ASSISTING INDIVIDUALS IN CRISIS

The following guidelines are provided as general recommendations only and are not intended to be clinical prescriptions, nor are they intended to be used by those other than individuals qualified to do so.

ASSISTING INDIVIDUALS IN CRISIS

Topical Outline

Section One - Key Terms & Concepts

Section Two - Are You Listening?

Section Three - Crisis Communication Techniques

Section Four - Questions

INTERNATIONAL CRITICAL INCIDENT STRESS FOUNDATION

ASSISTING INDIVIDUALS IN CRISIS

Topical Outline

Section Five - Psychological Reactions in Crisis

Section Six - Mechanisms of Action

Section Seven - Do No Harm!

Section Eight - The SAFER-Revised Model

Revised 10/2005

INTERNATIONAL CRITICAL INCIDENT STRESS FOUNDATION

OBJECTIVES: Participants will…

1. Understand the natures & definitions of a psychological crisis and psychological crisis intervention.

2. Understand key issues and findings of evidence-based, and evidence-informed practice as it relates to psychological crisis intervention.

3. Understand the resistance, resiliency, recovery continuum.

OBJECTIVES: Participants will…

4. Understand the nature and definition of critical incident stress management and its role as a continuum of care.

5. Practice basic crisis communication techniques.

6. Be familiar with common psychological and behavioral crisis reactions, including empirically-derived predictors of posttraumatic stress disorder.

7. Understand the putative and empirically-derived mechanisms of action in psychological crisis intervention.

OBJECTIVES: Participants will…

8. Practice the SAFER-Revised model of individual psychological crisis intervention.

9. Understand how the SAFER-Revised model may be altered for suicide intervention.

10. Understand and discuss the risks of iatrogenic "harm" associated with psychological crisis intervention and will further discuss how to reduce those risks.

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SECTION ONE

KEY TERMS

&

CONCEPTS

THE NEED

- Over 80% Americans will be exposed to a traumatic event (Breslau) About 9% of those exposed develop PTSD (40-70% IN RAPE, TORTURE) (Surgeon General, 1999)

- Disasters may create significant impairment in 40-50% of those exposed (Norris, 2001, SAMHSA)

THE NEED

- About 50% of disaster workers likely to develop significant distress (Myers & Wee, 2005)

- Terrorism likely to adversely impact majority of population (IOM, 2003); Ranges from ~ 40 - 90% (JHU, 2005)

- Dose response relationship with exposure

THE NEED

- PTSD Prevalence: 10 - 15% of Law Enforcement Personnel (see Everly & Mitchell, 1999)

- PTSD Prevalence: 10 - 30% of those in Fire Suppression (see Everly & Mitchell, 1999)

- PTSD Prevalence: 16% Vietnam Veterans (Nat PTSD Study)

THE NEED

- PTSD Prevalence: ~ 12% Iraq War Veterans (NEJM, 2004)

- As many as 45% of those directly exposed to mass disasters may develop PTSD or depression (North, et al., 1999, JAMA)

At the heart of any field of study or practice resides a basic vocabulary. The following definitions will set the stage for the material we will cover in this course.

DEFINITIONS

CRITICAL INCIDENTS are unusually challenging events that have the potential to create significant human DISTRESS and can overwhelm one's usual coping mechanisms.

THE ICEBERG EFFECT OF TERRORISM (and disasters)…

more psychological casualties than physical casualties…80/20 Effect?

(Holloway, et al., 1997, JAMA; DiGiovanni, 1999, Am. J. Psychiatry)

INTERNATIONAL CRITICAL INCIDENT STRESS FOUNDATION

DEFINITIONS

The psychological DISTRESS in response to critical incidents such as emergencies, disasters, traumatic events, terrorism, or catastrophes is called a PSYCHOLOGICAL CRISIS

(Everly & Mitchell, 1999)

PSYCHOLOGICAL CRISIS

An acute RESPONSE to a trauma, disaster, or other critical incident wherein:

1. Psychological homeostasis (balance) is disrupted (increased stress)
2. One's usual coping mechanisms have failed
3. There is evidence of significant distress, **impairment**, dysfunction

(adapted from Caplan, 1964, *Preventive Psychiatry*)

INTERNATIONAL CRITICAL INCIDENT STRESS FOUNDATION

DEFINITIONS

CRISIS INTERVENTION

- A short-tem helping process.
- Acute intervention designed to mitigate the crisis response.
- Not psychotherapy.

CRISIS INTERVENTION

Goals: To foster natural resiliency through…

1. Stabilization
2. Symptom reduction
3. Return to adaptive functioning, or
4. Facilitation of access to continued care

(adapted from Caplan, 1964, *Preventive Psychiatry*)

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IMPORTANT!
Crisis intervention targets the RESPONSE, not the EVENT, per se.

Thus, crisis intervention and disaster mental health interventions must be predicated upon assessment of need.

INTERNATIONAL CRITICAL INCIDENT STRESS FOUNDATION

CRITICAL INCIDENT STRESS MANAGEMENT (CISM)

(Everly & Mitchell, 1997, 1999; Everly & Langlieb, 2003)

A comprehensive, phase sensitive, and integrated, multi-component approach to crisis/disaster intervention.

