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# U.S. NAVY SPECIAL PSYCHIATRIC RAPID INTERVENTION TEAM (SPRINT)

B. G. MC CAUGHEY

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U.S. Navy Special Psychiatric Rapid  
Intervention Team (SPRINT)

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SUMMARY

Problem:

Catastrophic events cause immediate and long-term psychological distress. Examples of these problems were exhibited by military personnel involved in two peacetime disasters: the collision between the USS Kennedy and USS Belknap and the sinking of the USCGC Cuyahoga.

Objective:

A group of mental health professionals called the Special Psychiatric Rapid Intervention Team (SPRINT) has attempted to aid military disaster victims by using the principles of combat psychiatry. The objective of this paper is to describe their approach to treating disaster victims and relate some observations made during their deployments.

Approach:

Information for this paper came from the author's own observations, interviews with personnel who deployed on SPRINT interventions, and those involved in the formation of the original team.

Results:

SPRINT used the principles of combat psychiatry as the basis of the intervention. They include brevity, immediacy, centrality, expectancy, proximity, and simplicity. Functionally their deployments were divided into six parts: preparation, pre-deployment, deployment, planning with the command, treatment and memorial services, and debriefing.

Conclusions:

The response to SPRINTS' services by many of the survivors, their families, and those in the chain of command have been very enthusiastic. However, scientific studies are needed to document its long-term effectiveness.



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U.S. Navy Special Psychiatric Rapid  
Intervention Team (SPRINT)

Introduction

Victims involved in events such as the Buffalo Creek disaster, the collapse of the Hyatt Regency Hotel Skywalks, and various other kinds of traumatic events often have immediate and long-term psychological distress (1-3). Likewise, military personnel exposed to traumas on the battlefield (4-5) as well as a variety of catastrophic situations during peacetime also manifest psychological distress. Ship collisions, aircraft accidents, fires, and explosions occur regularly and pose the question of how best to treat these victims. For instance, on November 22, 1975, the USS Belknap and USS Kennedy collided, resulting in loss of life and severe physical damage to the Belknap. Subsequently, the USS Belknap was towed to the Philadelphia Naval Shipyard with part of its crew accompanying the ship. Many of the crewmen appeared in the outpatient psychiatry clinic of the Philadelphia Naval Hospital complaining of various psychological symptoms, such as depression, sleeplessness, poor concentration, and intrusive thoughts about the accident. At that time it appeared to the psychiatry staff that the symptoms often persisted in spite of using the best treatment techniques available at the time. This was observed again when the Psychiatry Department was transferred to the Portsmouth Naval Hospital, Virginia, near Belknap's homeport, where even more crewmen were found to be in distress (6-7). Another accident involving sailors and Marines stationed on the USS Guam and USS Trenton in Barcelona Harbor on January 17, 1977, again raised questions about treatment techniques for peacetime military disaster victims. The central problem seemed to be that the disasters caused long-term emotional problems which resulted in an increased incidence of medical boards, early discharges, psychiatric hospitalizations, poor work performance, marital discord, etc., and that these victims' symptoms and problems were not responsive to the psychiatric treatment techniques available. Clearly, improved methods were needed to help victims involved in future disasters.

Concept of SPRINT

In January 1977 staff at the Portsmouth Naval Hospital Psychiatry Department observed that the kinds of psychological problems generated by military-related disasters were similar to those encountered by the battlefield soldier and that a method had been developed to deal only with combat-related trauma. In 1954 Glass (8) had suggested a treatment method specifically for soldiers in a combat zone. He advocated using the principles of immediacy, expectancy, and proximity as a means of rapidly treating and returning soldiers to duty. Immediacy indicated that treatment should commence as soon after the trauma occurred as possible; expectancy that the treatment staff would convey an attitude that the victim had a temporary condition which was expected to improve; and proximity that the location of the treatment was as close to the victim's unit as possible and not far removed from the battle line. Additionally, three other principles, brevity, centrality, and simplicity have been suggested (9). Brevity means that initial treatment should last for a short period of time (perhaps only three days); centrality that combat fatigue victims should be treated in one location and away from a medical or other facility that would promote the identification of the victims as patients; and simplicity that the treatment plan not

involve extensive analysis but rather be supportive and strengthen healthy defenses. All six principles form the acronym BICEPS (9). Since the catastrophic nature and psychological problems resulting from combat zone trauma were similar to those encountered by disaster victims, it was hypothesized that using the same early and aggressive treatment intervention techniques (BICEPS) for disaster victims would result in lower morbidity. Accordingly, a team of mental health professionals trained in the use of these techniques called the Special Psychiatric Rapid Intervention Team (SPRINT) was established. The following information about SPRINT came from observations made at the Portsmouth Naval Hospital while it was formed and from interviews of SPRINT members and others involved in its formation and operation.

