Psychological Interventions in Crisis settings

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Abstract

Crisis Intervention in getting into focus by media as natural disasters, wars and catastrophies are unfortunately getting more and more common, different questions are raised regarding their efficacy particularly as a preventive measure against Post Traumatic Stress Disorder PTSD. Issues regarding the proper timing and optimal modality is still not well defined. This article come across crisis intervention from concepts to implimentations.

BASIC PRINCIPLES

Over the years, crisis intervention has proven an effective, front – line intervention for victims of all types or critical incidents, especially the extreme stressors that may result in psychological trauma. [1] Crisis intervention is defined as the provision of emergency psychological care to victims as to assist those victims in returning to an adaptive level of functioning and to prevent or to mitigate the potential negative impact of psychological trauma. [2]

Consistent with the formulations of Caplan , crisis intervention may be thought of as urgent and acute psychological intervention. The hallmarks of these first interventions are: Immediacy, Proximity, Expectancy and Brevity.

Furthermore, the goals of crisis intervention are:

1. Stabilization, i.e., cessation of escalating distress;
2. Mitigation of acute signs and symptoms of distress; and,
3. Restoration of adaptive independent functioning, if possible ; or, facilitation of access to a higher level of care. 3

While there is no one single model of crisis intervention, there is common agreement on the general principles to be employed by EMH practitioners to alleviate the acute distress of victims, to restore independent functioning and to prevent or mitigate the aftermath of psychological trauma and PTSD.

1. Intervene immediately. By definition, crisis is emotionally hazardous situation that place victims at high risk for maladaptive coping or even for being immobilized. The presence onsite of EMH personnel as quickly as possible is paramount.
2. Stabilize. One important immediate goal is the stabilization of the victims or the victim community actively mobilizing resource of order and routine. Such a mobilization provides the needed tools for victims to begin to function independly.
3. Facilitate understanding. Another important step in restoring victims to pre crisis level of functioning is to facilitate their understanding of what has occurred. This is accomplished by gathering the facts about what has occurred, listening to the victims recount events, encouraging the expression of difficult emotions and helping them understand the impact of critical event.
4. Focus on problem –solving. Actively assist victims to use available resources to regain control is an important strategy for EMH personnel. Assisting the victims in solving problems within the context of what the victim feels is possible enhance independent functioning
5. Encourage self reliance. Active problem solving is the emphasis on restoring self-reliance in victims as an additional means to restore independent functioning and to address the aftermath of traumatic events. 4

TO WHOM CRISIS INTERVENTION TO BE PROVIDED?

An inescapable reality is that not everyone exposed to a traumatic event develop PTSD. Clearly, some individuals possess a natural resistance to extreme stress. Furthermore, many individual who are traumatized possess natural recovery mechanisms sufficient enough to preclude external psychological support. [5]

Once again it is argued that the most important element of the critical incident- crisis response complex is the person and the person's idiosyncratic reaction to the critical incident. As noted personolgist Theodore Millon has postulated, some individuals are primarly cognitive in their experience-processing orientation. Cognitively oriented individuals tend to require emotional distance, information, and assistance in problem- solving and re-establishing control as they recover from a crisis. Conversely affectively oriented individuals tend to prosper from cathartic ventilation and empathetically-based interventions. [6]

WHEN TO PROVIDE CRISIS INTERVENTION?

Timing for crisis intervention is based upon psychological readiness, rather than the passage of time. A useful model for understanding the timing of crisis intervention is the model developed by Faberow and Gordon (1981). These authors describe four phases of disaster:

1. Heroic phase- This phase begins immediately upon the onset of the disaster and may even begin in anticipation of the impact of the event itself. It consists of efforts to protect lives and property.

2. Honeymoon phase- This phase is characterize by optimism and thanksgiving. There is a sigh of relief as the realization of survival is appreciated. Congratulatory behavior is common.

3. Disillusement phase- This phase may begin as early as 3- 4 weeks post disaster, is replete with the realization that something “disastrous “has really taken place. There is great deal of “second –guessing” where in anger, frustration, and even efforts to place blame are revealed.

4. The question, “Why did this have to happen?” is often posed. Religious belief may be challenged Here the mourning process actually begins. This phase may last weeks, months, or even years. For some, the phase never ends. It is the goal of crisis intervention to facilitate the transition from this disillusionment phase to the final phase.

5. Reconstruction phase- In this final phase restoration of “normal” routine functioning is achieved. Memories of the disaster are not erased, but life does continue on.

While the model described above was developed for understanding the human response to disaster, it will prove useful in understanding how individuals psychologically progress through any crisis reaction.

Obviously, the duration of each of these phases may be drastically constricted. Nevertheless, the goal of crisis intervention remains the same whether in response to a mass disaster or an acute isolated event. From the model offered by Faberow and Gordon (1981), the goal is to facilitate transition from the disillusement phase to the reconstruction phase. [7]

PSYCHOLOGICAL DEBRIEFING

There is conceptual and definitional confusion in the use of the term debriefing. The word “ debriefing” is in very common usage , its popular meaning being that reviewing or going over an experience or set of actions to achieve some sort or order or meaning concerning them . Being debriefed implies being enabled or assisted to achieve such a review. [4]

The concept of debriefing itself developed into what was known as psychological debriefing in the 1970s. A number of different models of this procedure evolved with respect to emergency, military or incident response workers and their needs.

