs. I knew I had to touch sand within a minute or it was all over for both of us. Fortunately, the power of one large wave propelled us in far enough to get one foot down and I anchored myself to the spot and began to shout for assistance. As I clung to this tiny island of safety with the tops of my toes I can still remember my rage because no one would answer my pleas for help. Had I been more rational, I would have realized that no inexperienced surfer would dare venture that far into the water, but that did not lessen my anger. By then all I could do was hold on to the back of the woman's bathing suit as fatigue overtook me.

I remember shouting profanities at men watching from the beach. Finally we were hit by

another wave and moved closer to the shoreline. At this point a heavyset man waded out to help me pull the woman to shore. I took her pulse as I was trying to gain my composure and catch my breath. There was no pulse. I asked someone to get professional help while I started to resuscitate her.

The next trauma for me was produced by individuals in the crowd who found it necessary to criticize or make negative comments about my attempts at revival. No one volunteered to help but there was plenty of judgmental verbal comment. After what seemed an eternity the professional arrived and took over, even though it was apparent by then that the young woman was dead. Another extremely traumatic aspect of this total failure was the effect this total scene had been having on my deeply committed Diane.

It is important that you know that Diane had been abandoned at the age of four. As you are all aware the emotional scars of the abandoned child never completely heals, so it doesn't take more than a minimal threat to their security to open up a terrifying emotional wound. As I turned to pick up my things I saw her for the first time; she was sitting by herself on the sand curled up in almost a fetal position. Her head was bowed forward and she was grasping her knees with all the strength she could muster. When I approached her and reached down to touch her, she exploded in anger followed by expressions of being hurt, as though I had thoughtlessly subjected her to a cruel and unnecessary threat. Even then as a relatively uneducated young man I sensed Diane was convinced she had lost me too, this person to whom she had made her first love commitment. I somehow sensed that the hurt and fear, and certainly the anger, were not a reflection of lack of love but were the reawakening of her old fears of abandonment. My total attention now was turned to reassuring Diane and helping her to recover her equilibrium. I lifted her to her feet, wrapped my arms around her, and we made our way back to the car.

In some ways trying as best I could to focus on Diane's need enabled me to escape from dealing with the whole array of my own confused feelings. It was most unfortunate, like many of you who have been through similar experiences know, that a trained person with sufficient

psychological training was not there to help me reprocess the entire experience. We know now that by reliving the entire episode we may reduce the potency of such negative thoughts and feelings. Yet there was no one to help me as I began to lead Diane away from the scene. It is so apparent now, at least to me, that one can carry a whole variety of mixed feelings about such feelings through a lifetime. What does one do with the questions one continues to ask one's self? Need the young woman have died? Did you select the victim with the greatest possibility of survival? Could you have behaved in ways that increased survival possibilities? What responsibility do we have to refuse to take such risks when those we love might be subject to trauma?

As so many of you already know from personal experience, the quest to make some sense out of what has gone before and to find someplace inside your very being where you can put the experience to rest can become a real emotional burden. Now what are my motives for my foregoing attempt at disclosure? I want to reinforce a universal truth about the caregiver, and that truth is we are all at some level psychologically and socially vulnerable in times of physical and emotional trauma. Also, that the only thing that will distinguish us one from the other is our capacity to confront these vulnerabilities at the moment of crisis.

It may seem trite to state that we are all vulnerable when a crisis crashes through emotional defenses which we habitually use to ward off pain. The threat of annihilation — whether it is primarily physical or emotional — will awaken a well orchestrated symphony of deeply embedded feelings. We are each left with one of two choices: that of using our vulnerability to give direction to personal growth, or to hide behind repression, denial or sublimation. We can almost be assured that the emotional residue will be directly proportional to our questionable skill in hiding from those experiences that have tested us. As I now move into the more objective or formal aspect of my presentation, I reserve the right to return to the issue of emotional residue and the psychological strategies that individuals employ at the expense of stunting their emotional growth, particularly those that are relevant to rescue team members.

THE CASE FOR POST-TRAUMATIC STRESS SYNDROMES

There have been a number of studies of the traumatic stress generated by both natural, physical and socially threatening disasters. The follow-up studies of individuals who have been victims of such disasters have contributed to a new psychiatric label. It is unfortunately true that it has taken almost twenty years to gather sufficient data to support the reality of this human response to catastrophic events or unbearable personal threats. One equally significant aftereffect of such disasters which has not received sufficient attention has been the needs of rescue party members.

