Critical Incident Response via an EAP Lens: Literature Review

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Abstract

This paper reviews the literature in critical incident response (CIR) as it intersects with the employee assistance field (EAP). A review of basic terminology is presented as well as various critical incident response models and pivotal research initiatives regarding the effectiveness of crisis intervention. A specific study illuminates the lack of evidence-based research of the effect on the organization arising from traumatic incidents. Then a brief discussion is offered about the current needs for collaboration of professionals around uniformity of definitions and interventions as well as further efforts to develop rigorous measures that will establish the effectiveness and efficiency of these interventions. Finally a series of next steps are enumerated for consideration to stimulate further thoughtful discussion, particularly as to how CIR relates to the EAP field.

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"Words decay with imprecision…"

- TS Eliot

I. Introduction

Over the last 75 years, crisis intervention has evolved from theoretical and empirical studies into a specialty mental health practice. The foundation of crisis intervention arose from the pioneering work of two community psychiatrists in the 1940s - Erich Lindemann and Gerald Caplan. Beginning in 1943, Dr. Erich Lindemann conceived of crisis theory interventions from his work at Massachusetts General Hospital with acute and grief stricken survivors and relatives of the nearly five hundred victims of Boston's Coconut Grove nightclub fire. Gerald Caplan, a psychiatry professor at Massachusetts General Hospital and the Harvard School of Public Health, expanded Lindemann's (1944) pioneering work. Caplan (1961, 1964) was the first clinician to describe and document the four stages of a crisis reaction:

- initial rise of tension from the emotionally hazardous crisis precipitating event,
- increased disruption of daily living because the individual is stuck and cannot resolve the crisis quickly,
- tension rapidly increases as the individual fails to resolve the crisis through emergency problem-solving methods, and
- the person goes into a depression or mental collapse or may partially resolve the crisis by using new coping methods (Roberts and Otten, 2005)

While many twists and offshoots have spread in the crisis intervention field, this brief summary highlights key points in its history, evolving changes in terminology, intervention approaches and models, research findings, and in particular intersects with the EAP Field.

Differing views are associated with how and when Crisis Intervention Response (CIR) emerged as a concern and service within the EAP world. Some relate the traumatic events of the late 1980s and early 1990s including the Gulf War, Hurricane Andrew, World Trade Center bombing, and the Oklahoma City bombing each of which resulted in employees and organizations needing various types of support to return to their pre-event functioning and productivity level in the workplace (DeFraia, 2015). Others cite the tragic 1988 Aloha Airline Flight 243 crash in Maui where the pilot, Madeline "Mimi" Tompkins, was approached by the Air Line Pilots Association (ALPA) to explore better ways to deal with tragic disasters. This event led to the creation of an ALPA task force that hired Jeffrey Mitchell as a consultant to tailor Critical Incident Stress Debriefing (CISD) practices to airline disasters (Mitchell, 2006). Additional unions followed this lead and corporations eventually began to adopt CISD as a method of dealing with workplace trauma.

Irrespective of how CIR emerged as an EAP service, by the early 1990s critical incident stress debriefings was considered one of the many functions of the new "broad brush" model of EAP services (Masi, 1994). Some of the more common workplace critical incidents that EAP counselors respond to include: robberies, sexual assaults, natural and man-made disasters,

criminal incidents, workplace accidents, family violence, and workplace violence.

One important clarification in the literature is the functional difference between crisis intervention and disaster management. Crisis states amongst individuals can be precipitated by natural disasters such as Hurricane Sandy or the more recent earthquakes in Nepal. However, a large-scale community disaster first requires coordination and management of the emergency search and rescue services as well as electrical and communication infrastructure restoration. These immediate priorities represent a response to the event itself while crisis intervention addresses the psychological needs of those experiencing the disaster and takes place some time after the initial event (Roberts and Otten, 2005).

II. Background & Terminology

Critical Incident Stress Debriefing (CISD) was developed by Jeffrey Mitchell in 1974 for use with small homogenous groups of paramedics, firefighters and law enforcement professionals who experienced varying levels of distress from exposure to a singular or accumulation of traumatic events. Mitchell's model is firmly rooted in the crisis intervention and group theory of Eric Lindemann, Gerald Caplan, and Irwin Yalom appearing in the *Journal of Emergency Medical Services* in 1983.

Over time, the use of CISD as an effective tool spread to other groups outside the emergency services professions. The military services, airlines, and railroads found the approach helpful in their industries and amongst other high risk groups across the globe. It was widely used in the United Kingdom, especially during the 1980s, most notably following the terrorist attack of Pan Am Flight 103 (Regel and Dyregov, 2012). Up until then, with only a few exceptions from the United States (Mitchell,1983), Scandinavia (Dyregov, 1989), and Australia (Raphael, 1990), there were few published papers on post-trauma service support.

