“The fate of the wounded rests in the hands of the ones who apply the first dressing.”

Nicholas Senn, 1898 (Former President of AMA)
What Is A Crisis?

“Crisis:

- An acute emotional reaction to a powerful stimulus or demand. A state of emotional turmoil. Three characteristics of crisis: The usual balance between thinking and emotions is disturbed; the usual coping mechanisms fail; there is evidence of impairment in the individual or group involved in the crisis.”

Jeffrey Mitchell, P.hD

Situations That Can Lead to a Crisis

“Everyone has experiences that make them feel upset, disappointed, or fatigued. When these types of feelings are combined with certain life events or situations, they often lead to mounting tension and stress. Five types of situations have been identified that may produce stress and, in turn, contribute to a state of crisis. Types of client crisis situations presented in the CSO are typically related to the following:

- Family Situations - a child abuse investigation, spouse abuse, an unplanned pregnancy, a parent’s desertion, a chronically ill family member, and lack of social supports are examples of family situations that can create stress and crises.
- Economic Situations - sudden or chronic financial strain is responsible for many family crises, such as loss of employment, eviction, no food, a theft of household cash or belongings, high medical expenses, missed child support payments, repossession of a car, utilities cut off from service, money ‘lost’ to gambling or drug addiction, and poverty.
- Community Situations - neighborhood violence, inadequate housing, a lack of community resources, and inadequate educational programs illustrate some ways the community may contribute to family crises.
- Significant Life Events - events that most view as happy, such as a marriage, the birth of a child, a job promotion, or retirement, can trigger a crisis in a family; a child enrolling in school, the behaviors of an adolescent, a grown child leaving the home, the onset of menopause, or the death of a loved one can also be very stressful life events.
- Natural Elements - crises are created by disasters such as floods, hurricanes, fires, and earth quakes, or even extended periods of high heat and humidity, or gloomy or excessively cold weather.”

www.dshs.wa.gov/manuals/socialservices/sections/CrisisInter.shtml
**Four Causes of Stress Injury**

- **Life Threat**: A traumatic injury due to an experience of death-provoking terror, horror or helplessness.
- **Loss**: A grief injury due to the loss of cherished people, things or parts of oneself.
- **Inner Conflict**: A moral injury due to behaviors or the witnessing of behaviors that violate moral values.
- **Wear & Tear**: A fatigue injury due to the accumulation of stress from all sources over time without sufficient rest and recovery.

**More on the Stress Injuries**

- **Life Threat/Traumatic Injury**: “I think I’m going to die or someone close to me is going to die.”
- **Loss/Grief Injury**: death, divorce, job loss, status loss, etc.
- **Inner conflict/Moral Injury**: “This it isn’t right; God abandoned me; I’ve been wronged by the agency;” etc.
- **Wear and Tear Injury/Fatigue**: burnout, cumulative incidents, cumulative stress, etc.

fls113.everyonegoeshome.com/stress-first-aid.html
## Stress Continuum Model

<table>
<thead>
<tr>
<th>READY (Green)</th>
<th>REACTING (Yellow)</th>
<th>INJURED (Orange)</th>
<th>ILL (Red)</th>
</tr>
</thead>
</table>
| **DEFINITION** | • Optimal functioning  
• Adaptive growth  
• Wellness | • Mild and transient distress or impairment  
• Always goes away  
• Low risk | • More severe and persistent distress or impairment  
• Leaves a scar  
• Higher risk |
| **FEATURES** | • At one’s best  
• Well-trained and prepared  
• In control  
• Physically, mentally and spiritually fit  
• Mission-focused  
• Motivated  
• Calm and steady  
• Having fun  
• Behaving ethically | • Feeling irritable, anxious or down  
• Loss of motivation  
• Loss of focus  
• Difficulty sleeping  
• Muscle tension or other physical changes  
• Not having fun | • Clinical mental disorder  
• Unhealed stress injury causing life impairment |
| **CAUSES** | • Any stressor | | |

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## Critical Incidents and Stress

**“Critical Incidents:”**
- Powerful traumatic events that initiate the crisis response. These events are usually outside of the usual range of normal human experiences on the job or in one’s personal life. Examples are line of duty deaths or serious injury to operations personnel. Child deaths, multiple casualty events and severe threats to emergency personnel are also classified as “critical incidents”.

