Chapter 10
Crisis Intervention and Psychological First Aid

Throughout this text, we have discussed the body and mind's continuing struggle to maintain homeostasis. As the body struggles to maintain a physical homeostasis (Cannon, 1932), or "steady state," the mind struggles to maintain a similar balance. As a medical crisis is a state wherein physiological homeostasis has been disrupted with resultant physical distress and dysfunction, we then see the possibility of a psychological analogue. A psychological crisis is a *response* to a critical incident or distressing event wherein the individual's psychological balance has been disrupted. There is, in effect, a psychological disequilibrium. This disequilibrium results because the individual's usual coping mechanisms have failed. The predictable result is the emergence of evidence of acute psychological or behavioral distress coupled with some degree of functional impairment.

More practically speaking, a crisis may be defined as a state of acute distress wherein one's usual coping mechanisms have failed in the face of a perceived challenge or threat and there results some degree of functional impairment (see Caplan, 1961, 1964). This description argues more for an acute stress management-based intervention platform rather than traditional psychotherapeutic engagements. In 1952, F. C. Thorne wrote

> In our opinion, … preoccupation with depth psychology [psychotherapy] has had a very detrimental effect in causing us to overlook presenting complaints which may be very distressing to the client and about which he urgently wishes us to do something … Prophylactically, it is probable that many disorders could be nipped in the bud if prompt attention could be given to germinating seeds which may later grow into tall oaks … Diagnostically, one of our problems is to identify these emergency situations so that we can discriminate what needs to be done immediately…Therapeutically, much will be gained if the client can be made more comfortable even though no deep cure can be effected by first aid methods (Thorne, 1952, p. 210).

In this chapter, we shall examine crisis intervention and its popular subset psychological first aid (PFA) as interventions that target acute distress seeking stabilization and acute mitigation rather than resolution and therapeutic growth.

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Crisis Intervention

The natural corollary of a psychological crisis is psychological crisis intervention (hereafter referred to as crisis intervention). The term crisis intervention may be thought of as urgent psychological/behavioral care designed to first stabilize, then reduce symptoms of distress/dysfunction so as to achieve a state of adaptive functioning; or, to facilitate access to continued care, when necessary.

Crisis intervention is sometimes confused with counseling and psychotherapy. The P-I-E principles, derived and currently adapted from military psychiatry (Artiss, 1963; Salmon, 1919), may assist in this differentiation. P-I-E represents the defining characteristics of crisis intervention:

P—proximity (the provision of services wherever needed),
I—immediacy (urgency; rapid intervention as close to the emergence of adverse reactions as possible),
E—expectancy (the view that the current state of disequilibrium is a result of a current perturbation; therefore, the goal of intervention is to address that current reaction, not cure any pre-existing psychiatric syndrome, even if it is present). Perhaps a useful way of conceptualizing crisis intervention is in the context of medical therapeutics. "As physical first aid is to surgery, crisis intervention is to psychotherapy."

Simply stated, the goals of crisis intervention should include (1) stabilization and mitigation of the individual's symptoms of acute distress, (2) restoration of a more "steady state" of psychological functioning (i.e., psychological homeostasis), and (3) reduction of the level of manifest functional impairment, that is, to assist the person in returning to an adaptive level of functioning (see Artiss, 1963; Caplan, 1964; Neil, Oney, DiFonso, Thacker, & Reichart, 1974). When the goal of restoration of adaptive independent functioning is not deemed to be obtainable, it becomes the responsibility of the crisis interventionist to move the individual in crisis to a more advanced level of psychological care. It should be remembered that the focus of the intervention is always the present crisis reaction. Pre-existing problems are attended to only as so far as they contribute to the current crisis.

In a 1982 study of Israeli soldiers, Solomon and Benbenishty (1986) investigated the core crisis intervention principles of proximity, immediacy, and expectancy. Their investigation revealed that all three were positively correlated with returning to the fighting unit. Further analyses revealed that immediacy and expectancy were correlated inversely with the development of posttraumatic stress disorder. "The effects of proximity, immediacy, and expectancy seem to be interrelated … the findings of this study clearly demonstrate the cumulative effect of implementing all three treatment principles" (Solomon & Benbenishty, 1986, p. 616). Most importantly, however, are the implications of the 20-year longitudinal follow-up by Solomon et al. (2005). The study evaluated the long-term effectiveness of the frontline interventions provided to combat stress reaction casualties. Using a longitudinal quasi-experimental design, the same combat stress reaction casualties of

the 1982 Lebanon War who received frontline treatment ($N = 79$) were compared to matched combat stress reaction casualties who did not receive frontline treatment ($N = 156$), and other soldiers who did not experience combat stress reaction ($N = 194$). Twenty years after the war, traumatized soldiers who received frontline crisis intervention, following the core principles of proximity, immediacy, expectancy, had lower rates of posttraumatic and psychiatric symptoms and reported better social functioning than similarly exposed soldiers who did not receive frontline intervention. The cumulative effect of the core crisis principles was documented in that the more principles applied, the stronger the effect. The authors conclude, "Frontline treatment is associated with improved outcomes even two decades after its application. This treatment may also be effective for nonmilitary precursors of posttraumatic stress disorder" (p. 2309).

In the wake of a terrorist mass casualty disaster, Boscarino, Adams, & Figley, (2005) conducted a random sample of 1681 New York adults interviewed by telephone at 1 year and 2 years after 9/11. Results indicate that crisis interventions had a beneficial impact across a variety of outcomes, including reduced risks for binge drinking, alcohol dependence, PTSD symptoms, major depression, somatization, anxiety, and global impairment, compared with individuals who did not receive these interventions. A follow-up analysis (Boscarino et al.), found that 1–3 sessions of brief crisis intervention were useful at reducing various forms of distress from mass disasters.