In 1994 Bisson and Deahl published an editorial in the *British Journal of Psychiatry* entitled "Psychological Debriefing and the Prevention of Post-Traumatic Stress – More Research is Needed." It sparked a debate that has persisted for a couple of decades The article suggested that psychological debriefing can increase an individual's level of anxiety and sorrow, therefore potentially posing more harm than good. Several authors advocated the practice of CISD be discontinued (Rose et al. 2003). This contradictory exchange of views continues today. However without further empirical evidence about the effectiveness of CISD or any of the other derivative models (CISM) , it has been difficult for the EAP community to reach a consensus on next steps.

Let us begin a discussion of these issues with a consideration of how the term **crisis** is used. A crisis has been defined as "an acute disruption of psychological homeostasis in which one's usual coping mechanisms fail and there exists evidence of distress and functional impairment" (Roberts, 2005, p. 778). The main cause of a crisis is an intensely stressful, traumatic, or hazardous event but two other conditions are also necessary: (1) the individual's perception of the event as the cause of considerable upset and/or disruption; and (2) the individual's inability to resolve the disruption by previously used coping mechanisms. Simplistically the term crisis refers to "an upset in the steady state" (Roberts, 2005, p. 778).

Next, for there to be a "**critical incident**" a stressor event such as a suicide of a family member or colleague, bank robbery, or some form of a natural disaster must occur. The stressor event frequently leads to some form of intervention defined as the provision of emergency psychological care to the victims to assist them in returning to an adaptive level of functioning and to prevent or mitigate the potential negative impact of psychological trauma (Everly and Mitchell, 1999). Another term frequently used is **Crisis Intervention Response (CIR)** to indicate a comprehensive crisis approach addressing the human emotional factors of acute life events. This term is also referred to as **Psychological First Aid (PFA)** or **Critical Incident Debriefing (CID)** (Beyer & Vanderpol, 2009). De-briefing, specifically **Psychological Debriefing (PD)**, is yet another phrase used generically to characterize a variety of brief intervention techniques aimed at mitigating the trauma from contributing to the development of a life-long psychopathology or specifically Post Traumatic Stress Disorder (PTSD) (Devil, Wright & Gist, 2003). Within the genre of PD models, the oldest and most enduring has been the model that Mitchell devised in 1974 for first responders and accepted as the blueprint for numerous variants (Everly & Lating, 1995). In 1997 Everly and Mitchell introduced the term **Critical Incident Management (CISM)** and defined it as a comprehensive, integrative multicomponent crisis intervention system. It differs from the original Mitchell CISD model in that it spans the entire temporal spectrum of a crisis. CISM ranges from pre-crisis through the acute crisis and post-crisis phases. In addition, it may be applied to individuals, small functional groups, large groups, families, organizations, and communities.

With multiple labels and practice descriptions in use, one can see how confusion abounds as to what crisis intervention means to a service provider, published author, or the rigor of the individual protocol adopted and practiced within each model of intervention delivery. Nevertheless, the end goal as espoused by those offering CISD services remains consistent. Crisis interventions are designed to reduce acute distress following an extreme event, encourage short and long term employee functioning, and facilitate both employee and organizational resiliency (Vanderpol, Everly and Clarke, 2011).

III. Models

Since Mitchell's early 1970s CISD model, many iterations and variants have emerged. While the principal modifications are addressed below, it is important to emphasize that in today's world of increasingly complex systems and causal dependencies, no singular model can be expected to fit the subtleties demanded by every situation or individuals involved. Vanderpol et al. (2006) address this reality directly by encouraging practitioners to keep abreast of emerging research to enable the provision of robust services to individuals and organizations impacted by calamitous events.

Mitchell's Models CISD/CISM - The CISD Model, launched in the early 1970s, was initially designed for first responders such as firefighters, paramedics, and law enforcement personnel. Mitchell was the first to formulate a structured procedure utilized in group debriefings with this population. According to Mitchell (1983), CISD can best be characterized as a psycho-educational small "structured group story telling process combined with practical information to normalize group members" reactions to a critical incident and facilitate their recovery. A CISD session can take from 1 – 3 hours and is usually conducted 2-14 days post incident. In 1997 Everly and Mitchell published a paper expanding upon the earlier CISD model that became the

CISM Model specifying a seven stage systematic treatment approach addressing pre-crisis, acute-crisis, and post-crisis event phases.

CISD link: http://www.info-trauma.org/flash/media-e/mitchellCriticalIncidentStressDebriefing.pdf
CISM link: http://www.icisf.org/a-primer-on-critical-incident-stress-management-cism

Psychological Debriefing Model – PD is referred to as a structured group activity organized to review in detail the facts, thoughts, impressions, and reactions following a critical incident and to provide information on effective coping reactions (Dyregov, 1997). PD has developed over the years and now is considered a tool to use with either individuals or groups and encompasses a single session that may last one to several hours depending on the complexity of the situation. This session is generally held in the days soon after the incident and administered by a professional team specializing in medical services. The slight difference in PD and Mitchell's CISM Model seems to be that Mitchell actually formulated the structure and procedures to be followed in these group meetings — thus the elaborated seven-step format. Some of the controversy about the PD Model has been the question of when the appropriate time is for this particular service to be provided. Should PD take place immediately after the event, within 2 hours, 14 hours, or 30 days?

