Reaching Out of the Abyss: A Reflection on an Animal-Assisted Crisis Response Deployment

Batya G. Jaffe

Abstract: In the wake of crises and disasters, Animal-Assisted Crisis Response (AACR) is an innovative intervention that provides comfort and support to survivors and bystanders. This article recounts the palpable and gratifying contributions of AACR in the aftermath of a tragedy, and a crisis scene in a city in Israel demonstrates the support that can be provided through this AACR handler and her dog.

***Keywords*:** Animal-Assisted Crisis Response, animal-assisted interventions, human-animal relations, trauma

The following recollection shares how a normal day looks for an Animal-Assisted Crisis Responder while responding to abnormal circumstances, treating in an abnormal scene, with abnormal pain. Details of the event have been omitted and/or adjusted in order to protect the privacy of those involved.

It's 8:30 p.m. I just finished putting my four amazing and mischievous girls to sleep. Separated in two rooms, I had to conquer them while they were trying to conquer me. There is nothing like looking at them while they are finally sleeping calmly. I head over to my room, exhausted, and look at my phone. There is a new dispatch from the Psychotrauma Unit. I volunteer in the Psychotrauma Unit of United Hatzalah, a non-profit organization in Israel that is motivated by saving lives during crises, similar to the Red Cross. *Psychotrauma* arises as an outcome of traumatic events that may involve witnessing severe injuries to themselves or others and presents a threat to physical or psychological integrity (Vitzthum et al., 2009). The Psychotrauma Unit provides Psychological First Aid (PFA) to those at the scene of a crisis (United Hatzalah, n.d.). PFA is an initial disaster response intervention provided by mental health professionals and first responders (Jacobs & Meyer, 2006). Its goal is to promote safety and stability to disaster survivors, as well as to connect the affected individuals with help from the community and to provide them with resources in the aftermath of a disaster (Ruzek et al., 2007).

Inside of the Psychotrauma Unit, I belong to a specialized division: the Animal-Assisted Crisis Response (AACR) Unit. It is composed of trained human-animal teams that provide support and comfort to individuals affected by crises and disasters (Eaton-Stull & Flynn, 2015). In the U.S., this intervention can be seen through HOPE AACR (https://www.hopeaacr.org). HOPE is a non-profit organization dedicated to giving comfort and emotional support in crises through specially trained dogs and their handlers (HOPE AACR, n.d.). I respond to crisis calls with Lucy, my wonderful canine partner. Lucy is a Cavalier King Charles Spaniel, and she is a certified therapy dog with extensive training, experience, and certifications in crisis response across Israel and the U.S. My professional experience comes from background in animal-assisted therapy, an MSW and PhD in social work focused on AACR in Israel, and ten years of volunteering in the Psychotrauma Unit of United Hatzalah with Lucy.

I look back at my phone—the alert message I have received is describing a situation in which a young mother has passed away, and it clarifies that not all the family members have arrived yet. The Psychotrauma Unit wants an AACR response team on-scene to provide mental health support for the family and neighbors. Even though I imagined that the day was over and that I was on my way to bed to watch a Netflix movie, I gather my strength and decide to deploy. I grab my gear, my United Hatzalah vest, and Lucy's matching vest as well. Lucy sees the vest and enthusiastically jumps over to the door. She loves her work, as I do. It is our mutual passion.

I report the dispatch to the United Hatzalah Hotline, and I drive to the scene of the crisis. It's always hard to drive to a scene, but as a young mother myself, my thoughts are on the young mother that just passed away. I pass the streets that I know so well, and everything seems so calm outside, like the atmosphere of a regular evening, but I know that at the end of the road, things are not so simple and calm anymore. A crisis is unfolding, and I am on my way to it.

It is difficult to get close to the scene by car. The whole street is full of first responders, including ambulances and lots of police cars. The scene is full of blue and red lights and radio chatter. So, I park my gray Renault a block away, and we start walking. I get a cold breeze that reaches into my spine, and Lucy shakes, nervous and excited at the same time. I see tons of people in the street, the different vest colors of first responders, neighbors, and other curious folk eyeing the scene inquisitively. It is night, and uncomfortably cold out, and the many vehicles' lights render the scene even more unpleasant, along with the crowds gathered in different circles.

The whole scene is happening in the context of the COVID-19 crisis disrupting society at full force, and everyone is concerned with the possibility of infection. First responders especially fear that exposure to the virus may put their lives at risk (McAlearney et al., 2022). Nevertheless, people are outside wandering around on a cold and dark evening, supplementing the atmosphere with a feeling of confusion and unsettledness.