The first deployment was for USCGC Cuyahoga survivors in October 1978 (10). Since the Cuyahoga there have been a total of 13 deployments involving the following kinds of incidents: 3 ship collisions and sinkings, 5 aircraft accidents, 2 terroristic incidents, 3 suicides, and 1 incident involving body recovery. SPRINT has provided service once to the Marines, twice to the Navy, and 11 times to the Coast Guard. All catastrophies involved deaths, ranging from 1 to 241. The majority of the deployments were to one intervention site (n=10) although four were multi-sited. The length of the intervention has ranged from 5 to 46 days.

#### SPRINT Staff

In February 1983 SPRINT became part of the Navy's Mobile Medical Augmentation Readiness Team (MMART). SPRINT teams are now located at three Naval Hospitals and each are staffed by two psychiatrists, a psychologist, chaplain, psychiatric nurse, and four corpsmen. At times females have been a part of the team; however, plans now call for it to be staffed solely by males. It was desirable to pick experienced care providers who also had operational experience (e.g. duty aboard ship, with aircraft units, etc.). Having members with diverse training, occupation, age, and background facilitated rapid identification with the team by the victims. The role of each of the members was as follows. Of the two psychiatrists, one was the team leader, and both were capable of prescribing medication. The psychologist and the psychiatric nurse were involved in group therapy, as were all team members to varying degrees. The chaplain, serving in a traditional role, dealt extensively with bereavement. The corpsmen's presence represented an attempt to enable enlisted personnel to relate to the team in a non-threatening manner. The concept for the team's utilization was immediate deployability to any location(s). Implied was the need for adaptability to a variety of situations and demands. The goals were to lessen the adverse psychological consequences resulting from a catastrophe and enhance the recovery rate of the affected military unit.

#### Functional Aspects of SPRINT

Based on the observations and interviews mentioned above SPRINT functioning was divided into six parts: preparation, pre-deployment, deployment, planning with the command, treatment, and debriefing. Each phase is briefly described below.

Preparation Phase: This was basically a training period and used to develop a sense of group identity, designate roles, discuss anticipated problems (e.g., staff burnout and sleep deprivation) and their solutions, and deal with various administrative requirements (uniforms, immuniza-

tions, recall system, and patient record keeping system). Regular training sessions provided information on post-traumatic stress disorder (11), combat psychiatry, bereavement, stress responses, and suicide. Handouts on SPRINT, bereavement, and stress reactions were assembled. Meetings with non-deploying hospital staff on such topics as patient coverage and feelings about SPRINT's notoriety and public attention were best addressed at this time.

Pre-deployment Phase: During the pre-deployment phase, which started immediately following notification that a catastrophe had occurred, the leader worked with others to help decide whether or not to deploy. Although it was impossible to obtain complete information about any catastrophe, it was nonetheless desirable to know as much as possible about it to ensure that SPRINT was needed, and if it was, to begin planning the intervention. The decision as to whether or not to deploy was made rapidly because of the principle of immediacy. The following information typically was obtained: 1. description of the catastrophe (including intensity, duration, and location); 2. whether or not it was mission-related; 3. type (aviation, ship collision, etc.); 4. cause (act of God, man-made purposeful (war, terrorism), man-made non-purposeful (misjudgements such as pilot error)); and 5. amount of physical damage to ship, aircraft, etc., and prospects for its eventual recovery or repair. Information on the categories and numbers of people involved included: 1. survivors (whether or not their lives were threatened, they witnessed death, recovered bodies, stayed with the main group of victims, or were injured), 2. missing (whether or not efforts were being made to find them and what were the expectations for their eventual return); 3. dead (relationships to survivors, whether or not the bodies had been or were expected to be recovered and their condition), 4. family members (of deceased, survivors, or persons not directly involved); 5. rescuers (differentiating those that recovered bodies from those that did not; conditions under which they worked); and 6. others at the command not directly involved.

Deployment Phase: While en route to the scene of the catastrophe much was accomplished. Realizing that each catastrophe was unique, the team used this time to prepare a plan for the current one. Establishing a plan with explicit goals and methods was considered critical to success. In most cases to date SPRINT was asked to lend assistance and was welcomed, but this was not universally so. The personnel affected by the tragedy were often in great distress, confused, guarded, and trying to restructure their lives and did not want to deal with strangers. In some cases they were suspicious of SPRINT's motivations, or thought the team's presence indicated that they were incapable of helping themselves. Other misconceptions were that SPRINT was there to: dispense tranquilizers, tell people how to feel, investigate the tragedy to determine blame, discharge personnel, or work as an agent of the command.

Planning with the Command: Upon arriving at the scene, the team leader and others met with the commanding officer and other senior military personnel. Good liaison was of great importance since command approval allowed others to participate. Explaining the team's purposes, goals, and methods, distinguishing themselves from investigators, requesting confidentiality, and providing for support (telephone, billeting, transportation) were important issues for the initial meeting. Key personnel at the command such as department heads, and others if they were assigned to the unit such as medical personnel, chaplain, or social worker, were given the same information and

their support was requested. Personnel at high risk, such as survivors, those who recovered bodies or traded duty with one of the deceased, or family members of the deceased were identified at these meetings. SPRINT attempted to coordinate and facilitate the use of support groups already in place but not to supplant them. The presence of these groups varied considerably but usually included wives' clubs, local mental health and medical facilities, religious organizations, and casualty care assistance officers. Various means were used to communicate to the community the identity of SPRINT members and its mission. This included articles in the plan of the day and local newspapers or having announcements on television stations.