PD Link: http://www.debriefing.com/psychological-debriefing/

Psychological First Aid – (PFA) The term Psychological First Aid was first coined by Drayer, Cameron, Woodward, and Glass (1954) in a manuscript written for the American Psychiatric Association at the request of the US Federal Civil Defense Administration. PFA differs from CISD due to its practical coping skills approach, adherence to the assumption that most people are resilient, and that they will recover from a traumatic event if given basic support. Debriefing as a distinct process step is not a part of PFA in that the practitioner assumes more of a nurturing and supportive coaching capacity in assessing the situation, selecting and tailoring appropriate remedial approaches, and facilitating partnerships that promote resilience (Young, 2006).

PFA is an "evidence-informed" approach providing psychosocial support to individuals and families immediately after a disaster, terrorist or traumatic event, or other emergency. It consists of a set of helping actions, which are systematically undertaken in order to reduce initial post-trauma distress and to support short-term and long-term adaptive functioning and coping (Ruzek et al. 2007). PFA includes basic common sense principles to promote normal recovery. These are actions to help people feel safe and calm, connected to others, hopeful, and empowered to help themselves, access to physical resources, and emotional and social support. It is called "first aid" because it is the first thing helpers might think to offer disaster-affected people and commonly offered soon after a disaster (Australian Red Cross and Australian Psychological Society, 2010).
Link: http://www.who.int/mental_health/publications/guide_field_workers/en/

Seven Stage Crisis Intervention Model (R-SSCIM) – In 1991 Roberts described a systematic and structured conceptual framework for crisis assessment and intervention that facilitates planning for effective brief treatment in outpatient psychiatric clinics, community mental health centers, counseling centers, and crisis intervention settings. Roberts's R-SSCIM Model is the current approach used in heath-care and mental health settings to assist clinicians. This seven-stage crisis intervention approach facilitates the clinician's by emphasizing rapid assessment of the client's problem and available resources, collaborating on goal selection and attainment, considering alternative coping methods, developing a working alliance, and building

upon the client's strengths. Many if not most of those presenting at mental health clinics and hospital-based programs are in the midst of acute crisis and that was the reason for developing this particular model. Both the population where this model is used as well as the amount of time required to conduct the protocol are the main differentiators of this approach compared to the others mentioned in this paper. Another differentiator that Roberts notes is the importance of built-in evaluations, outcome measures, and performance indicators for all crisis intervention services and programs (Roberts and Otten, 2005).

Link: http://btci.edina.clockss.org/cgi/reprint/5/4/329

FBI – CISM Program - The FBI Critical Incident Response Group (CIRG) was established in 1994 to integrate tactical, negotiations, behavioral analysis, and crisis management resources into one cohesive organizational structure to facilitate the FBI's rapid response to critical incidents. The FBI indicates that approximately two-thirds of all police officers involved in shooting incidents experience significant emotional reactions. Typical responses include a heightened sense of danger, flashbacks, nightmares, intrusive imagery and thoughts, anger, guilt, sleep difficulties, withdrawal, depression, and stress symptoms. The FBI tailored their Critical Incident Stress Management (CISM) program to safeguard and promote the psychological well-being of FBI employees following traumatic experiences. Program participants include individuals from the FBI's Employee Assistance department, chaplains, peers, and mental health professionals with expertise in police psychology and trauma. The CISM program offers a continuum of interventions and services that incorporate both immediate and long-term support. One important item to note in the program description is the statement that no "psychological debriefing approach can interfere with the natural healing process".

FBI CISM Link: https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=176790

Multi-Systemic Resiliency Approach – In 2013, Intveld, after studying crisis intervention at the International Critical Incident Stress Foundation, as well as participating in numerous CIRs during his career in EAP, tailored this information into a book *EAP Critical Incident Response*, specifically for the Employee Assistance field. He identifies and expands upon five core principles:

1) assessing the interconnections between four key systems: employees, employer, critical incident responder and the EAP;

2) determining whether connections were historically problematic or recently disrupted by the critical incident;

3) connecting or re-connecting systems is best accomplished in a manner that is culturally congruent;

4) ensuring responders facilitate rather than interfere with naturally occurring trajectories of resilience and,

5) recognizing that organizational influences are as critical in promoting resilience as individual resilience.