Protocol states that when arriving at a scene, the first thing to do is to check in with the Psychotrauma responders that are already there. As they have the information, they can debrief and explain to me where I am most needed (Vernberg, et al., 2008). This time, I don't get a chance to do that. Instead, I hear someone yelling, "Psychotrauma Unit needed here! Please!"

I approach the distressed individual with Lucy. They explain that the teenage brother of the young mother who passed is being questioned by a police officer. They say the brother was the only one with her when she passed, and he had unsuccessfully tried to resuscitate her with CPR. This is the moment when the adrenaline kicks in, all the senses are sharpened, and Lucy and I start working. I am on my way to the brother, but someone else calls to me: "We need your help here!"

I am feeling increasingly tense and overwhelmed. I feel confused— things are not clear. I am unsure who is in more urgent need of help. Making a call in the moment, I continue heading in

the direction of the teenage brother. I see the brother in front of a police officer, both in the middle of the street, sitting in folding chairs. I believe I understand what is happening and where I am needed. Lucy initially agrees to go in that direction, but she senses something different and walks to the police officer questioning the brother instead. "So, tell me. How come you were alone with your sister when it all happened?" she asks as Lucy approaches.

I do not want to interfere with the police officer's job, so I try to redirect Lucy to the brother. The brother, however, shows no interest, unlike the police officer, who reaches out to pet Lucy. Lucy goes in between the officer's legs. The officer starts crying, hugs Lucy, and says, "I need her here with me for this." Right now, the officer is the one in need of support. She is performing a terribly harsh task, and she is looking for the strength to do so. By briefly distracting the officer amid heavy stress that threatens her working capacity, Lucy does more than give simple comfort: She provides a break in the tension, an opportunity to express grief, and, ultimately, the power the officer needs to continue doing her job (Smith-Forbes et al., 2014).

"I was the one in charge of my sister while my parents were running some errands," the brother says. "Her husband is a firefighter, and he was at work." I can see that he feels guilty, but he doesn't want to be reached out to, not yet. On the other hand, the police officer resumes the questioning while holding Lucy in her arms: "Okay, so then what happened? Did your sister call you and say she had a problem?" The questioning continues, and we stay there to provide support to the police officer.

Just as Lucy and I finish our discussion with the police officer, the chief of police approaches me. "Thank you for being here," he says. I gain a sense of satisfaction from the knowledge that people are using my help, and it is easy to see Lucy's interest in helping too. We have a purpose here, and we have work to do. We have seen that after years of working in the Psychotrauma Unit, slowly but surely the various first responders at crisis scenes have started to understand our role and have learned to use our services for their benefit (Chandler, 2008). We are a resource at a trauma scene, available for whoever needs us.

"I need you to please approach the husband of the young mother. I need to understand his state of mind, how he is feeling, and if we can step in for questioning to get background on the case," the chief explains to me.

I turn to approach the husband, and again I am asked to go elsewhere and help someone else: "I need your help here, please!" I feel as though it is a multiple casualty event. In the wake of crises and disasters, a regular day can become disrupted by numerous causalities of different levels that require immediate attention. The chaos impedes logical thoughts and challenges decision-making skills. Training and preparation for these kinds of events is essential to provide an effective response (Baker, 2007). I have not even had the opportunity to reach the Psychotrauma team leader to tell him I am present at the scene, so I message him quickly before continuing with my work. Again, Lucy and I provide assistance. We decide to approach the husband first.

The husband is sitting next to his parents and his own brother in a half-circle. They are sitting also on folding chairs next to the street, on the sidewalk. Nothing seems in place. Imagine a family just sitting together in a half-circle on a sidewalk. It's the beginning of the winter, and the scene is outdoors, and it's cold, and windy, and it's late in the evening, and it's dark. But the darkness we are concerned with is to be found indoors.

His brother bursts into uncontrollable sobbing: "I just can't believe this is happening!" he cries, and the whole family starts crying again.

His mother is overwhelmed, repeating over and over again, "I can't think, I can't think!"

The husband looks at me, with red puffy eyes, and asks, "What am I supposed to do now with a four-month-old baby?" His whole world has just collapsed; he feels destroyed, beaten up by life. As is common in crises, he repeatedly makes remarks that alternate between a sense of helplessness and of guilt (Farchi et al., 2018), guilt that he wasn't there, next to her, when his wife left this world.

I zoom out for a second and try to examine the scene as if I am not part of it. I realize there is not a dry eye on the whole street. Even the police officers are crying. Everyone is crying—some loudly, some silently, and some, like me, are happy they can hide their tears behind their masks (Gispen & Wu, 2018).