CRISIS INTERVENTION

Historical roots of current crisis intervention practices can be found in military psychiatry, community mental health, and suicide intervention initiatives.

Military foundations for crisis intervention have evolved since 1919:

- Proximity
- Immediacy
- Expectancy

And later added:

- Brevity
- Simplicity

RESEARCH FINDINGS

Not all mental health professionals agree that crisis intervention / disaster psychological intervention is useful.

Note: The term “debriefing” is often used as a synonym for crisis intervention / disaster mental health / early psychological intervention.

Concern over perceived indiscriminant use of psychological crisis intervention has led to recommendations to wait 1-3 months post event before initiating formal psychological intervention using 4-12 sessions of Cognitive Behavioral Therapy (CBT).

[see Friedman, M., Foa, E., & Charney, D. (2003). Toward evidence-based early intervention for acutely traumatized adults and children. Biological Psychiatry, 53, 765-768.]

Concerns have been fueled by publication of the Cochrane Reviews…

Major concern over the applicability of early psychological intervention arose largely from the Cochrane Reviews (1998, 2002).

Other negative reviews (van Emmerick, et al., 2002; McNally, et al., 2003) were based largely upon Cochrane data sets, and subsequent theoretical speculation as to potential mechanisms of pathogenic iatrogenesis.

COCHRANE REVIEW (2002)

- "Debriefing" = 11 RCT studies of 1:1 counseling with medical / surgical patients, "loosely based" upon outdated (1983) model

- "Debriefing" = "single session individual debriefing did not reduce psychological distress nor prevent PTSD"

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COCHRANE REVIEW (2002)

- 3 studies showed worsening of symptoms

- The authors conclude: “We are unable to comment on the use of group debriefing, nor the use of debriefing after mass traumas.”

Findings more recent and more relevant to disaster mental health tend to support the use of crisis intervention…

LESSONS LEARNED FROM CONSULTATION MENTAL HEALTH

(Stapleton, Medical Crisis Intervention, 2004)

- Early Psychological Intervention is enhanced via the use of multiple interventions on PTS (.62 vs .55)

LESSONS LEARNED FROM THE WORKPLACE

Post disaster crisis intervention (CISM) was associated with reduced risk for

- binge drinking (d=.74),
- alcohol dependence (.92),
- PTSD symptoms (.56),
- major depression (.81),

LESSONS LEARNED FROM THE WORKPLACE

Post disaster crisis intervention (CISM) was associated with reduced risk for

- anxiety disorder (.98), , and
- global impairment (.66),
- compared with comparable individuals who did not receive this intervention (Boscarino, et al, IJEMH, 2005).

“There is now emerging evidence that prompt delivery of brief, acute phase services in the first weeks after an event can lead to sustained reduction in morbidity years later, reducing the burden of secondary functional impairment, presumed daily average life years lost (DALYS), and costs to both the individual and the public” (p.15).

Schreiber, M. (Summer, 2005). PsySTART rapid mental health triage and incident command system. The Dialogue: A Quarterly Technical assistance Bulletin on Disaster Behavioral health, 14-15.

Value added of Crisis Intervention: Screening & Increasing Access to Care

- First responders, military personnel, and civilian disaster workers (North, et al., 2002, J. T. Stress; Hoge et al. 2004, NEJM; Jayasinghe, et al., 2005, IJEMH) often resistant to seeking MH treatment, therefore crisis intervention may be their only access to mental health services

- Up to 76% of those that go on to develop posttraumatic morbidity may show predictors within 24 hours (North, et al., 1999, JAMA)

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- EARLY PSYCHOLOGICAL INTERVENTION SHOULD NOT BE USED SPECIFICALLY AS A MEANS TO PREVENT PTSD; RATHER, consider as a platform for screening, reducing acute distress, fostering group cohesion, providing info, anticipatory guidance (Litz, et al., 2002, Clin Psychol; Everly & Langlieb, 2003, IJEMH; Arendt & Elklit, 2001, Acta Psyc Scand)

EMPLOYEE ASSISTANCE PROFESSIONAL'S ASSN – DISASTER RESPONSE TASK FORCE (EAPA, 2002)

- EAPs should develop workplace disaster plans.
- Plans should consist of a continuum of interventions:
  - Pre-Incident Training / Coordination (early intervention CISM training, resiliency training, risk assessment, policy development)
  - Acute Response
  - Post-Incident Response (defusing, CISD, crisis management briefings, assessment/ referral, self-care)
  - Follow-up (supervisory briefings, assessment, training)
  - Post-Incident review and plan reformulation

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REASONABLE EVIDENCE-BASED CONCLUSIONS

- More, better controlled, research needed
- Care must be taken
- Data reviewed support use of group “debriefing” with emergency services personnel (Arendt & Elklit, 2001)
- Data reviewed tend to support use of group “debriefing” subsequent to disasters, war, robbery (see NIMH, 2002, tables 2-3;)

REASONABLE EVIDENCE-BASED CONCLUSIONS

- Data do not support single session individualized interventions after medical, surgical distress with minimal training
- Data support multi-component intervention systems
- NIMH (2002), Institute of Medicine (2003) recommend acute phase “psychological first aid” (no direct data available)

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Recent recommendations for early intervention include the use of a variety of interventions matched to the needs of the situation and the recipient populations

(Mental Health & Mass Violence, 2002; IOM, 2003)

A CONTINUUM OF CARE

The Johns Hopkins'
RESISTANCE, RESILIENCE, RECOVERY
An outcome-driven continuum of care

Create Resistance	Enhance Resiliency	Speed Recovery
Assessment	Assessment	Assessment
Intervention	Intervention	Intervention
Evaluation	Evaluation	Evaluation

[Kaminsky, et al, (2005) RESISTANCE, RESILIENCE, RECOVERY. In Everly & Parker, Mental Health Aspects of Disaster: Public Health Preparedness and Response. Balto: Johns Hopkins Center for Public Health Preparedness.