Intveld Link: http://www.eap-rda.com

IV. Research

Since the 1994 Bisson study challenging the benefit and effectiveness of crisis intervention debriefing, numerous research studies and analytic reviews have investigated the question of efficacy of CISM interventions. These studies tend to fall into three categories: support for the importance of CISD/CISM; challenges to the effectiveness of this approach with some questioning if it is more harmful than helpful; and an emerging approach concentrated on bolstering people's resiliency as a way to help them return faster to their level of pre-event functioning. Teague et al. (2004) state that in order to measure effectiveness and crisis resolution, it is critical that outcome measures are clearly explained in behavioral and quantifiable terms. Use of a standardized set of performance indicators and granular measures should eventually lead to improved quality and effective crisis intervention services. Unfortunately, this author was unable to find any research studies that adhered to the criteria Teague recommends. However, the following is a sampling of what was discovered.

Everly & Mitchell Review (2000)

This paper reminds us that the foundation of all scientific inquiry is reliability. "Unfortunately, the field of emergency mental health, and crisis intervention has become unnecessarily complicated because of an imprecise and unreliable utilization of even the most fundamental of terms" (Everly and Mitchell, 2000, p. 211). Although enjoying a long and rich history (see appendix), the crisis intervention field is muddled by a lack of coherence in the use of language and lack of clarity in meaning.

Claims about the effectiveness of crisis intervention were first introduced in the literature in the early 1960s. Artis (1963) reported positive psychotherapeutic elements of immediacy, proximity and expectancy had been employed successfully in the military to increase the adjustment of American soldiers returning home from conflicts abroad. Bordow and Porritt (1979) demonstrated, through randomized experimental design, that multicomponent crisis intervention was superior to singular methods. While numerous studies challenge the effectiveness of CISD practice (McFarlane, 1988; Kenardy et al. 1996 and Rose et al. 2003), in each case there were methodological issues raised related to the lack of adherence to the accepted international standard in debriefing that arose from the CISD model.

In 1999 Everly and Boyle conducted a meta-analysis of five studies (Robinson and Mitchell, 1995; Nurmi, 1999; Wee et al. 1999; Bohl, 1991; and Jenkins 1996) all of which included control conditions. The results of the meta-analysis found cumulative evidence suggesting that the CISD model was clinically effective across applications. While debate and empirically tested re-examination is healthy in all forms of medically related interventions, the conflicting debate about the effectiveness of CISM seems to have taken on a political component interfering with the scientific process.

The Cochrane Collaboration (2009)

This 2009 report is the third update analyzing results from a single session psychological "debriefing" first reported by Bisson in 1997. The report challenges the empirical evidence for

the efficacy of psychological "debriefing" as a preventive measure. Researchers remark that while this form of intervention has become popular and spread to a variety of settings, an extensive review of the literature finds that there remains a lack of empirical evidence for its efficacy.

The latest literature review concentrates on persons recently (one month or less) exposed to a traumatic event. The intervention consisted of a single session only, and involved some form of emotional processing/ventilation, by encouraging recollection/reworking of the traumatic event, accompanied by normalization of emotional reaction to the incident. Their conclusions, after rigorous review of the literature (2009), was that no evidence could be found that single session individual psychological debriefing is a useful treatment for the prevention of post traumatic stress disorder for those experiencing a traumatic event (Bisson, 1997, Rose et al. 2003, and Nice, 2005).

It should be noted that the report does acknowledge that the available evidence of randomized trials of debriefing have all followed a broad definition of "debriefing". Implied is the assumption that there may be inadequate debriefing practices included in the data that have contributed to these results. Perhaps if a more prescribed debriefing protocol such as CISD/CISM were used for comparison, the research outcomes might be different. Until more rigorous research is conducted, there is currently no scientific support for effectiveness of the de-briefing intervention in the literature.

Bonanno, Westphal and Mancini (2011)

This research study, undertaken at Columbia University, used both traditional analytic tools and sophisticated latent trajectory modeling to identify a set of prototypical outcome patterns. The most common outcome they found is a stable trajectory of healthy functioning or resilience following what they label a **Post Traumatic Event (PTE).**

The study recognizes limitations of focusing on individual psychopathology and deep debriefing approaches and encourages the development of a broader research agenda emphasizing individual differences to outcomes across time. Bonanno et al. (2010) advance the notion of a more natural heterogeneity of human stress responses. The researchers were able to document that individuals with high levels of resilience experienced more transient symptoms, minimal impairment, and a relatively stable trajectory of healthy functioning soon after the PTE.

The growing interest in resilience among psychological researchers over the past decade has resulted in a broadening of research protocols and intervention agendas to include the possibility of positive outcomes in the face of adversity; as well as raising the question if a concentration on resilient-building interventions can actually make people more resilient. The authors fully admit limitations and pitfalls to this approach, yet urge continued systematic and thoughtful analysis of resilience outcomes in the face of trauma exposure..

Chan et al. (2012) published a paper on "Improving Resistance and Resiliency through Crisis Intervention Training." It includes a brief survey of students taking the Individual Crisis Intervention Stress Foundation (ICISF) course and found the students' levels of resistance and resiliency to improve. These results led the authors to ask whether organizations should view the training of their employees in life coping skills and crisis intervention practices as contributing to the overall resiliency of their organization?