Finally, I get the opportunity to approach my team. We gather outside the house, the core of the scene, and find some privacy in the garden at its side. The team leader explains that the young woman had been treated in the hospital for an inexplicable stomachache. After she took a few trips to the hospital, her doctors decided to perform surgery. However, the surgery didn't ease her pain. This evening, while her husband was at his long shift at the fire department and her parents ran some errands, she collapsed. Her teenage brother tried his best to save her, but it was too late. That four-month-old baby girl would never see her mother again.

Now, here at the crisis scene, the Psychotrauma team leader is asked to go help the grandmother, the mother of the young woman who passed. She is inside the house, but one can hear the yelling and sobbing even from the outside and into the streets. This woman is in hysterics, and the team leader does a formidable job attending to her needs. After finding her a support friend, he leaves her in good hands. It is part of our work as PFA workers to connect the survivors of the trauma to the community resources that are available to them (Shultz & Forbes, 2014).

Patients receiving negative news from physicians have been shown to have the best emotional outcomes when family is involved in the process (Monden et al., 2017). As such, our team leader must next accompany a family member to the house just at the end of the street for another impossible task: breaking this heart-wrenching news to the ailing maternal great-grandmother. The team leader grabs his gear and goes. The list of people needing emotional support seems endless. And it keeps growing and growing.

At this point, my attention returns to the younger brother who had attempted to resuscitate the young mother. He seemed too relaxed earlier, so I decide to find a different way to "reach" him. I find another Psychotrauma responder and, together with Lucy, we return to find the brother. He is now sitting in the back of the family's white SUV, inside the trunk with the door open, unable to confront what is happening. He won't stop saying he is fine. He doesn't even connect with Lucy. I feel frustrated, but fortunately my co-responder has this wonderful ability to say what someone needs to hear when there is nothing left to say. He consoles the brother himself, then uses a tenet of the PFA protocol to provide the support he most needs: By reuniting him with his waiting friends, he restores the brother's connection to his community. It seems for a moment that there is a drop of light in this dark scene.

The police officers are not only in charge of a job at the scene, but they are also eyewitnesses to the trauma involved in the scene. They, too, are apt for the Psychotrauma Unit intervention. They are visibly broken by the difficulty of the situation, yet they are able to demonstrate an immense amount of sensitivity and empathy towards the family. They do their job without compromising the family's mental health. The neighbors are outside on the street to lend the family support, bringing hot tea, providing hugs, and comforting them with blankets. Everyone is hurting.

In a moment of clarity, the husband realizes he has not checked on the baby. He cannot see her yet but needs to know that she is being cared for. We quickly learn she is with a neighbor. The husband's mother, broken-hearted, says she cannot find the strength to take the baby now. The PFA provides eight different core actions that constitute the basic objectives of immediate assistance in the aftermath of a crisis. As part of these core actions, we offer practical immediate assistance and stabilization (National Child Traumatic Stress Network & National Center for PTSD, 2006). As such, I offer to go to the neighbor's home and check on the baby for the family.

We work as a team: My co-Psychotrauma responder stays with the husband while I go to check on the baby. This doesn't fix what happened, but it comforts the husband to know his baby girl is well. Now he can mourn and not worry about the wellness of his daughter at this delicate time. I find the baby with the neighbors. She is being loved and fed, and she even had her diaper changed. What a world. Everything is so crooked. And yet, there are sparks. Sparks of goodness and love are visible along the street. Neighbors and friends are reassuring the family that they will be there along the way, for the husband, and for the baby that will grow up without her mother.

We leave the family after we connect each mourner to a friend or family member that can care for them. The brother of the husband is no longer sobbing inconsolably. The mother of the young deceased is not in hysteria anymore, but quietly sitting in their living room, yet still not wanting visits. The mother of the husband has agreed to care for the baby and put her to sleep. The husband is still heartbroken, but he has a "village" caring for him, hugging him, both physically and in spirit.

Lucy and I now approach the police officers who remained at the scene long after they had finished their duties. They are sitting in their police car, but they are not ready to go. They seem shocked. Their windows are open, they don't have seat belts on, they seem stuck, trying to process the scene. They felt part of the scene, and now they are hurting just as everyone else is.

"It's part of the job," one police officer explains to another. "I would love to tell you that you are not going to cry or experience harsh stories, but you will. I have been in this job for 25 years and only because of stories like this I need to retire. It costs too much of my well-being."