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In the present context, the term *resistance* refers to the ability of an individual, a group, an organization, or even an entire population, to literally ***resist*** manifestations of clinical distress, impairment, or dysfunction associated with critical incidents, terrorism, and even mass disasters.

Resistance may be thought of as a form of psychological / behavioral ***immunity*** to distress and dysfunction.

Resistance may be best built via pre-incident / pre-deployment training.

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In the present context, the term *resilience* refers to the ability of an individual, a group, an organization, or even an entire population, to ***rapidly and effectively rebound*** from psychological and / or behavioral perturbations associated with critical incidents, terrorism, and even mass disasters.

It is likely that early psychological intervention (i.e., response oriented crisis and disaster mental health intervention) is best thought of as a means of enhancing resiliency.

The term *recovery* refers to the ability of an individual, a group, an organization, or even an entire population, to literally ***recover the ability to adaptively function,*** both psychologically and behaviorally, in the wake of a significant clinical distress, impairment, or dysfunction subsequent to critical incidents, terrorism, and even mass disasters.

Treatment and rehabilitation programs are most likely the interventions of choice to speed recovery.

A REVIEW OF INTERVENTION TOOLS

Categories of Disaster Mental Health Interventions

(adapted from NVOAD- EPI Subcommittee Consensus Points, 2005)

- Pre-incident training
- Incident assessment and strategic planning
- Risk and crisis communication
- Acute psychological assessment and triage
- Crisis intervention with large groups

Categories of Disaster Mental Health Interventions

(adapted from NVOAD- EPI Subcommittee Consensus Points, 2005)

- Crisis intervention with small groups
- Crisis intervention with individuals, face-to-face and hotlines
- Crisis planning and intervention with communities
- Crisis planning and intervention with organizations
- Psychological first aid

Categories of Disaster Mental Health Interventions

(adapted from NVOAD- EPI Subcommittee Consensus Points, 2005)

- Facilitating access to appropriate levels of care when needed
- Assisting special and diverse populations
- Spiritual assessment and care
- Self care and family care including safety and security
- Post incident evaluation and training based on lessons learned

One approach, that has been frequently used, to integrate such an array of crisis / disaster mental health interventions across a continuum of need is **Critical Incident Stress Management** (CISM; Everly & Mitchell, 1999).

As noted earlier…

CRITICAL INCIDENT STRESS MANAGEMENT (CISM)

(Everly & Mitchell, 1997, 1999; Everly & Langlieb, 2003)

A comprehensive, phase sensitive, and integrated,

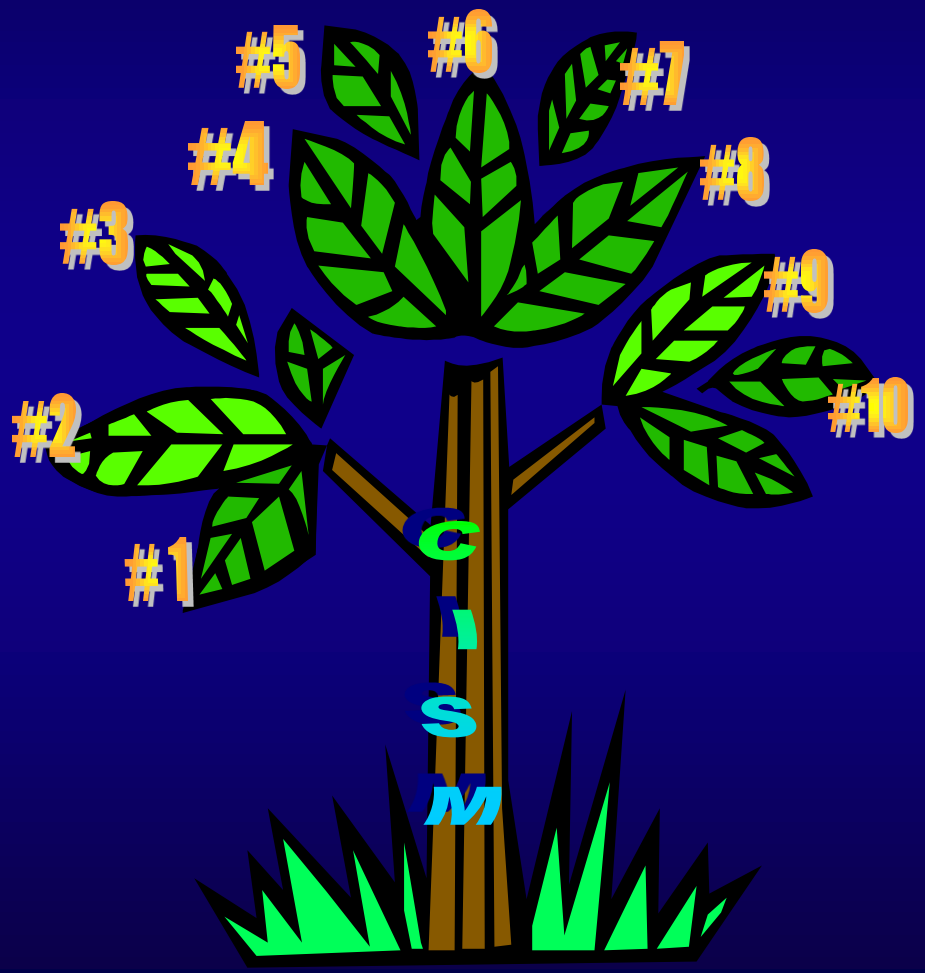
multi-component approach to crisis/disaster intervention.