From the numerous examples of catastrophic aftereffects we could select the followup examples of Three-Mile Island, the Hyatt-Regency balcony collapse, the crash of the PSA 727 into the San Diego residential area or post-Vietnam stress syndrome. What is of most significance to our present topic is the universal finding that many of the caregivers also become the victims of the tragedy. One of the shocking findings has been that the psychological and physical symptoms may not be expressed in an overt form until three to eight years after the traumatic rescue experience. Before exploring this issue of trauma to both victims and caregivers, let us examine some of the evidence for disaster reactions and their general features.

Ramifications of a Natural Disaster

One of the best demographic studies to appear in the literature was that of the Mount St. Helen's Ashfall Study (Adams and Adams, 1984). These authors have published one of the most scrupulously controlled studies which has permitted a more reliable picture of catastrophic sociopsychological and physical aftereffect. They offer evidence from their study of the 5,000 citizens in the the city of Othello, Washington during the seven month post disaster period. It will become immediately apparent to those unfamiliar with the disaster literature that the catastrophic response patterns take such a characteristic form. First, let us examine the social implications in terms of their affect upon family functioning.

The reported increase in family behavioral problems pre-post trauma were: domestic

violence up 98.5%; divorce up 6.3%; referrals to alcoholism centers up 20%, and arrest for alcohol violations up 43.6%. Aggression and violence increased as follows: criminal cases filed in superior court up 37.5%; juvenile criminal bookings up 22%; adult criminal bookings up 22.2%; disorderly conduct up 10%; vandalism/malicious mischief up 23.7%; assaults up 27% and domestic violence up 45.6%. One of the most striking and threatening findings was the 89.5% increase in child abuse. Referrals to the community alcohol center increased 20%, police arrest for alcohol violations increased 43.6%. The findings relating to pre-post physical illnesses were equally as dramatic. There was a 21% increase in emergency room visits; an 18.6% increase in the death rate; employee sickness leaves increased 25.5% and use of hospital clinics increased 37.8%.

In our discussion specifically dealing with the psychological consequences of catastrophic stress reactions, the data on pre-post disaster consequence is overwhelming. The monthly average of mental illness reflected a 235.8% increase, psychosomatic illnesses 218.8%, and stress aggravated illness 198.2%. In terms of general adjustment, psychiatric commitments went up 33.8%, mental health appointments up 21.9% and crisis calls up 79.2%. The foregoing demographic data documents all too clearly the physical, social and psychological erosion that characterizes every catastrophic event. The social and physical disintegrative effects represent the classic stages of decompensation that occur when the individual's stress threshold has been breached. It will be extremely important for the caregivers and members of the rescue team to recognize the stages and signs of the decompensation as the emotional overload manifests itself over time.

One of the best theoretical models for both comprehending and responding in the appropriate mentally hygenic way to the human decompensation process has been propounded by Professor Hans Selye. (Selye, 1972, *Stress Without Distress,* Philadelphia: J.B. Lippincott.) We should first distinguish between the effects of positive stress and then review the manifestations of distress.

The Alarm Reaction

The first level of adaptation to stress which Selye labeled as the Alarm Reaction Phase represents the individual's psychophysiologic response to any given stressor. The most prominent features of this reaction are an increase in vital body signs, increased adrenal-gland output, a hightening of sensory awareness and a general preparation for either flight or fight.

Mobilization of Resources

This is the beginning phase of the resistence reactions as the individual attempts to model the appropriate problem solving behaviors that will bring the stressor under personal control. In this phase the individual attempts to select the best adaptive response. There will be an increased utilization of the defense mechanisms that have aided in the containment of anxiety in the past. It is even quite possible for some that during this mobilization phase the defensive strategy which they have selected becomes non-functional. In other words, there is no lessening of their state of anxiety. For many the response becomes one of an increase in inflexibility and a retreat to behavior that has even less opportunity for positive adaptation. At this point we see an intensification of the maladaptive process and a search for solutions based upon irrational premises. These irrational solutions often lead to pathological consequences which we will discuss shortly.

Terminal Response Phase

Selye described this phase as an exhaustion reaction which was related to the degree of decompensation that was evident on the part of the individual. The most significant signal the caregiver will receive will be the inability for the individual to use reality as a guide for action or choices. Their idiosyncratic defensive stratigies begin to collapse and they become prey to their unbridled anxieties. With the increased free-floating fear of loss of control, the individual's coping skills seriously deteriorate. This might be described as the point of total physical and emotional overload as the individual flounders and flails like a trapeze artist about to fall from a great height.