Talking to them, I realize how traumatized they are. This incident has been a turmoil of feelings and watching a family fall apart is not easy. Imagine how it might be for the police officers to interrogate the family members. I speak with each officer. One expresses her concerns to me:

"I am new in the job," she says. "This is only my first call. I can't believe this is so tough. How am I supposed to deal with this and go back home like nothing happened?"

Another police officer, the one I heard talking when I approached, expresses her feelings as well: "We have support groups, and we have [police mental health resources] to turn to, but only the ones that were at the scene really understand how hard it is. I have had enough of seeing this suffering."

The officers cry, hug, and then cry some more. They are mad, they are sad, they are hurt. I speak to them about psychoeducation (Whitworth, 2016), I explain how it is normal to feel this way in such an abnormal situation (McManus, 2005). I explain what the next few days might look like for them, and the importance of talking about it. I also provide them with some tips that can help them recover and keep going. For tonight, our work is done.

When I get back to the car, I realize how cold I am. At the scene, my own needs had not even crossed my mind. But now, my fingers are numb from the cold, my toes are as well, and I am in urgent need of a bathroom. In my old car, I find myself again—my body and my feelings. My mind and heart had been displaced somewhere else, outside, caring for the others. I had the privilege of working next to the marvelous team of the Psychotrauma Unit that was there with me. Lucy, my dearest partner, showed her immense ability to give love to those who need her, to give hugs without having hands. Together, we were able to provide support to the family, the friends, the neighbors, and the police officers.

Lucy inspires me. Lucy doesn't see external identities; she doesn't make assumptions; she is just looking for whom to help. She will not judge someone by their age, gender, or economic status. She will not check if a person wears a uniform and then assume that person is immune to trauma. Lucy feels trauma and helps treat it. Lucy only wants to help. Lucy teaches me and others not to assume but to support, without judgment, just with love.

Going back to real life after experiencing such a scene requires us finding time to recover and practice some self-care strategies (Lee & Miller, 2018). Downing et al. (2021) recognizes the

increasing relevance of self-care among social workers and other frontliner responders, especially with the added stressors of COVID-19. Without self-care strategies, one can easily develop negative consequences and indirect trauma, such as compassion fatigue, which may develop itself at the cost of caring for others and their pain (Cocker & Joss, 2016), vicarious trauma, which is also an occupational challenge by the continuous exposure to victims of trauma (Jenkins & Baird, 2022), and secondary traumatization, which arises from the knowledge of traumatizing events experienced by our peers (Bride et al., 2004). Self-care not only safeguards us against compassion fatigue, vicarious trauma, and secondary traumatization but also enables us to keep going so we are healthy and strong enough for the next call. According to Burnett and Sherman (2023), it is crucial to actively participate in meaningful self-care practices for the enhancement of personal and team resilience and well-being. Important self-care strategy for crisis responders can be mental, physical, and relationship focused (Bozym, 2023). Furthermore, a key self-care approach to mitigate the adverse impacts of compassion fatigue and vicarious traumatization involves dedicating time to enhance one's resilience capacity (Burnett & Sherman, 2023).

Sitting in the car, I give Lucy a few of her favorite treats and then she dozes into a deep sleep. I need to process a bit before I drive home. I don't like bringing all these feelings into my sanctuary. I stay in the car for a while and write about the dispatch. Writing helps me put my thoughts in order, understand them better, and release the emotional pain (Bressi & Vaden, 2017). Moreover, I like sharing my writing with my partners in the Psychotrauma Unit. They are my support system; they understand what I have been through and know to direct me better for the next crisis. But this is only the first step of my mental health self-care process. Caring for ourselves provides us with the ability to care for others in the future.

While this is only a single case for some crisis responders, it is the life and the tragedy of a whole community, and its consequences are multidimensional. While crisis responders treat at the scene, they need ongoing support from their organizations and their peers in order to continue their work. More research is needed regarding what would be considered helpful support for crisis responders. According to Marcus and Stergiopoulos (2022), police, co-responders, and non-police models urgently need cross-sectional studies that inform, develop, and test effective models of crisis response support. Moreover, specific research investigating animal-assisted crisis responders and their most essential support circles is crucial. Finally, the imperative self-care for the canine partners and their welfare is a fundamental value of this wholesome approach to crisis response and not only its survival but its success and flourishment (Jaffe, 2023).

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***About the Author*:** Batya G. Jaffe, PhD, MSW, AAT is Adjunct Professor, Wurzweiler School of Social Work, Yeshiva University, New York, NY, and Associate Investigator, G.I.L.I. Lab, Geha Mental Health Center, Petach Tikvah, Israel (bjaffe2@mail.yu.edu).