The most widely used model of debriefing is that developed by Jeffry Mitchell and known as critical incident stress debriefing (CISD) this form of psychological debriefing has a specific structure and format, and has been developed for the management of critical incident stress experienced by emergency service workers .It has more recently been expanded to encompass a program of interventions known as critical incident stress management (CISM). [8]

Debriefing has extended for beyond its original context and is now widely applied to almost any life experience, even those that may be relatively positive. Core debriefing issues include the frameworks in which debriefing may be conceptualized:

- As narrative modality.
- As crisis intervention.
- As psycho education.
- As stress management.
- As prevention.
- As therapy.
- As an integrated intervention. 4

As Narrative or talking through the experience

A question that is not answered , yet it is critical: How much talking through resolves what has happened and assists with mastery of the experiences , as compared to reinforcing helplessness?

Much talking through of experiences happens naturally. Mc Farlane suggests that there is inadequate information about the degree to which “telling the story” solves the problem despite a profound belief that it will. [9]

Some authors recognized that the repetitive play of traumatized children does not assist resolution, but rather represents ongoing traumatization, with repeated and unsuccessful attempts at mastery and integration. They become fixed in their victim status that they become “tellers” of their story. But no resolution occurs , rather they remain locked into the incident , even though they may not appear outwardly stressed or symptomatic. [10]

This mode of coping may have been reinforced for them by powerful feelings of importance related to the event, which make them feel significant in ways that they have not felt before. If formal debriefing has an effect, it is also reasonable to believe that natural debriefing – the normally occurring interpersonal processes of talking to friends and significant others about the trauma , and hearing of the universality of the stress response from coworkers – should also facilitate recovery following trauma. [11]

AS CRISIS INTERVENTION

Recently debriefing has taken on a crisis intervention mantle as part of its contextualization of potential benefit. Debriefing has a more formal structure of intervention as proposed by Mitchell and those using his framework, this model has been adapted to be less formal than was initially described so as it is nearly equated to Caplan's (1964) model of crisis intervention. [12]

AS PSYCHOEDUCATION

The traditional CISD model teaches those involved the psychological symptoms they may except to have and what is a “normal reaction to an abnormal experience “. The learning in such presentations is passive and not active. Educational theory emphasizes the value of active learning and problem solving. As noted, those involved may learn symptoms or pathological syndromes and identify with these. While as known from catastrophes in many different circumstances, that human resilience is a powerful force, even against the greatest odds, and that the personal battle to deal with stressor experiences may be even stronger. [13]

They may learn that all stress should be medicalized , even though it is a normal response to abnormal circumstances. Learning on the other hand may build on the stenghts , and recognition of each individual's pathway to mastery, as well as those of others. This also raises the question of what should be the focus of any teaching and learning in order to promote coping. Clearly these matters are at present hypothetical and research is needed to clarify positive and negative learning in relation to debriefing type interventions. [4]

AS STRESS MANAGEMENT

Shalev (1994) has described debriefing as fitting more within the stress management framework . This is possibly a useful way of viewing these interventions, particularly as they now encompass a whole spectrum of every circumstance. Yet debriefing may in fact actively interfere with a necessary phase of denial and numbing as the individual ego cushions against the excessive stress experienced. [14]

AS PSYCHOTHERAPY

Mitchell and Everly are empathetic that their debriefing model is not psychotherapy. Yet it shares some characteristics with psychotherapeutic techniques such as : exploration of experience , examining cognitive distortions , provision of information, emotional expression or even catharsis , reconfronting stressful experiences , education and support. [15]

Debriefing is not provided for those with the identified problems i.e. as treatment for a disorder. It might hope to lessen psychosocial morbidity, but as this is usually not definitely present when debriefing is provided. It can't be seen as treatment intervention. It may however, be seen on

the spectrum of interventions as a selective or indicated preventive intervention of the psychosocial kind. [16]

AS PREVENTION

Debriefing interventions have been suggested to have positive and potentially preventive benefits. In addition, there is pervasive belief that providing debriefing after traumatic incidents will prevent the development of PTSD.

Debriefing is also believed to prevent more broadly based psychosocial morbidity. It is also inferred that debriefing may allow screening for those at higher risk of PTSD and serve a prevention function in this way as suggested , for instance by Mitchell &Everly and Chemtob.[15-17]

Because preventive interventions are often most likely to demonstrate these effects with high-risk populations, reducing the risk to that of lower-risk groups when they are effective, debriefing could ideally be trialed with those at heightened risk. [4]

AS AN INTEGRATED PREVENTION

It is important to integrate debriefing processes and interventions into other organizational systems or structures , as in military settings , occupational health& safety response system. Therefore , what has evolved as a separate intervention system may more appropriately be integrated with other responses. [18]

CRITERIA FOR DEFINING A SUCCESSFUL DEBRIEFING

While verbal reports about the efficacy of a debriefing may be of value, they cannot always be accepted at face value, since some participant in the debriefing may not disclose personal concerns, stress reactions or symptoms in the wake of a traumatic event for several reasons including social pressure to say desirable things about the debriefing or owing to avoidance, numbing and emotional restriction in the early period after the event. Criteria defining a successful debriefing must therefore determine a set of common measures that could be applied across different stressful events to ascertain which mechanisms worked best for the participants. [19]

Everly& Mitchell (1997) , after a review of the literature , proposed a five-stage model that is useful in terms of identifying the parameters that should be considered:

1. stabilization of the situation
2. acknowledgement of the crisis or stressful event and its impact on self and others.
3. facilitating understanding
4. homeostatic functioning. 20

Finally, attempting to determine criteria for evaluating the efficacy of a debriefing is related to the goals that are established for a particular situation. Clearly goals may vary depending on organizational priorities.

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