Four Stages of Overload

When we address the separate stages of overload we must remain aware that these stages may overlap to a significant degree so we will discuss them as only functioning in a relatively independent form.

The first stage of psychophysiological overload will be represented by a general elevation in nervousness. The caregiver will best recognize this stage by the significant change in body tension. Facial grimacing, spastic contractions of body segments, wringing of hands, agitated movement and for some, rambling speech patterns. Also there is often a breakdown in control of aggression or hostility and a general reduction in all forms of emotional control. This is often accompanied by irrational behavior that interferes with rescue efforts or the treatment program.

The second stage of the warning system can be recognized by the increased level of anxiety which is so often accompanied by significant increases in self-doubt. You will also be aware of serious reductions in motor skill responses and a considerable diminution of former highly developed performance skills. What were only inappropriate forms of behavior now become unusual or exaggerated. The individual may demonstrate extraordinary effort, take excessive risk, particularly those which make no positive contribution to the actual crisis situation. At this stage there will be those whose loss of emotional control is expressed by a serious alteration in mood. They may become depressed or have manic flights, and there will be those who respond in a cyclical manner by swinging from high to low moods.

The third maladaptive stage is evidenced by an increase in the intensity of most of the foregoing response patterns. There will be serious disruption of coping skills. This stage is fraught with special problems for rescue team members because the behaviors are often so unreasonable that the caregiver may react in kind. The victim may become extremely hypersensitive and overreact negatively, even to those with his/her best interest at heart. When the victim takes the defensive stance of suspiciousness and a refusal to place trust in the caregiver, the rescue situation can deteriorate to the point of total disintegration. When the

victim reacts to the crisis by placing blame on others or on something external to themselves, serious problems of communication arise. The last aspect of behavior that may occur in the third stage could be the most difficult for the caregiver. These are the individuals who characteristically respond to physical or emotional trauma by turning their anger, frustration or hostility inward and begin to savage themselves. We will return to this human tendency and explore it at a deeper level subsequently.

The Final Stage of Maladaptation

Rescue team members and caregivers will not need special training in order to recognize the response patterns in this devastating stage of the decompensation process. There will be a gross loss of inner emotional control and the victim's behavior becomes chaotic and often bizarre. There may be a serious breakdown in social awareness whereby the victim acts out in a way that indicates a total disregard for the needs of others. These are the individuals who lose all contact with reality and begin to respond to their own delusional frames of reference. Physical restraint or medication become essential tools for the caregivers.

Redefining Some of the Most Frequent Psychosocial Forms of Decompensation

Attempts to increase the level of awareness of the psychodynamic features that underly the various forms of human decompensation may be best achieved by showing how such responses parallel human grief reactions. The degree to which the psychological trauma is experienced as an irretrievable loss will determine to a great degree the depth of the pain, the period of time the pain will last, and the possibility of total recovery. The discussion session with experienced rescuers which preceeded my presentation illuminated the importance of remaining alert and aware of the nature of the grieving process. Such foresight may be our best weapon for keeping a healthy distance from the emotional and physical pain of the victim. Novice rescue team members and other caregivers should be trained to honor and accept totally that freedom from pain can never occur without a reintegration through the grieving process.

Response Pattern One

Depending upon the level of trauma and the consequent feelings of being violated psychologically, the first defensive reation will be shock, disbelief or some attempt to block out reality. The victim will marshal all their mental powers in an attempt to deny what has occurred. All attention may be diverted towards emotionally insulating oneself against the shocking event or crisis. This protective mechanism may best be understood as the victim's emotional shield, the barrier that will protect them from the full impact of harsh reality.

Those who have experienced such devastating grief need no reminder that we must permit each to process in their own unique experiential way all that is relevant for them wihin this grieving process. Each in their own way and in their own good time must be provided with the personal freedom to search out the meaning and try to make sense out of the loss.

Pattern Two

For many, the next step in the reintegration process will be the exaggerated use of a projected defensive reaction. In order to avoid their personal pain they will try to find something or someone upon whom they can place the blame for their terrifying loss. They may try to hide behind a variety of rationalizations in an attempt to make sense of what has occurred. These avoidance reactions may be particularly difficult to treat or deal with if we are in a crisis situation such as an actual survival or rescue scene. Here is when the rescue team leader or team members who are unable to set their own personal needs aside at such a moment may be traumatized by what seems to an ungrateful victim.