**Critical Incident Stress:**
- A state of cognitive, physical, emotional and behavioral arousal that accompanies the crisis reaction. The elevated state of arousal is caused by a critical incident. If not managed and resolved appropriately, either by oneself or with assistance, it may lead to several psychological disorders including Acute Stress Disorder, Post Traumatic Stress Disorder, Panic Attacks, Depression, Abuse of Alcohol and Other Drugs, etc.

*Jeffrey Mitchell, PhD*
Crisis Intervention – What is it?

Crisis Intervention:
➢ “Emergency psychological care aimed at assisting individuals in a crisis situation to restore equilibrium to their bio-psychosocial functioning and to minimize the potential for psychological trauma.”
   en.wikipedia.org/wiki/Crisis_intervention

Crisis Intervention:
➢ “TEMPORARY, but ACTIVE and SUPPORTIVE entry into the life of individuals or groups during a period of extreme distress. ‘Emotional First Aid.’” Jeffrey Mitchell, PhD

Basic Tenants of Crisis Intervention
➢ “Identify a Crisis and Act
   ➢ Take a quick inventory of the situation;
   ➢ Identify the type of crisis;
   ➢ Take action;
   ➢ Attempt to defuse situation and/or reassure the client;

➢ Once the situation is calm:
   ➢ Identify and contact available community resources in your area that can assist the client through the crisis
   ➢ Document events to the extent possible, maintaining confidentiality when required.

➢ Maintain your professional skills and resources:
   ➢ Identify and post information about available community resources. Keep that information available to all clients and staff.
   ➢ Seek additional training opportunities when available.”
   www.dshs.wa.gov/manuals/socialservices/sections/CrisisInter.shtml
Goals and Principles

“Goals of Crisis Intervention:
- Mitigate impact of event (lower tension)
- Facilitate normal recovery processes, in normal people who are having normal reactions to abnormal events
- Restoration to adaptive function

Principles of Crisis Intervention:
- Simplicity – People respond to simple not complex in a crisis
- Brevity – Minutes up to 1 hour in most cases (3-5 contacts typical)
- Innovation – Providers must be creative to manage new situations
- Pragmatism – Suggestions must be practical if they are to work
- Proximity – Most effective contacts are closer to operational zones
- Immediacy – A state of crisis demands rapid intervention
- Expectancy – The crisis intervener works to set up expectations of a reasonable positive outcome”

Jeffrey Mitchell, PhD

Societal Influences on the Development of Crisis Intervention

- Religion
- Warfare
- Disasters
- Medicine
- Law enforcement
- Emergency Medical Services
- Psychiatry / Psychology

Jeffrey Mitchell, PhD
Crisis Intervention and Providers

- Different interventions tools are used for individuals vs. groups.

Providers of Crisis Intervention:
- Although some Psychiatry / Psychology is crisis oriented, most frequently crisis intervention is provided by firefighters, emergency medical or search and rescue personnel, police officers, physicians, nurses, soldiers, clergy, hospital workers, communications personnel and community members."

Jeffrey Mitchell, P.hD

Who Uses Multi-Tactic Early Intervention Programs?