Psychological First Aid (2012)

The Advisory Council of the American Red Cross Disaster Services requested an independent study be conducted to determine whether first-aid providers without professional mental health training, when confronted with people who have experienced a traumatic event, offer a "safe, effective and feasible intervention" when using the principles of Psychological First Aid. The commissioned research study only examined PFA when utilized in a large scale natural disaster or mass casualty event, not individual traumatic occurrences.

It was determined that while adequate scientific evidence for psychological first aid offered by non-professionals is lacking, the practice is widely supported by expert opinion and compassionate common sense. Perhaps the practice best fits the category of "evidence informed effectiveness" (Fox et al. 2010). Further outcome research is recommended.

Crisis Care Network (CCN) – Data Mining (2013)

Following the response to the US terrorist attacks of September 2001, requests for workplace critical incident response (CIR) services have continued to increase (Jacobson, 2006; Jacobson & Attridge, 2011). Employers often rely on their Employee Assistance Programs (EAPs) to provide and coordinate on-site and other CIR support services following a workplace crisis or traumatic event. In response to the increased number of service requests, EAPs have begun to collaborate with private companies that provide workplace CIR services such as Crisis Care Network (CCN).

In 2013 CCN in collaboration with Jodi Jacobson Frey, from the University of Maryland School of Social Work, conducted data mining of five years of EAP case management notes from 132 EAP organizations in the US offering approximately 32,000 CIR Services. There were two main findings. The first was that there were primarily three types of traumatic events that occurred when CCN was called to provide intervention services. They were:

1. employee death — both natural or accidental
2. bank robberies — both with and without weapons
3. layoffs or downsizing announcements

The second and perhaps most important finding "suggests that a successful CIR as defined by the end user — has as much to do with business objectives as it does with clinical efficacy" (Gorter et al. 2015, p.12). CCN data mining results shift the focus from an entirely clinical intervention designed to address pathology toward one that facilitates natural resilience — reducing dysfunction and a return to pre-incident functioning (Gorter et al. 2015). Data mining was the first step in CCN's process of documenting the efficacy of their interventions in a more empirically strong manner.

Workplace Trauma Studies – DeFraia (2013)

Attridge and Vanderpol (2010) point out the lack of significant research performed on the effectiveness of CIR regarding organizational issues. A few have examined the issues of disability claims (Smith and Rooney, 1999) and legal exposure and risk management issues (Tehrani, 2012). Far less attention has been given to the impact of such events on organizations.

CISM units have been established within some external EAP programs to support both individuals and organizations. Studies in the literature tend to focus on individual emotional stress reactions and this focus has lead to a more individual clinical treatment approach as opposed to organizational interventions. In 2013, DeFraia conducted an exploratory study of an EAP-based CISM unit's data over a 20-year period (1990-2010). The unit typically responded to 3,000 critical incidents/year, which translated to approximately 60,000 incidents that were explored. Due to an inability to find a scale to accurately assess the severity level of an incident, they developed the Critical Incident Severity Index Scale (CrISIS – R) (DeFraia, 2013).

The intent of the analysis was to examine how critical incident severity levels vary among disparate types of incidents. Clinical data mining (similar to the CCN methodology) was utilized to generate "evidence-informed" practice recommendations for other EAP-based CISM units. These recommendations included the following areas: intake assessment, organizational consultation and incident response planning.

An example of the results from this study was that disasters, which are destructive on a large scale, had the highest mean incident severity score, as did criminal acts, suggesting that both these types of critical events require strong organizational attention and response. Illness, death, and even organizational lay offs had lower scores indicating that while these events are stressful, there is less dysfunction at the organizational level.

V. Discussion

As we have briefly reviewed, crisis intervention has a long history of people from all walks of life responding to helping individuals, organizations, communities, and even countries cope and recover from various catastrophes, critical events, and natural disasters.

The questions facing practitioners and researchers are many. Is there a particular model that is more effective for particular troubling events and populations? Should bank and retail robberies be handled differently than deaths in the workplace (Gorter et al. 2015)? Is there a more nuanced approach that would be more flexible and effective in responding to individuals, organizations, cities, and countries? Perhaps a pragmatic approach to seeking consensus answers to these questions is to focus on developing consistent and universal terms to assist in reliability both in terms of clinical application and research ventures.

The second theme revolves around the question of how best to prove the effectiveness of these interventions. That process will be greatly assisted when a consensus is reached on definitions of terms. Until then, research in crisis intervention cannot easily follow the gold standard of randomized control trials (RCT) due to the quick onset as well as the vulnerability of the individuals impacted by the event. Perhaps a place to start is to initially define **what** practitioners want measured and for what purposes. Once the what to be measure is identified, it will be easier to move on to the **when** or timing of the intervention while also being sensitive to not re-traumatize individuals. Then finally the field can move forward on better defining the **how** or what particular methods will be used to collect the necessary data.