The caregiver must get their own ego out of the way and understand that this is another way that the victim can distance themselves, temporarily, from the pain of personal responsibility. For some, temporary emotional survival is best served by blaming other team members, the rope, the ice, the mountain. Each victim in their own way and in their own good time will begin to pull in the ropes of responsibility as reintegration continues.

Pattern Three

The next step in the grieving cycle, the depressive reaction, may cause the most mixed feelings in the caregiver. As the individual moves through their feelings of helplessness and despair, it is difficult for the caregiver not to get caught up in their own feelings of helplessness. The victim who continually ruminates about the hopelessness of it all or constantly questions why he/she has become the victim will test even the most experienced members of the rescue team. The team member who offers platitudinous statements for victims going through this grief reaction tend only to deepen their feeling of helplessness and therefore, their depression. To tell a victim who has just sustained a compound fracture of the left tibia that everything will be OK because you had one and look at how well you are doing, would represent the grossest form of insensitivity.

Should you have sufficient reins on your own emotions, you may best help at this moment by moving with the victim as they explore their feelings of helplessness. Even more importantly, you should respond to the possibly deeper underlying problems such as their fear of being at the mercy of the environment or of finding themselves in a totally dependent situation. The victim who has had his/her self-esteem, pride, or sense of mastery as a skilled person eroded by the trauma may be the most vulnerable to depression. Use any verbal or physical mean to start the reintegration process moving forward by appealing to these basic strengths.

Pattern Four

The final step in the process is the most difficult to write about because so many factors come into play to determine its course. Each victim will have their own capacity to confront and deal with loss or the residual effects of injury. The unique personality of each will determine much about the period of rehabilitation and the resources they have available to aid in their own recovery. Yet there are some guidelines for the caregiver which if followed could contribute positively to the reintegration process.

Point one — Tend to your own personal integration and use any of your insights to decide

how you will best function in various crisis situations. Mentally rehearse by seeing yourself in all possible situations and dealing with the varieties of victim responses in each of these situations. Should you have leadership responsibilities, include this role in your mental rehearsal.

Point two — Try to keep your own ego at a distance from those you are seeking to serve. Avoid letting the administration of your skills become the measure of your worth as a person or your self-esteem.

Point three — Remember as team member or leader that the mentally hygenic environment that you create at the crisis will contribute greatly to a positive physical and mental prognosis for the victim.

Point four — Remember that the psychotherapeutic process begins at your moment of contact with the victim. Your only therapeutic requirements are that you genuinely care and that you are totally focused upon the immediate needs of the victim.

Point five — Should the role of the mental hygienist be uncomfortable for you personally, then your only responsibility is that of selecting one who best fits such a model.

Point six — Your greatest therapeutic weapon will be the degree to which you can encourage the victim to participate in his own recovery. Whatever the victim can do physically or emotionally to participate in their own rescue should be encouraged and supported.

Point seven — Guide those rescue team members away from the victim who may tend to reinforce helplessness and despair; particularly those who will overidentify with pain, suffering or loss because of unresolved problems of their own.

Point eight — Often the best agent for beginning the reintegration process is the team member who has been through the grief experience themselves. A word of caution, however; they must have completed the process in order not to be trapped within their own former grief. As we tell young clinicians in training — compassion, empathy and identification with the victim's pain are the hallmarks of the therapeutic process, but that does not mean that you join the person in their despair.

The Nature of Severe Reaction to Catastrophic Stress

Using the St. Helen's demographic data and findings from other studies of both victims and caregivers, we can expect that between 10% and 12% will react with severe neurotic defenses. A brief description of most frequent forms of neurotic symptoms may be helpful for wilderness rescue team members.

The 218.8% increase in psychosomatic disorders for the citizens of Othello once again reflects the urgent need an individual has to displace the tension, fear, and anxiety that are the consequence of uncontrollable tragedies. What psychosomatic disorders most have in common is that the anxiety becomes translated into some bodily symptom. Why some individuals internalize their fears in this form is only partially understood. We speak of multiple causality in that constitutional, genetic and social learning all interact to produce the propensity to internalize stress in some physically symptomatic form.