- “American / International Red Cross
- National Organization of Victims Assistance
- Salvation Army
- Community Crisis Centers
- Crisis Hot Lines
- Hospitals
- Clergy
- United Auto Workers
- Amtrak
- Airlines
- American Academy of Experts in Traumatic Stress
- International Critical Incident Stress Foundation
- National and International Disaster Relief Agencies
- Police Departments
- Fire Services
- Emergency Medical Services Organizations throughout the world
- School systems
- United States Army; United States Air Force
- United States Navy; United State Marine Corps
- United States Coast Guard
- Federal Aviation Administration
- United States Department of Agriculture
- Environmental Protection Agency
- The United Nations
- Federal Bureau of Investigation
- Secret Service
- US Marshals Service
- Bureau of Alcohol, Tobacco, and Firearms
- Federal Emergency Management Agency
- Homeland Security (many branches)
- Numerous other organizations, agencies and private practitioners"

Jeffrey Mitchell, P.hD
History of Organized and Systematic Crisis Intervention:

“Note: Crisis intervention is often referred to as ‘early intervention’

- 1906 Edwin Sterlin – Mining disaster in Europe
- 1917 Thomas Salmon – Battlefields of World War I
- 1943 Eric Lindermann – Coconut Grove fire Boston, MA
- 1960’s Gerald Caplan – Contributed most of the modern crisis intervention theory
- 1970’s - The field of CISM begins in 1974. It is a subset of crisis intervention. It shares the same goals, principles and interventions.
- 1980 and 90’s - refinements to the CISM field”

Jeffrey Mitchell, P.hD

Some Widely Recognized Models

- National Organization for Victim Assistance (NOVA)
- Crisis Incident Stress Management (CISM)
- Psychological First Aid (PFA)
- Mental Health First Aid (MHFA)
- Stress First Aid (SFA)
National Organization for Victim Assistance (NOVA, 1975)

- Created to serve victims of crime and crisis
- Requires a minimum of 3 day basic training
- Basic training includes basic trauma information, group intervention techniques, death notification, effects of long term stress, dealing with media, cultural nuances
- Creates and deploys Crisis response Teams (CRTs) as requested
- NOVA CRT members are certified as same

Critical Incident Stress Management (CISM, 1983)

“The mission of the International Critical Incident Stress Foundation, Inc. is to provide leadership, education, training, consultation, and support services in comprehensive crisis intervention and disaster behavioral health services to the emergency response professions, other organizations, and communities worldwide.”

Jeffrey Mitchell, PhD
Critical Incident Stress Management:

- CISM is designed to help people deal with their trauma one incident at a time, by allowing them to talk about the incident when it happens without judgment or criticism.
- The program is peer-driven and the people giving the treatment may come from all walks of life, but most are first responders or work in the mental health field.
- All interventions are strictly confidential, the only caveat to this is if the person doing the intervention determines that the person being helped is a danger to themself or to others.
- The emphasis is always on keeping people safe and returning them quickly to more normal levels of functioning.
- Normal is different for everyone, and it is not easy to quantify.
- Critical incidents raise stress levels dramatically in a short period of time and after treatment a new normal is established, however, it is always higher than the old level. The purpose of the intervention process is to establish or set the new normal stress levels as low as possible.

Wikipedia, the free encyclopedia

“A comprehensive, systematic and integrated multi-tactic crisis intervention approach to manage critical incident stress after traumatic events. CISM is a coordinated program of tactics that are linked and blended together to alleviate the reactions to traumatic experiences.” Jeffrey Mitchell, PhD

CISM Focus

- “The primary focus in the field of CISM is to support staff members of organizations or members of communities which have experienced a traumatic event.
- What CISM does not share with the field of crisis intervention is the range of the populations served.
- For example, CISM does not focus on primary victims such as auto accident victims, dog bite victims, women suffering post-partum depression, women who have lost a child in a miscarriage, child abuse victims, substance abusers, victims of elder abuse or sexual assault victims all of whom are typically served through various other crisis intervention programs.
- Should primary victims with those concerns come into contact with CISM trained personnel, the best course of action is a referral to appropriate crisis intervention or psychotherapy resources which are beyond the central focus and capabilities of most CISM teams.”