The bottom line questions is: What is the best way to gather appropriate data in a sensitive manner, minimize prolonging the traumatic experience, while also obtaining accurate and relevant information to assist in evaluating the effectiveness and efficiency of the intervention.

VI. Conclusion and Next Steps

Both the CCN historical analysis and the development of the CrISIS-R scale are great initial steps towards documenting trends in the CIR world. It is important that the EAP field understand it's role in critical incident response in contrast to that of first responders. Intveld (2015) has contributed greatly to the better understanding of the specific EAP role in critical incidents; and, DeFraia (2013) reminds us to pay greater attention to both the organization and individual client. However, more is needed. Practitioners, researchers, corporations, and EAP professionals need to have a conversation to articulate clearer goals as to the variables to study in this arena. The need exists to identify what can be offered, to whom, in what timeframe, with robust and reproducible outcomes to learn if we have accomplished our goals. The field needs to continue to identify trends about which services are requested, whether services are requested for individuals or corporations or both, hours utilized, and finally outcome evaluation data to refine the process of developing empirical benchmarks.

Next Steps:

1) Standardizing the use of service practice terms, definitions, and meanings

2) Understanding the nuances of what type of service is needed for a given type of crisis event (robbery, death in the workplace, layoff, terrorist attack, natural disaster)

3) Building on the CCN data analysis trends by requesting additional data sources

4) Gaining a consensus in the field on type of service approach appropriate for a given event for both the individual employees and the organization as a whole

5) Developing a more robust assessment and effectiveness measurement model

6) Increasing training of EAP Professionals particularly in the area of resiliency

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Appendix

HISTORICAL MILESTONES IN CRISIS INTERVENTION & DISASTER MENTAL HEALTH

- World War I - the first empirical evidence that early intervention reduces chronic psychiatric morbidity;
- World War II - the processes of proximity, immediacy, and expectancy identified as important "active ingredients" in effective emergency psychological care
- 1944 - Lindemann's observations of grief reactions to the Coconut Grove fire begins "modem era" of crisis intervention;
- late 1950s - community suicide prevention programs proliferated;
- 1963/64 - Caplan's three tiers of preventive psychiatry delineated and implemented within the newly created community mental health system (primary, secondary, tertiary prevention)
- late 1960s/early1970s - crisis intervention principles applied to reduce the need for hospitalization of potentially "chronic" population
- 1966 at the University of Texas, Charles Whitman shot and killed 16 people from a clock tower on campus until he was ultimately shot by the police.
- 1980 - formal nosological recognition of posttraumatic stress disorder (PTSD) in DSM-Ill "legitimizes" crisis and traumatic events as threats to long-term mental health;
- 1982 - Air Florida 90 air disaster in Washington DC prompts reexamination of psychological support for emergency response personnel; first mass disaster use of the group crisis intervention Critical Incident Stress Debriefing (CISD) which as originally formulated in 1974 by Mitchell (1983);
- 1986 - "violence in the workplace" era begins with death of 13 postal workers;
- 1989 - International Critical Incident Stress Foundation (ICISF) formalizes an international network of over 350 crisis response teams trained in a standardized and comprehensive crisis intervention model referred to as Critical Incident Stress
- Management (CISM); ICISF gains United Nations affiliation in 1997;
- 1980s – National Organization for Victims Assistance (NOVA) provides crisis intervention and psychosocial support for crime victims and extends services to disaster victims
- 1992 - American Red Cross initiates formal training for the establishment of a nationwide disaster mental health capability; Hurricane Andrew tests new mental health function;
- 1993 - Social Development Office (Amiri Diwan), ICISF, Kuwait University, et al., implement a nationwide crisis intervention system for post-war Kuwait;
- 1994 - DSM-IV recognizes Acute Stress Disorder; emphasizes impairment criterion in PTSD
- 1995 - Bombing of the Federal Building in Oklahoma City underscores need for crisis services for rescue personnel, as well as civilians;
- 1996 - TWA 800 mass air disaster emphasizes the need for emergency mental health services for families of the victims of traumas and disasters;
- 1996 - OSHA 3148-1996 recommends comprehensive violence/crisis intervention in social service and healthcare settings;

Historical Moments (Cont)