Some authorities in discussing this human tendency speak of bodily system or organ vulnerability which implies that the individual is constitutionally predisposed to handle their stress and anxiety in a predetermined manner. I mention this only to improve the potential caregiver's ability to recognize the important symptoms so they may able to act with confidence in the crisis situation. The injured, disabled or frightened may channel their anxiety in such a way that they seem to mimic the entire range of possible physical disorders. You should be assured that even physicians and highly trained therapists have extreme difficulty when trying to establish whether symptoms have a physical or psychological basis. What is of greatest importance to the rescue team member is that for the victim the pain or discomfort is real. The migraine headache, intestinal distress, the lower back pain, the visual disorientation, the heart palpitations—whatever the symptom—to the victim these are physical realities.

Obsessive-compulsive disorders are usually linked together because they describe systematic ways that individuals attempt to control or avoid some painful aspect of reality. The obsessive defense is more one of thoughts and association patterns which the individual

employs to protect against those things that arouse uncontrolled anxiety. The frightened individual mentally dwells upon thoughts or associations which are of an innocuous nature in order that the threatening association cannot appear as conscious thoughts. In essence, the threatening aspect of their real world is denied a conscious representation, and therefore, the individual temporarily does not have to deal with them.

Compulsive defensive reactions are acted out in some behavioral form. The highly stressed individual may engage in ritualistic acts or movements which upon objective observation, seem meaningless or purposeless. The individual feels compelled to act out their rituals even though at some level of awareness they realize that they can in no way contribute to problem resolution. In a wilderness situation, head rocking, body swaying, incessant pacing and other idiosyncratic body movements of a repetitive nature are classic examples of how individuals protect against the intrusion of unbearable anxiety.

Phobias seem to cover the entire range of possible human behaviors. The individual's defensive reaction is best defined as an irrational fear, that is a fear reaction for which no actual stimulus can be found in reality. An excellent example for wilderness rescue teams would be agoraphobia which is one of the most frequent of the phobic reactions. These are individuals who have developed an inordinate fear of open space or the outdoors. They tend to panic in a variety of situations which cause them to feel totally alone, separated or isolated from human contact. Simply imagining themselves to be in such situations can produce levels of anxiety that border upon panic. It is rare that the fear is based upon their direct personal experience; the fear of a snake, heights, knife, water or whatever have served only to document the irrational nature of the individual's response pattern. The cause will be found to be totally unrelated to that which they have come to fear.

Conversion reactions cover a wide array of human stress responses because the anxiety is channeled into some specific body system. The wilderness caregiver may observe more of the hysterical conversion reactions. These will be the highly stressed individuals who will react with partial paralysis or specific interruptions in movement or locomotion. This may include a

loss of sensory receptivity or a total loss of motor control. There is no implication here that the worker in the field should be able to make medical or psychological descrimination but only to be aware that such behavior can also occur in the wilderness.

Dissociative disorders which should be best understood for the wilderness caregiver are fugue states and amnesic reactions. The fugue state can be distinguished by the total nature of the amnesic reaction and the extended period of time before recovery. The victim represses their total identity and may live out a new identity for months or years. Amnesia is more selective and has a much shorter duration. In a sense it is selective forgetting whereby the stressed individual represses those aspects of reality that are too painful to confront. Amnesia would be more frequent a defense in a wilderness crisis situation. You will function best as a mental hygienist if you recognize that selective forgetting will be necessary should the magnitude of the trauma be such that it could totally shatter the person's integration.

The final defensive reaction covers a wide range of human responses and bears the label "anxiety neuroses." The only one we shall discuss here will be "free floating anxiety" because it is the most frequent reaction that I have experienced in athletic or recreational areas. You will have little difficulty recognizing this reaction because the individual will manifest almost every physical sign of a person in serious physical distress. Irregular breathing, hyperventilation, agitated movements, restlessness, inattentiveness, cardiovascular distress and almost any other physiological response that may be associated with terror. As you come to the aid of persons under such enormous stress you find that they are rarely able to relate their panic to real causes or situations. What you will find with patient exploration is that the trauma, whatever it's nature, has played upon old or latent fears. The trauma has opened doors to something of an extremely painful nature that occurred in the past.

Your best weapon until the victim is transported to where professional help is available will be your skill in reassuring the victim. The more you can encourage the victim to take some control in the situation, the sooner they will be able to process what is happening in the present.

Qualities of the Team Leader

The absence of empirical data describing the qualities of a wilderness rescue team leader forces me to draw off of my research into the personality of high achieving men and women. In early years I studied the personality of successful, professional university and high school coaches (Ogilvie, 1968, Ogilvie & Tutko, 1968). I have been unable to find published studies investigating the personality structure of wilderness leaders or rescue crew leaders. James A. Wilkerson, M.D., in his text *Medicine for Mountaineering*, addresses the issue of selection of rescuers and speaks from his experience with respect to physical fitness, technical skill and personality. Restating his recommendations of the attributes which best describe the personality of the selected leader overlaps greatly with my own early findings.