Jeffrey Mitchell, PhD
Critical Incident Stress Management (CISM): The Seven Core Components
(Adapted from: Everly and Mitchell, 1997)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Timing</th>
<th>Activation</th>
<th>Goals</th>
<th>Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-crisis preparation</td>
<td>Pre-crisis phase</td>
<td>Anticipation of crisis.</td>
<td>Set expectations, improve coping, stress management</td>
<td>Group</td>
</tr>
<tr>
<td>Defusing</td>
<td>Post-crisis (within 12 hours)</td>
<td>Usually symptom driven.</td>
<td>Symptom mitigation. Possible closure. Triage.</td>
<td>Small Group</td>
</tr>
<tr>
<td>Critical Incident Stress Debriefing (CISD)</td>
<td>Post-crisis (1 to 7 days)</td>
<td>Usually symptom driven. Can be event driven.</td>
<td>Facilitate psychological closure. Symptom mitigation. Triage.</td>
<td>Small Group</td>
</tr>
<tr>
<td>Family CISM</td>
<td>Anytime.</td>
<td>Either symptom driven or event driven.</td>
<td>Foster support, communications. Symptom mitigation. Closure, if possible. Referral, if needed.</td>
<td>Families, Organizations</td>
</tr>
<tr>
<td>Follow-up, referral</td>
<td>Anytime.</td>
<td>Usually symptom driven.</td>
<td>Assess mental status. Access higher level of care.</td>
<td>Individual, Family</td>
</tr>
</tbody>
</table>

Debriefing

- Although many have co-opted the debriefing process for use with other groups, the primary focus in the field of CISM is to support staff members of organizations or members of communities which have experienced a traumatic event. The debriefing process (defined by the International Critical Incident Stress Foundation [ICISF]) has seven steps:
  1. introduction of intervenor and establishment of guidelines and invites participants to introduce themselves (while attendance at a debriefing may be mandatory, participation is not);
  2. details of the event given from individual perspectives;
  3. emotional responses given subjectively;
  4. personal reaction and actions;
  5. followed again by a discussion of symptoms exhibited since the event;
  6. instruction phase where the team discusses the symptoms and assures participants that any symptoms (if they have any at all) are a normal reaction to an abnormal event and “generally” these symptoms will diminish with time and self-care;
  7. following a brief period of shared informal discussion (generally over a beverage and treat) resumption of duty where individuals are returned to their normal tasks.

The intervenor is always watching for individuals who are not coping well and additional assistance is offered at the conclusion of the process.

Wikipedia, the free encyclopedia
Debriefing – the Controversy

“Debriefing was found to be at best, ineffective, and at worse, harmful. There are several theories as to why debriefing increased incidents of PTSD.

1. First, those who were likely to develop PTSD were not helped by a single session.

2. Second, being re-exposed too soon to the trauma could lead to retraumatization. Exposure therapy in cognitive behavioral therapy (CBT) allows the person to adjust to the stimuli before slowly increasing severity. Debriefing did not allow for this.

3. Also, normal distress was seen to be pathological after a debriefing and those who had been through a trauma thought they had a mental disorder because they were upset. Debriefing assumes that everyone reacts the same way to a trauma, and anyone who deviates from that path, is pathological. But there are many ways to cope with a trauma, especially so soon after it happens.”

The Controversy Continues

➢ “This article does not advocate a blanket rejection of CISD because it seems to help some people. What is suggested is use of the medical model where the process is assessment, diagnosis, and then treatment. Consider physical medicine where insulin that can be a lifesaver for diabetics can kill people with low blood sugar. Likewise, targets of mental interventions need to be similarly differentiated. CISD ran into trouble because it was universally applied for many years and no attempt was made to differentiate the resilient from the vulnerable.”

Carl V. Rabstejnek www.HOUD.info
Psychological First Aid (PFA, 2006)

For Disaster Responders To Deliver To The Community

- "Developed jointly with the National Child Traumatic Stress Network, PFA is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism: to reduce initial distress, and to foster short- and long-term adaptive functioning.