- 1997 - Gore Commission recommends crisis services for airline industry;
- 1998 - OSHA 3153-1998 recommended crisis intervention programs for late-night retail stores;
- late 1990s – Salvation Army initiates emotional and spiritual care for disaster
- April, 1999 – 14 students including two shooters are killed at Columbine High School in Littleton, Colorado
- 2001 – Terrorist attacks at the Pentagon and World Trade Center in NYC reveal unique challenges of mass disasters in dense urban settings and those associated with mass terrorism
- 2002 – two snipers terrorize the northern Virginia and Washington, DC areas; the use of electronic town meetings emerges as a risk communication crisis intervention
- 2003-2007 – war in Afghanistan & Iraq challenges military to develop new crisis intervention (combat stress control)
- August 2005 - Hurricane Katrina becomes one of the deadliest and the most costly natural disaster in American history; a putative failure in leadership leads to delayed and inadequate disaster response
- On April 16, 2007 the deadliest shooting in U.S. history occurred at Virginia Polytechnic Institute and State University. Thirty-three students and faculty members including the shooter were killed and at least twenty-one others were injured.
- 2007 – The United Nations adopts an integrated multi-component critical incident stress management approach as the overarching intervention system for the psychosocial support of its own field personnel thereby recognizing the importance of providing such support, as well as endorsing an integrated multi-component intervention systems' formulation
- 2012 Hurricane Sandy - a late-season post-tropical cyclone, swept through the Caribbean and up the East Coast of the United States in late October 2012. The storm left dozens dead, thousands homeless and millions without power. Total damage is expected to be in the billions of dollars.
- 2012 – Sandy Hook Elementary School Shootings occurred December 14, in Newtown Connecticut when a 20 year old Adam Lanza fatally shoot 20 children and 6 adult Staff members. The incident was the deadliest mass shooting at a high school in US history and the second-deadliest mass shooting by a single person – other than the Virginia Tech shooting in 2007
- 2013 – Boston Marathon Bombing - was a terrorist attack, followed by subsequent related shootings, that occurred when two pressure cooker bombs exploded during the Boston Marathon on April 15, 2013. The bombs exploded about 12 seconds and 210 yards (190 m) apart at 2:49 pm EDT, near the marathon's finish line on Boylston Street. They killed 3 people and injured an estimated 264 others.
- 2015 Nepal Earthquake – In April 2015 *Nepal earthquake* (also known as the Gorkha earthquake) killed more than 9,000 people and injured more than 23,000. It occurred at 11:56 NST

Courtesy of George Everly

Everly, G. & Mitchell, J. (1999) Critical Incident Stress Management (CISM)

1.	Pre-crisis preparation.	Pre-crisis phase.	Crisis anticipation.	Set expectations, Improve coping, Stress management.	Groups/ Organizations.
2a	Demobilizations & staff consultation (rescuers).	Shift disengagement.	Event driven.	To inform and consult, allow psychological decompression. Stress management.	Large groups/ Organizations.
2b.	Crisis Management Briefing (CMB) (civilians, schools, business).	Anytime post-crisis.			
3.	Defusing.	Post-crisis (within 12 hours).	Usually symptom driven.	Symptom mitigation. Possible closure. Triage.	Small groups.
4.	Critical Incident Stress Debriefing (CISD)	Post-crisis (1 to 10 days; 3-4 weeks mass disasters)	Usually symptom driven; can be event driven.	Facilitate psychological closure. Sx mitigation. Triage.	Small groups.
5.	Individual crisis intervention (1:1).	Anytime, Anywhere.	Symptom driven	Symptom mitigation. Return to function, if possible. Referral, if needed.	Individuals.
6.	Pastoral Crisis Intervention.	Anytime, Anywhere.	Whenever needed.	Provide spiritual, faith-based support.	Individuals/ Groups.
7a.	Family CISM.	Anytime.	Either symptom driven or event driven.	Foster support & communications. Symptom mitigation. Closure, if possible. Referral, if needed.	Families/ Organizations.
7b.	Organizational consultation.				
8.	Follow-up/Referral.	Anytime.	Usually symptom driven.	Assess mental status. Access higher level of care, if needed.	Individual/ Family.

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Psychological First Aid (PFA)

What is Psychological First Aid?
Psychological First Aid (PFA) is an evidence-informed approach that is built on the concept of human resilience. PFA aims to reduce stress symptoms and assist in a healthy recovery following a traumatic event, natural disaster, public health emergency, or even a personal crisis.

Why use PFA?
Emotional distress is not always as visible as a physical injury, but is just as painful and debilitating.

After going through a life altering experience it is common to be effected emotionally.

- Everybody who experiences a disaster is touched by it
- Reactions manifest differently at different periods of time during and after the incident.

Some common stress reactions include:

- Confusion
- Fear
- Feelings of hopelessness and helplessness
- Sleep problems
- physical pain
- anxiety
- Anger
- Grief
- Shock
- Aggressiveness
- Withdrawal
- Guilt
- Shaken religious faith
- Loss of confidence in self or others.

While Physical First Aid is used to reduce physical discomfort due to a bodily injury, Psychological First Aid is a strategy to reduce the painful range of emotions and responses experienced by people exposed to high stress

The Goal of PFA
The goal of Psychological First Aid is to create and sustain an environment of:

1) Safety
2) Calm & Comfort
3) Connectedness
4) Self-Empowerment, and
5) Hope

Psychological First Aid addresses basic needs and reduces psychological distress by providing a caring comforting presence, and education on common stress reactions. It empowers the individual by supporting strengths and encouraging existing coping skills. It also provides connections to natural support networks, and referrals to professional services when needed.