CISM is a strategic intervention system.

It possesses numerous tactical interventions.

A Comprehensive, Integrated Multi-Component Crisis Intervention System

(adapted from: Martha Starr)



Each “leaf” represents a specific tactical intervention.

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ELEMENTS OF CISM

- Pre-incident education, preparation
- Assessment
- Strategic Planning
- Large Group Crisis Intervention:
  - Demobilizations (large groups of rescue / recovery)
  - Respite / Rehab Sectors
  - Crisis Management Briefings (CMB)

INTERNATIONAL CRITICAL INCIDENT STRESS FOUNDATION

ELEMENTS OF CISM

- Small Group Crisis Intervention:
  - Defusings (small groups)
  - Small group CMB
  - “Debriefing” Models: Critical Incident Stress Debriefing (CISD); HERD; NOVA; Multi-stressor debriefing model; CED

ELEMENTS OF CISM

- One-on-one crisis intervention, including individual PFA
- Family CISM
- Organizational / Community intervention, consultation
- Pastoral crisis intervention
- Follow-up and referral for continued care

CORE COMPETENCIES OF COMPREHENSIVE CRISIS INTERVENTION

- Assessment/ triage benign vs. malignant symptoms

- Strategic planning and utilizing an integrated multi-component crisis intervention system within an incident command system

CORE COMPETENCIES OF COMPREHENSIVE CRISIS INTERVENTION

- One-on-one crisis intervention
- Small group crisis intervention
- Large group crisis intervention
- Follow-up and referral

REVIEW:

"The Evolving Nature of Disaster Mental Health Services"

APPENDIX A provides a brief overview of numerous crisis. Disaster mental health interventions.

THOUGHTS ON STRATEGIC PLANNING

The challenge in crisis intervention is not only developing TACTICAL skills in the "core intervention competencies," but is in knowing WHEN
to best STRATEGICALLY employ the most appropriate intervention for the situation.

STRATEGIC PLANNING FORMULA

1. **THREAT**
2. **TARGET** (Who should receive services? ID target groups.)
3. **TYPE** (What interventions should be used?)
4. **TIMING** (When should the interventions be implemented, with what target groups?)

STRATEGIC PLANNING FORMULA

5. **RESOURCES** (What intervention resources are available to be mobilized for what target groups, when? Consider internal and external resources.)

[Note: **THEMES** which may modify impact and response should be considered (children, chem-bio hazards, etc?)]

PEER SUPPORT:
A Special Kind of Crisis Intervention

The provision of crisis intervention services by those other than mental health clinicians and directed toward individuals of similar key characteristics as those of the providers, e.g., emergency services peer support, student peer support, etc.

Jerome Frank, PhD, MD once noted that at the core of psychological healing resides an "anti-demoralization effect"

SECTION TWO

ARE YOU LISTENING?

GROUP EXERCISE

GROUP EXERCISE

George
Ralph
Dawn
Capt
Tom

HAVING COMPLETED THE GROUP EXERCISE

- What role did "ASSUMPTIONS" play?
- What role did VALUES play?
- What are the implications for COUNTERTRANSFERENCE REACTIONS, especially with regard to PEER INTERVENTIONISTS?

SECTION THREE

CRISIS COMMUNICATIONS

CRISIS COMMUNICATION TECHNIQUES

- Paracommunications: Silence and Nonverbal Behavior
- “Mirror” Techniques
- Questions
- Action Directives

BEWARE!

Excessive use of silence in crisis situations can communicate lack of interest, thus causing an escalation.

Nonverbal behavior sends a powerful message.
Often, the first impression you make is based upon how you look.
The challenge is how to make that impression useful in the service of crisis intervention.