- It is for use by first responders, incident command systems, primary and emergency health care providers, school crisis response teams, faith-based organizations, disaster relief organizations, Community Emergency Response Teams, Medical Reserve Corps, and the Citizens Corps in diverse settings."


Psychological First Aid (PFA)

"PFA seems to address many of the issues in debriefing.

- It is not compulsory and can be done in multiple sessions and links those who need more help to services.

- It deals with practical issues which are often more pressing and create stress.

- It also improves self efficacy by letting people cope their own way.

- PFA has attempted to be culturally sensitive, but whether it is or not has not been shown.

However, a drawback is the lack of empirical evidence. While it is based on research it is not proven by research. Like the debriefing method, it has become widely popular without testing.

NC-PTSD
Psychological First Aid

According to the NC-PTSD, psychological first aid is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism to reduce initial distress and to foster short and long-term adaptive functioning. It was used by non-mental health experts, such as responders and volunteers. Other characteristics include non-intrusive pragmatic care and assessing needs. PFA does not necessarily involve discussion of the traumatic event.

Components:
- Protecting from further harm
- Opportunity to talk without pressure
- Active listening
- Compassion
- Addressing and acknowledging concerns
- Discussing coping strategies
- Social support
- Offer to return to talk
- Referral

Overview of PFA

Preparing to Deliver Psychological First Aid
1. Preparation
2. Entering the setting
3. Providing services
4. Group settings
5. Maintain a calm presence
6. Be sensitive to culture and diversity
7. Be aware of at-risk populations

Contact and Engagement
1. Introduce yourself/ask about immediate needs
2. Confidentiality

Safety and Comfort
1. Ensure immediate physical safety
2. Provide information about disaster response activities and services
3. Attend to physical comfort
4. Promote social engagement
5. Attend to children who are separated from their parents/caregivers
6. Protect from additional traumatic experiences and trauma reminders
7. Help survivors who have a missing family member
8. Help survivors when a family member or close friend has died
9. Attend to grief and spiritual issues
10. Provide information about casket and funeral issues
11. Attend to issues related to traumatic grief
12. Support survivors who receive death notification
13. Support survivors involved in body identification
14. Help caregivers confirm body identification to a child or adolescent

Stabilization
1. Stabilize emotionally-overwhelmed survivors
2. Orient emotionally-overwhelmed survivors
3. The role of medications in stabilization

Information Gathering: Current Needs and Concerns
1. Nature and severity of experiences during the disaster
2. Death of a loved one
3. Concerns about immediate post-disaster circumstances and ongoing threat
4. Separations from or concern about the safety of loved ones
5. Physical illness, mental health conditions, and need for medications
6. Losses (home, school, neighborhood, business, personal property, and pets)
7. Extreme feelings of guilt or shame
8. Thoughts about causing harm to self or others
9. Availability of social support
10. Prior alcohol or drug use
11. Prior exposure to trauma and death of loved ones
12. Specific youth, adult, and family concerns over developmental impact
Overview of PFA, cont’d

Practical Assistance
1. Offering practical assistance to children and adolescents
2. Identify the most immediate needs
3. Clarify the need
4. Discuss an action plan
5. Act to address the need

Connection with Social Supports
1. Enhance access to primary support persons (family and significant others)
2. Encourage use of immediately available support persons
3. Discuss support-seeking and giving
4. Special considerations for children and adolescents
5. Modeling support

Information on Coping
1. Provide basic information about stress reactions
2. Review common psychological reactions to traumatic experiences and losses
   - Intrusive reactions, Avoidance and withdrawal reactions
   - Physical arousal reactions, Trauma reminders, Loss reminders
   - Change reminders, Hardships, Grief reactions, Traumatic grief reactions, Depression, Physical reactions
3. Talking with children about body and emotional reactions
4. Provide basic information on ways of coping
5. Teach simple relaxation techniques
6. Coping for families
7. Assisting with developmental issues
8. Assist with anger management
9. Address highly negative emotions
10. Help with sleep problems
11. Address alcohol and substance use

Linkage with Collaborative Services
1. Provide direct link to additional needed services
2. Referrals for children and adolescents
3. Referrals for older adults
4. Promote continuity in helping relationships

Mental Health First Aid (MHFA, 2008 in the US)

What is Mental Health First Aid (MHFA)?