Wilkerson places impulse control at the very top of his list for persons in high risk activities, combined with a high level of emotional integration. He next recommended initiative which once again describes the successful coach—these individuals measure extremely high in autonomy, independence, and took a hard-nosed view of reality. Wilkerson valued attention to details of procedures and equipment in his ideal leader, which is consistent with the personality structure of my samples who ranked highly for orderliness, organization and planning ahead. His valuing a sense of humor fits perfectly with my intuition about the ideal wilderness leader but I have no data to support this attribute in my coaches. The only thing we really know about sense of humor is that it correlates highly with intelligence.

Some of the other personality trends provide an extension of our discussion as to a leadership ideal. My coaching personality samples were deficient in a number of qualities which my clinical background suggests to be extremely important. These samples included extremely driven success oriented individuals who sought recognition through achievement. They tended to be strongly authoritarian and not particularly affiliative. They rated low in terms of an inclination to play a nurturing role in the lives of others; there tended to be a disproportionate number of "Chiefs" and very few "Indians." They were optimistic and had a positive view of their capacity to take the hand that was dealt them. But for the attribute that

Wilkerson included in his ideal, "empathic," the foregoing personality picture suggests a low presence.

Until such time as we can gather hard data on members of rescue teams, I would like to speculate about the personality structure that reflects my present understanding of the role you must play as a rescue team leader. Almost every attribute where coaches measured low would be advantageous in the personality of wilderness caregivers. I would prefer to see the caregiver's personality strengths blended with those attributes that we use to describe those who gravitate into the helping arts. I am not implying that those in leadership roles who lack a mixture of these skills could not function adequately, but my interest would be that of insuring that nurturant, compassionate and introspective individuals be a part of the team.

My final requirements may seem superfluous; no order in terms of importance is implied. First—experience, experience, experience—no substitute here. Be decisive and make tough decisions. Integrate information and views of team members; be a good listener. Be willing to delegate responsibility, and be capable of honoring that delegation unless team members prove otherwise. Possess a high threshold for tolerating criticism by others, yet have the capacity to function as a leader without the need for deceit. Finally, carry no ego problems and be able to lose or bury personal needs while acting in the leadership role—that rare capacity for "selflessness" which we can only attain for such brief periods in our lives.

Recognizing the Process of Reintegration

Here are the steps the caregiver can recognize indicating the trauma victim has begun the road to recovery:

Step 1. The victim begins to re-examine the role they actually played and how their behavior might have contributed to the crisis situation.

Step 2. Increasingly becomes self reflective and begins to distribute responsibility based upon more objective criteria.

Step 3. Becomes increasingly more responsive and engages in realistic assessment of objective data.

Step 4. Becomes increasingly more open to the various options that will permit best solutions to occur.

Step 5. The individuals external behavior begins to express that increased reason now prevails and learning is continuing.

Step 6. The individual makes a recommitment to some form of healthy recreation though former levels of attainment may not be possible.

Step 7. The victim is now able to converse about pain; fright, loss and all other aspects of the crisis and use whatever insights are gained to continue the process of growth.

The Role of the Caregiver

I would recommend that time be devoted to actual rehearsals of the broadest range of actual rescue situations. It is important for each team member to reinact each of the roles as they would occur in the wilderness. Each member should be provided with the opportunity to feel and experience the reality of the victim in as many circumstances as is humanly possible. It would be advisable for each member to lead the group discussion where the entire rescue mission is reprocessed. Every team member should be afforded the opportunity to explore all their conscious feelings which might be associated with real trauma in the rescue scene. They should be offered the chance to explore their vulnerabilites and how they might lessen their effectiveness in the crisis situations. During these training sessions, those with natural clinical skills should be identified and possibly offered special training; it would be a significant contribution in quality care. Every recovery team should be followed with planned meetings so that they can continue to reprocess any emotional residue that is the consequence of traumatic rescue experience.

I hope it is clear by now, that along with education in rescue planning and medical aid for wilderness rescue leaders, it is essential to extend insight into stress reactions, human overload, and idiosyncratic response patterns of those who crack under traumatic strain.

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Corporate Source: The National Outdoor Leadership School (NOLS)

Publication Date: 1986

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