“MIRROR TECHNIQUES”

- Restatement
- Paraphrase (Summary & Extrapolation)
- Reflection of Emotion (Commonly Used By Hostage Negotiators)

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“MIRROR” TECHNIQUES

- Are effective when placed at a natural pause in the conversation
- Or, may be used to redirect the flow of a tangential conversation
- Or, can be used break an escalating emotional spiral

RESTATEMENT

- Takes the other person's words and restates only the term or phrase about which you wish to inquire or emphasize
- Do not overdo this technique
- Demonstrates concern, listening

SUMMARY PARAPHRASE

- Simply summarizes in your words, the main points made by the person in crisis
- Usually inserted when the person pauses
- Stems might include: “So, in other words…” or “Sounds like…” or “What I’m hearing you say is…”

EXTRAPOLATION PARAPHRASE

- People in crisis seldom understand the consequences of their actions
- Extrapolation = summary + consequences
- May be a behavior change tool

REFLECTING EMOTION

- Based upon verbal or nonverbal cues
- Attempts to accurately label the experienced emotion of the other person (“you seem really angry…”)
- Builds empathy, rapport
- Encourages ventilation
- Helps defuse anger

COMMUNICATION EXERCISE:

INTERVIEW USING SUMMARY PARAPHRASING & REFLECTING EMOTION

(Observer's Form #1)

SECTION FOUR

QUESTIONS AND THE "DIAMOND" COMMUNICATION STRUCTURE

QUESTIONS

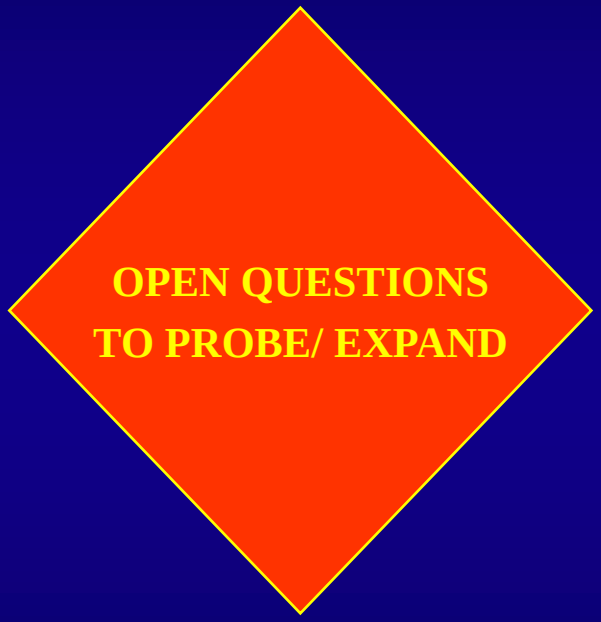
- CLOSED-END (“do you…?” “Is this…?” “Did you…?”)
- Multiple choice
- Open-end (“How?” “What”)
- Remember, paraphrases and reflections are closed-end questions

A simple structure for asking questions is called the “diamond” structure.

“DIAMOND” STRUCTURE

- Begin asking closed-ended questions in order to establish basic facts
- Move to open-ended questions in order to probe and obtain more information
- Use paraphrase and reflection of emotion to summarize key points and acknowledge emotions

CLOSED END QUESTION (“YES-NO”)
TO ESTABLISH FACTS



PARAPHRASE (closed question)
TO SUMMARIZE

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INCIDENT
STRESS
FOUNDATION

ACTION DIRECTIVES

- Providing direction on what to do

- If someone asks a direct question, it is usually best to provide a direct answer, unless the answer will cause an escalation of the crisis

COMMUNICATION EXERCISE:

EMPHASIZING USE OF YES-NO QUESTIONS

(Be sure to use open-end questions, paraphrasing & reflection of emotion)

(Use Observer's Form #2)

SECTION FIVE

PSYCHOLOGICAL REACTIONS IN CRISIS

EUSTRESS vs. DISTRTESS vs. DYSFUNCTION

Three intensity levels of stress:

Eustress = Positive, motivating stress

Distress = Excessive stress

Dysfunction = Impairment

SIGNS AND SYMPTOMS OF DISTRESS

I. COGNITIVE (Thinking)
II. EMOTIONAL
III. BEHAVIORAL
IV. PHYSICAL
V. SPIRITUAL

DISTRESS (excessive stress).
Rx…Identify, Assess, & Monitor
vs.
DYSFUNCTION (impairment)
Rx…Identify, Assess, & Take action

I. COGNITIVE (Thinking) DISTRESS

- Sensory Distortion
- Inability to Concentrate
- Difficulty in Decision Making
- Guilt
- Preoccupation (obsessions) with Event
- Confusion (“dumbing down”)
- Inability to Understand Consequences of Behavior

I. SEVERE COGNITIVE DYSFUNCTION

- Suicidal/ Homicidal Ideation
- Paranoid Ideation
- Persistent Diminished Problem-solving
- Dissociation
- Disabling Guilt
- Hallucinations
- Delusions
- Persistent Hopelessness/ Helplessness

II. EMOTIONAL DISTRESS

- Anxiety
- Irritability
- Anger
- Mood Swings
- Depression
- Fear, Phobia, Phobic Avoidance
- Posttraumatic Stress (PTS)
- Grief

II. SEVERE EMOTIONAL DYSFUNCTION

- Panic Attacks
- Infantile Emotions in Adults
- Immobilizing Depression
- Posttraumatic Stress Disorder (PTSD)

Posttraumatic stress (PTS) is a normal survival response; Posttraumatic Stress Disorder (PTSD) is a pathologic variant of that normal survival reaction.