- MHFA is a public education program that can help individuals across the community to understand mental illnesses, support timely intervention, and save lives.
- MHFA is an 8-hour course that introduces participants to risk factors and warning signs of mental health concerns, builds understanding of their impact, and overviews common treatments.
- The course uses role-playing and simulations to demonstrate how to assess a mental health crisis; select interventions and provide initial help; and connect persons to professional, peer and social supports as well as self-help resources.
- MHFA allows for early detection and intervention by teaching participants about the signs and symptoms of specific illnesses like anxiety, depression, schizophrenia, bipolar disorder, eating disorders, and addictions.
- The program offers concrete tools and answers key questions like “What can I do?” and “Where can someone find help?”
- Participants are introduced to local mental health resources, national organizations, support groups, and online tools for mental health and addictions treatment and support.

The National Council for Behavioral Health
What All MHFA Participants Learn

- Overview of mental health problems
  - Depression/Mood disorders
  - Anxiety disorders
  - Disorders in which psychosis can occur (Schizophrenia, Bi Polar, Depression)
  - Substance use disorders
  - Eating disorders

- Mental Health First Aid for crisis situations

- Mental Health First Aid for non-crisis situations
Mental Health First Aid

The Action Plan

- Assess for risk of suicide or harm
- Listen non-judgmentally
- Give reassurance and information
- Encourage appropriate professional help
- Encourage self-help and other support strategies

Stress First Aid (SFA, 2012)

- Created by the National Fallen Firefighters Foundation (NFFF)
- Modeled After Programs of the National Center for Post Traumatic Stress Disorder
- “Stress First Aid is designed to reduce the risk for stress reactions in fire and rescue personnel.
- It recognizes quickly those individuals who are reacting to a wide range of stressors in their work and personal lives, and are in need of interventions to promote healing.
- SFA offers a spectrum of one-on-one or group interventions to ensure safety, reduce the risk for more severe stress reactions and to promote recovery.
- SFA monitors the progress of recovery to ensure return to full function and well-being.
- SFA bridges individuals to higher levels of care as needed.
- SFA training discusses the principles of peer teams in the fire service and how they can be organized to promote healing.”

NFFF
What Is SFA?

A flexible multi-step process for the timely assessment and preclinical response to psychological injuries ...

...in individuals or units with the goals to preserve life, prevent further harm and promote recovery

NFFF

When is SFA Needed?

When stress injury results in behavior or statements indicating:

- Impaired or diminished role function such as Firefighter, Spouse, Parent, Friend
- No longer feeling like normal self
- Excessive guilt, shame or blame
- Panic, anger or depression
- Loss of control

NFFF
Functions of SFA

SFA is designed to:
- Reduce the risk for stress reactions
- Continuously monitor stress levels
- Recognize quickly those who are reacting to a wide range of stressors
- Offer a spectrum of interventions
- Monitor progress of recovery
- Bridge individuals to higher levels of care when needed

NFFF

Essential SFA Skills

1. Recognize when a peer has a stress injury
2. If you see something, say something
3. Know at least 2 trusted resources you would offer to a peer in distress

NFFF
**SFA Core Principles**

- Recovery is promoted by augmenting, restoring and leveraging leadership, peer support and unit cohesion
- SFA occurs wherever and whenever it is needed
- SFA is individualized care, not one-size-fits all
- SFA is an ongoing process
- SFA requires a collaborative team effort

_NFFF_
“The fate of the wounded rests in the hands of the ones who apply the first dressing.”

Nicholas Senn, 1898  (Former President of AMA)

Questions?

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