Psychological First Aid is tool that each of us can use to reduce our stress level. By understanding your stress reactions and utilizing Psychological First Aid principles, you can enhance resilience in yourself, your family, workplace, and community.

Related Apps:

PFA Mobile: http://www.ptsd.va.gov/professional/materials/apps/pfa_mobile_app.asp

CERTIFICATION IN CRITICAL INCIDENT STRESS MANAGEMENT (CISM)

The CISM Certification examination will be available on June 1, 2015.

Overview - PRACTICE IS GROUNDED IN KNOWLEDGE

CISM is most accurately defined as an integrated multi-component continuum of psychological interventions to be provided in the context of acute adversity, trauma, and disaster on an as needed basis to appropriate recipient populations. CISM is not a singular technique nor a treatment for acute stress disorder, posttraumatic stress disorder, posttraumatic depression, or bereavement and grief.

The CISM Certification, offered in partnership by UMBC's Department of Emergency Health Services and UMBC Training Centers, is the world's first university-based certification in the field of Critical Incident Stress Management (CISM) and psychological crisis intervention.

The goal of the certification is to foster enhanced knowledge about crisis intervention and disaster response from the CISM perspective. In doing so it is hoped that research and practice shall be fostered as well. Certification is a certification of KNOWLEDGE, not practice per se, relevant to CISM and crisis intervention and disaster response. However, we believe that better practice is based upon increased knowledge.

The certification is EXAMINATION-based, which will be delivered online and will be in an open-book format.

CISM Certification is for:

- Emergency responders
- Mental health clinicians
- Public health personnel
- Disaster responders
- Educators
- Clergy
- Employee assistance professionals
- CERT team members and others who are interested in demonstrating knowledge in CISM.
- Organizations who desire to promote and ensure a fundamental and standardized knowledge base among its personnel who respond to crisis and trauma.

Website: http://cism.umbctraining.com/

Fostering Resilience after a Critical Incident

Critical Incidents are those events that have the power to overwhelm our usually effective coping skills. Surviving natural disasters such as hurricanes or man-made disasters such as acts of terrorism and criminal acts can be devastating and leave us feeling helpless, and disorientated. Sudden losses or events creating unexpected lifestyle changes, like a layoff, can equally be impactful. *If in our experience with these types of events,* ***our interpretations*** *were ones where we felt threatened, or those who are significant to us are threatened, we are likely to have a normal, but strong stress response.* One where our physiological survival skills are heighten in order to achieve safety from the threat. Afterwards, the release of such a powerful stress hormone may contribute in experiencing physical, emotional psychological and behavioral reactions. **Our reactions to such events are normal** and in time generally begin to fade away.

For the majority of us, these stress reactions will not be as intense, but there may be some challenges in our journey to bounce back. If your interpretation of the event was life threatening, know that the reactions listed in the left hand column are normal and can be the after-effects of such a powerful stress response. Using the tips that foster resiliency in the right hand column will aide in your return to a state of well-being.

Normal Reactions to Traumatic Events

Physical Responses

- Change in sleep patterns
- Change in appetite
- Shallow, rapid breathing
- Dizziness
- Headaches
- Muscle Tension
- Increased heart rate
- Stomach upset

Emotional Responses

- Shock or numbness
- Anger toward others involved
- Fear
- Guilt/Frustration
- Sadness
- Feeling unsafe or vulnerable
- Loneliness

Psychological Responses

- Confusion
- Difficulty concentrating
- Difficulty remembering details of event

Behavioral Responses:

- Withdrawal from others
- Angry Outbursts
- Crying
- Irritability
- Decreased energy/ambition
- Marital/relationship conflict
- Increased use of alcohol or medications

Tips to Foster Resilience

- **Believe in your abilities to bounce back**
- Care for yourself by eating well, exercising, and resting when needed.
- If you are on medication, continue on your prescriptions and schedule an appointment with your Dr.
- Seek out comfortable, familiar surroundings that promote a sense of safety.
- Share your experience with significant persons who are supportive and optimistic.
- Share your thoughts and feelings with those who are supportive and helpful -It helps to talk or write about them and keep your mood clear.
- Work on beginning to accept what has happened.
- Give yourself time to rebound. It is not a good time to make a life changing decision.
- Set a forward thinking positive goal for yourself and/or family member
- Return to or create daily routines for yourself and family.
- If you are spiritual, seek guidance
- Find your sense of humor. It is helpful to laugh especially during challenging times.
- It is normal that your body responds to sensory triggers. Sights, sounds, and odors may stir memories and reactions.
- Find/renew or recommit your purpose in life
- Consider consultation from a professional counselor if you feel stuck
- **Commit to succeed! So many do.**