Predicting PTSD

1. Dose - response relationship with exposure
2. Personal identification with event
3. Very important beliefs violated

PTSD results from violation of:

1. EXPECTATIONS

2. DEEPLY HELD BELIEFS
   (Worldviews)

CORE BELIEFS (Worldviews)

- Belief in a just and fair world
- Need to trust others
- Self-esteem, Self-efficacy
- Need for a predictable and SAFE world
- Spirituality, belief in an order and congruence in life and the universe

III. BEHAVIORAL DISTRESS

- Impulsiveness
- Risk-taking
- Excessive Eating
- Alcohol/ Drug Use
- Hyperstartle
- Compensatory Sexuality
- Sleep Disturbance
- Withdrawal
- Family Discord
- Crying Spells
- Hypervigilance
- 1000-yard Stare

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III. SEVERE BEHAVIORAL DYSFUNCTION

- Violence
- Antisocial Acts
- Abuse of Others
- Diminished Personal Hygiene
- Immobility
- Self-medication

IV. PHYSICAL DISTRESS

- Tachycardia or Bradycardia
- Headaches
- Hyperventilation
- Muscle Spasms
- Psychogenic Sweating
- Fatigue / Exhaustion
- Indigestion, Nausea, Vomiting

IV. SEVERE PHYSICAL DYSFUNCTION

- Chest Pain
- Persistent Irregular Heartbeats
- Recurrent Dizziness
- Seizure
- Recurrent Headaches

IV. SEVERE PHYSICAL DYSFUNCTION

- Blood in vomit, urine, stool, sputum
- Collapse / loss of consciousness
- Numbness / paralysis (especially of arm, leg, face)
- Inability to speak / understand speech

It is imperative that all evidence of physical dysfunction be taken seriously and referred to a physician. The same is true when dealing with any physical distress that does not remit, may be suggestive of a medical disorder, or seems ambiguous.

V. SPIRITUAL DISTRESS

- Anger at God
- Withdrawal from Faith-based Community
- Crisis of Faith

V. SEVERE SPIRITUAL DYSFUNCTION

- Cessation from Practice of Faith
- Religious Hallucinations or Delusions

NOTE!

ALL OF THE SIGNS AND SYMPTOMS OF SEVERE DYSFUNCTION WARRANT REFERRAL TO THE NEXT LEVEL OF CARE!

Also refer whenever in doubt.

11 Screening Factors:

1. Ask about nature & severity of exposure
2. Ask about peri-traumatic dissociation
3. Ask if person truly believed he / she was going to die
4. Ask about appraisal of symptoms (are they catastrophic?)
5. Physical injuries

11 Screening Factors:

6. Malignant sympathetic arousal – panic, loss of bowel or bladder control
7. Psychogenic amnesia
8. Peri-traumatic depression, numbing
9. Self-destructive ideation
10. Evidence of psychotic process
11. Whenever in doubt!

FOR EXAMPLE
Have you recently . . .

1. Seen anyone seriously injured or killed? Or have you seen any type of human remains?

2. Felt as if you were in serious danger, or thought that you were going to die?

In the last couple of weeks, or so, have you…

3. Felt hopeless, helpless, or seriously depressed?

4. Felt numb or detached from the people you were with, your surroundings, or even from your usual bodily sensations?

5. Seriously thought about hurting yourself, or ending you own life?

6. Seriously thought about hurting or killing someone else?

7. Thought you were “going crazy?”

8. Experienced panic?

9. Experienced a crisis of spiritual, or religious, belief?

10. Had difficulty getting along with close friends, family, or co-workers?

11. Used alcohol, or other substances specifically to help you relax or sleep?

12. Would you be interested in talking to someone about any of these, or other, concerns you might have?

SECTION SIX

MECHANISMS OF ACTION IN CRISIS INTERVENTION

Remember Maslow's (1943) Need Hierarchy

- Self – actualization
- Self – esteem
- Affiliation
- Safety
- Basic physical needs (START HERE)

PERSONALITY ALIGNMENT

COGNITIVE ORIENTATION

vs.

AFFECTIVE ORIENTATION

PSYCHOLOGICAL ALIGNMENT

- Don’t argue
- Don’t minimize problem
- Find something to agree upon
- Is the most important element in establishing rapport

MECHANISMS OF ACTION

(rec-Recommended; emp - Data based; rev - Review of literature)

- MEETING BASIC NEEDS (NIMH, 2002-rec)
- LIAISON / ADVOCACY (NIMH, 2002-rec
- CATHARTIC VENTILATION (Pennebaker, 1999-emp)
- SOCIAL SUPPORT, GROUP COHESION (Flannery, 1990-emp; APA, 2004-rec)
- INFORMATION (NIMH, 2002-rec)

MECHANISMS OF ACTION

(rec-Recommended; emp - Data based; rev - Review of literature)

- STRESS MANAGEMENT (Everly & Lating, 2002-rev)
- PROBLEM-SOLVING (Everly & Lating, 2002-rev)
- CONFLICT RESOLUTION (Everly & Lating, 2002-rev)
- COGNITIVE REFRAMING (Taylor, 1983-emp; Affleck & Tennen, 1996-rec)
- SPIRITUAL (Everly & Lating, 2002-rev)

AVOID!

- “I know how you feel.”
- “It’s not so bad.”
- “This was God’s will.”
- “God won’t give you more than you can handle.”
- “Others have it much worse.”