Treatment and Memorial Service: SPRINT's therapeutic goals were to deal with the immediate crisis and arrange for follow-up where necessary. A variety of techniques were used. Lectures describing what they might expect to experience were given to groups of varying sizes and composition. This teaching approach included such topics as what symptoms and feelings often occur following a tragedy and what would promote (e.g., expression of feelings) or retard (e.g., taking drugs or alcohol or suppressing feelings) resolution. In these deployments group therapy was used extensively; much more frequently than individual therapy. It was very desirable to meet with naturally occurring groups and do it in their natural environment. Examples of these groups are survivors, aircrews, personnel in various maintenance shops, and families. SPRINT members found that actively seeking these meetings was preferable to waiting for people to come to them. This was especially true of high-risk personnel including wives of the deceased, and survivors. While the number of meetings with each group varied from deployment to deployment, three or four times with each group was common. A group that was often unsuspected by themselves of needing help were the commanding and executive officers who by virtue of their positions as leaders might have been viewed as "strong" and unlikely to be affected by the tragedy. They often felt overwhelmed and unable to have support for their emotional needs. The phase involving therapy generally lasted less than two weeks and in several cases involved a memorial service at the end of the intervention. The memorial service symbolically acknowledged past and future shared risks and, in many cases, resolution of the tragedy.

Debriefing: Debriefings with senior officers occurred at the end of the deployment. The goals for these meetings were to critique the intervention and arrange for follow-up psychological care. These debriefings often closely followed a memorial service. At this time SPRINT often perceived that they were no longer needed, which was seen as an indication that resolution was progressing favorably. Upon returning to the hospital SPRINT members met amongst themselves to critique the intervention and suggest improved response techniques.

#### Observations

To date, SPRINT interventions have involved different team leaders working in a variety of extremely different situations, making it difficult to generalize their experiences. The outline presented above was based on what took place during many of the deployments. The following were recurring observations. It was very important to start the intervention as soon as possible because there seemed to be a period of receptivity lasting about 24 to 72 hours after the beginning of the tragedy. Arrival within 12 hours and before bodies were recovered was considered ideal.

Following a tragedy, anger was commonly expressed and realistic or not, it was directed at all causes, including lack of training, inanimate objects (a civilian ship in one case), adverse weather, and personnel up and down the chain of command. Another observation was that the loss of the survivors' ship had a special meaning. In two instances where the ship sank, the crew was observed to be affected by the loss of not only shipmates but their places of work, personal belongings, and abode. Their identity, in part fostered over time by the powerful trappings of military life, were dramatically and traumatically gone. Salvaging part of the ship as a memorial was found to benefit the survivors.

SPRINT members spent considerable time dealing with survivor guilt, bereavement, and issues about death. As would be expected, survivor guilt also occurred among those who traded duty with one of the deceased or those who had made the watch list or duty rotation. A similar problem occurred among some of the wives. These wives felt guilty that their husbands had survived and were concerned about how to deal with the wives of the deceased. This was of considerable consequence since military families typically lived in a close community setting and were used for frequent social contacts. Another observation was the persistent denial by a spouse of her husband's death when the body was not recovered or recognizable. This denial of death occurred several times in spite of convincing evidence that the serviceman had not survived. All of these death-related issues forced many of the people involved in the tragedy to see their own vulnerability to death. A question commonly asked by service members was whether or not they should continue on active duty.

It was apparent that one of the most helpful functions of SPRINT was promoting accurate communication. In the midst of these crises it was observed that speculation, misunderstanding, and rumors tended to make a situation already filled with distress much worse. In one of the deployments it was not clear whether a murder or suicide had taken place, and in others the causes of the ship collisions or aircraft accidents were not understood. Disseminating accurate information about the cause(s) of the tragedy was often one of the beginning steps for resolution.

#### Conclusions

The response to SPRINT's services by many of the survivors, their families, and those in the chain of command have been very enthusiastic. However, scientific studies are needed. Follow-up evaluations using questionnaires, and interviews and epidemiologic studies using health and service record data, would provide answers about SPRINT's long-term effectiveness. Detailed information about the psychological and physical events that affect survivors and their friends and families during and following the accident would provide more information that could be used to plan more effective interventions. Debriefings on the perceived efficacy and possible technical refinements of SPRINT, which would include representatives of the command affected and officials in the chain of command would also provide valuable information.

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→ The author interviewed personnel who have deployed on SPRINT interventions, those involved in formation of the original team and included his own observations made as it was conceived. SPRINT uses the principles of combat psychiatry. They include brevity, immediacy, centrality, expectancy, proximity and simplicity. Functionally their deployments can be divided into six parts: preparation, pre-deployment, deployment, planning with the command, treatment, memorial services and debriefing. The response to SPRINTS services by many of the survivors, their families and those in the chain of command have been very enthusiastic. However, scientific studies are needed to document its long-term effectiveness.

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