AVOID!

- "You need to forget about it."
- "You did the best you could."
  (Unless person has told you that.)
- "You really need to experience this pain."
- Psychotherapeutic interpretation!
- Confrontation
- Paradoxical intention.

EXERCISE

PRACTICE IN CRISIS INTERVENTION MECHANISMS

(Observer's Form #3)

SECTION SEVEN

DO NO HARM:

Cautions & Contraindications

CRISIS = RESPONSE

The failure to understand that the event is NOT the crisis, can easily lead to over intervention, and the potential to interfere with natural recovery mechanisms!

CAN CRISIS INTERVENTION BE HARMFUL ?

Theoretical Mechanisms/ Issues

(see Dyregrov, IJEMH, 1999; Watson, et al., in Ursano & Norwood, 2003)

- Excessive catharsis, disclosure, rumination
- Pathologizing otherwise “normal” reactions
- Vicarious traumatization in groups
- Coercive peer pressure in groups
- Scapegoating in groups

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CAN CRISIS INTERVENTION BE HARMFUL ?

Theoretical Mechanisms/ Issues

(see Dyregrov, IJEMH, 1999; Watson, et al., in Ursano & Norwood, 2003)

- Triggering of previous traumatic memories
- Intervention may be premature (inappropriate timing)
- May be inappropriate with highly aroused persons
- May interfere with natural coping mechanisms
- May not be accompanied by adequate assessment or follow-up

INTERNATIONAL CRITICAL INCIDENT STRESS FOUNDATION

The risk of adverse outcome is associated with all human intervention and helping practices including medicine, surgery and counseling.

Improper, inadequate training would appear the greatest risk factor associated with crisis intervention, as well as those practices just mentioned.

Thus, training and supervision may be the best way to reduce the risk of adverse outcome, rather than simply calling for an end to such helping practices

SECTION EIGHT

SAFER-Revised MODEL OF INDIVIDUAL CRISIS INTERVENTION

Crisis Intervention applications can be made easier by the utilization of simple models. The SAFER-R model is nothing more than a step-by-step model for working with individuals in crisis

The SAFER-Revised

- Stabilize (introduction; meet basic needs; mitigate acute stressors)
- Acknowledge the crisis (event, reactions)
  - Consider reflecting emotion, then asking the question what would be most helpful to the person in crisis.
- Facilitate understanding (normalization)
- Encourage effective coping (mechanisms of action)
- Recovery or Referral (facilitate access to continued care)

SAFER-R Model of Crisis Intervention with Individuals

(Everly, 2001)

Stabilization (plus Introduction) [1]

↓

Acknowledgement [1]

A. Event

B. Reactions

↓

Facilitation of Understanding: Normalization [1]

↓

Encourage Effective Coping (Mechanisms of Action) [1,2,3]

↓

Referral? [1, 2, 3]

[1= Assessment, 2= Generate intervention options, 3= Implement interventions]

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SAFER-R Model of Crisis Intervention with Individuals

(Everly, 2001)

Stabilization (plus Introduction) [1]

↓

Acknowledgement [1]

A. Event

B. Reactions

↓

Facilitation of Understanding: Normalization [1]

↓

Encourage Effective Coping (Mechanisms of Action) [1,2,3]

MEETING BASIC NEEDS
LIAISON/ ADVOCACY
CATHARTIC VENTILATION
SOCIAL SUPPORT
INFORMATION
STRESS MANAGEMENT
PROBLEM-SOLVING
CONFLICT RESOLUTION
COGNITIVE REFRAMING
SPIRITUAL

↓

Referral? [1, 2, 3]

[1= Assessment, 2= Generate intervention options,
3= Implement interventions]

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AN EXAMPLE

- Introduce yourself
- Meet basic needs, stabilize, liaison
- Listen to the “story” (events, reactions)
- Reflect emotion
- Paraphrase content
- Ask a transitional question: “What do you need most right now?”

AN EXAMPLE

- Normalize
- Attribute reactions to situation, not personal weakness
- Identify personal stress management tools to empower
- Identify external support / coping resources
- Use problem-solving or cognitive reframing, if applicable
- Assess person's ability to safely function

SUICIDE: A SPECIAL CASE

- Helplessness
- Hopelessness
- Extreme guilt
- Previous attempts
- Severe illness, disability
- Psychosis

SUICIDE: C-C-D-R Intervention

- CLARIFY
- CONTRADICT
- DELAY
- REFER for continued to care

SUICIDE INTERVENTION

- CLARIFY: “Do you really want to die, or do you simply want to change the way you live your life?

- CONTRADICT via:
  - Desired outcome will not be achieved
  - Suicide will create more problems than it solves
  - Suicide creates an adverse and undesired “ripple effect” affecting others

SUICIDE INTERVENTION

- DELAY
- ALWAYS ASSIST IN ACCESSING HIGHER LEVEL OF CARE

SAFER-R Model of Crisis Intervention with Individuals:

Modified for Suicide Intervention

(Everly, 2001)

Stabilization (plus Introduction) [1]

Acknowledgement [1]

A. Event

B. Reactions

Facilitation of Understanding: Normalization [1]

Encourage Effective Coping (Mechanisms of Action) [1,2,3]

CLARIFY, CONTRADICT, DELAY

Referral…ALWAYS! [1, 2, 3]

[1= Assessment, 2= Generate intervention options,

3= Implement interventions]

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EXERCISE

PRACTICE IN SAFER-Revised

(Observer's Form #4)

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END

APPENDIX A

Commonly Used Crisis and Disaster Mental Health Interventions

PRE-INCIDENT PREPARATION

- Assessment of risk
- Risk reduction
- Assessment of physical and psychological response preparedness
- Training to reduce vulnerabilities
- Training to create “resistance”
- Training to enhance “resilience” and response capabilities

ASSESSMENT

One element often left out of crisis intervention is acute assessment, e.g., mental status, behavioral assessment, the Johns Hopkins' "perspectives," etc.

ALL Crisis Intervention should be based upon the Assessment of NEED…and the further ASSESSMENT of the most appropriate intervention.

A strategic planning model may assist in this process.

STRATEGIC PLANNING FORMULA

1. **THREAT**

2. **TARGET** (Who should receive services? ID target groups.)

3. **TYPE** (What interventions should be used?)

STRATEGIC PLANNING FORMULA

4. **TIMING** (When should the interventions be implemented, with what target groups?)

5. **RESOURCES** (What intervention resources are available to be mobilized for what target groups, when? Consider internal and external resources.)

[Note: **THEMES** which may modify impact and response should be considered (children, chem-bio hazards, etc?)]

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DEMOBILIZATION

A one time, large-group information process for emergency services, military or other operations staff who have been exposed to a significant significant traumatic event such as a disaster or terrorist event

RESPITE/ REHAB SECTORS

Ongoing physical & psychosocial decompression (respite) areas constructed at the disaster venue to provide support (beverages, light food, protection from weather, and provision of psychological support / stress management) typically to emergency personnel.

CRISIS MANAGEMENT BRIEFINGS (CMB)

(Everly, 2000)

Structured large group (can be used in small groups, as well) community / organizational "**town meetings**" designed to provide information about the incident, control rumors, educate about symptoms of distress, inform about basic stress management, and identify resources available for continued support, if desired. Especially useful in response to violence / terrorism.

DEFUSINGS

Small group (< 20) structured

3-phase group discussion regarding a critical incident.

Typically done with homogeneous work groups usually within 12 hours of the event.

May be repeated for ongoing events.

“DEBRIEFING”

The term “debriefing” has been used frequently in the theory and practice of crisis intervention.

Used within the context of CISM, the term “debriefing” refers to a 7 - phase structured small group crisis intervention more specifically named Critical Incident Stress Debriefing (CISD).

CRITICAL INCIDENT STRESS DEBRIEFING (CISD)

(Mitchell & Everly, 2001)

A structured 7-phase group discussion typically conducted with homogeneous groups 2 - 10 days (3+ weeks in mass disasters) post incident.

Designed to mitigate distress, facilitate psychological closure, or facilitate access to continued care.

In 1983, Mitchell's original paper used the term CISD to refer to both the overarching response system and the small group discussion.
This resulted in semantic confusion.
Now, the term Critical Incident Stress Management (CISM) is used to denote the overarching response system, while CISD is used to refer to the 7-phase small group discussion.

The term “debriefing,” when used alone, has been used in so many different ways, it has lost its meaning and adds to confusion.

For example, research from the UK often uses the term debriefing to describe 1:1 counseling with medical patients.

Unfortunately, some reviews and studies have used the term debriefing to describe such forms of counseling. Further, the Cochrane Review has been inappropriately cited as evidence of the ineffectiveness of all forms of “debriefing,” even group CISD!

INDIVIDUAL (1:1) INTERVENTION

Most crisis intervention is done individually, one-on-one, either face-to-face or telephonically.

Psychological first aid (PFA) is the most elemental form of this intervention.

FAMILY CRISIS INTERVENTION

Traumatic distress can be “contagious;” family members are often adversely affected by those who initially develop posttraumatic distress.

AND

Families of victims require support, especially when loved ones are seriously injured or killed.

ORGANIZATIONAL / COMMUNITY CRISIS RESPONSE

Consists of risk assessment, pre- and post incident strategic planning, tactical training and intervention, consultation with leadership, and the development of a comprehensive crisis plan.

PASTORAL CRISIS INTERVENTION (PCI)

The functional integration of the principles and practices of psychological crisis intervention with the principles and practices of pastoral support.

(Everly, IJEMH, 2000)

FOLLOW-UP & REFERRAL

All forms of crisis intervention should possess some form of follow-up.

In addition, one of the most cogent reasons for instituting a crisis intervention program is to identify those who require or desire continued care, and to facilitate access to that care.

REMEMBER!

CISD / CISM are not substitutes for psychotherapy.

Rather, they are elements within the emergency mental health system designed to precede and complement psychotherapy, i.e., part of the full continuum of care.

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Appendix B – Background Papers

- Evolving Nature of Disaster Mental Health
- Thoughts on Peer Support
- Psychological Triage
- Early Psychological Intervention: A Word of Caution
- A Prospective Cohort Study of the Effectiveness of Employer – Sponsored Crisis Interventions after a Major Disaster
- Economic Evaluation of CISM