Boscarino, Adams, Foa, & Landrigan (2006) utilized a propensity score analysis of brief worksite crisis interventions after the World Trade Center disaster. In a prospective cohort design of 1121 employees, 150 received interventions. Interventions consisted of 1–3 brief interventions by a mental health clinician. Results indicated that the brief post-disaster interventions yielded positive outcome up to 2 years post-disaster in the forms of reduced depression, alcohol dependence, PTSD severity, and anxiety.

Boscarino, Adams, & Figley (2011) found that brief community-based crisis intervention was actually superior to traditional multi-session psychotherapeutic approached when applied after the World Trade Center disaster. Even more interestingly, the traditional multi-session cohort tended to get worse with time, not better. These findings raise serious doubts about the application of traditional multi-session therapeutics post-disaster.

Everly et al. (2006) employed a systematic statistical review of experimental and quasi-experimental research on workplace-based crisis intervention programs. Nine studies were identified that met inclusion criteria for further analysis. Results suggest that the workplace can be a useful platform from which to provide crisis intervention programs (overall effectiveness measured in the Cohen's d statistic expressed in standard deviations = 1.53; $d = 0.60$ with assaults removed from the analysis). More specifically, evidence was found that crisis intervention programs could reduce specific undesirable factors in the workplace:

- Posttraumatic distress: mean effect size: 0.65
- Assaults: mean effect size: 3.68

- Alcohol use: mean effect size: 0.83
- Depression: 0.81
- Anxiety: 0.98

Lastly, Stapleton, Lating, Kirkhart, and Everly (2006) in a meta-analytic review found brief crisis intervention effective in reducing stress, depression, and anxiety among medical patients. A meta-analysis of 11 studies ($N = 2124$) investigating the impact of individual crisis intervention with medical patients yielded a significant, overall moderate effect size, $d = 0.44$. The strongest effect of individual crisis intervention was on posttraumatic stress symptoms ($d = 0.57$) and anxiety symptoms ($d = 0.52$). Specific moderating factors, such as single versus multiple sessions, single versus multiple components of intervention, and level of interventionists' training, were also analyzed. The results support the use of a brief multi-session approach to intervention. The interventionist having received specific training in crisis intervention almost doubled the effectiveness of the intervention. This latter finding suggests that crisis intervention and acute disaster mental health interventions should be applied only after receiving specialized training therein.

A Systems Approach to Crisis and Disaster

In 1986, Australian psychiatrist Beverley Raphael wrote most cogently on the need for a multitude of psychosocial services, including PFA, in the wake of disaster (Raphael, 1986). In 1990, the British Psychological Society's Working Party wisely argued that psychosocial disaster services needed to be multi-component in nature, rather than a single one-off intervention applied without consideration for the situation or the recipient population (British Psychological Society's Working Party, 1990). Mitchell (1983) and Mitchell and Everly (2000) argued for an even more highly integrated combinatorial program to insure the potency of the intervention. Bordow and Porritt (1979) were presumably the first to actually demonstrate, in a well-controlled investigation, the dose–response potency of combined crisis intervention technologies (also see Solomon & Benbenishty, 1986; Solomon, Shklar, & Mikulincer, 2005).

The most widely used integrated crisis intervention and disaster response system in the world is Critical Incident Stress Management (CISM). As defined by Everly and Mitchell in 1999 and most recently in 2017 (Everly & Mitchell, 1999, 2017), Critical Incident Stress Management (CISM) represents an integrated and comprehensive multi-component approach to the provision of crisis intervention and disaster mental health services. More specifically, CISM is a framework by which the psychosocial aspects of crisis and disaster may be described, analyzed, and responded to. Operationally, CISM is an integrated multi-component continuum of crisis and disaster intervention services (Everly & Mitchell, 2017; Everly &

Langlieb, 2003) consisting of myriad of tactical elements including, but not restricted to, pre-disaster preparedness, acute assessment of need, individual crisis intervention, small group crisis intervention, psychological triage, large group crisis intervention, and follow-up assessment.

The CISM formulation is actually broader and more comprehensive in scope than the historical applications of crisis intervention and is more consistent with Caplan's comprehensive (1961, 1964) formulations of preventive psychiatry (Mitchell & Mitchell, 2006). CISM may be considered an emergent continuum of care. Specifically, CISM embodies:

1. Primary prevention (i.e., the identification and mitigation of pathogenic stressors)
2. Secondary prevention (i.e., the identification and mitigation of acute distress and dysfunctional symptom patterns)
3. Tertiary prevention (i.e., follow-up mental health treatment and rehabilitation services).

The core tactical elements of the CISM model consist of:

1. Pre-incident strategic planning and preparedness as a form of psychological "inoculation" (to enhance "resistance")
2. Surveillance and field assessment/triage capabilities
3. Crisis intervention with individuals (face-to-face or telephonically), including PFA
4. Crisis intervention with small groups
5. Crisis intervention with large groups >20
6. Leadership and incident command consultation
7. Pastoral or spiritually based crisis intervention
8. Establishment of mechanisms for follow-up and referral for continued care.

So as crisis intervention and disaster mental health interventions have become more tactically sophisticated, there has been an emergent need for planning and strategic application expertise as well. A prescriptive framework for strategic planning will be introduced in the next chapter.

Despite its demonstrated value for almost 100 years, the field of psychological crisis intervention is not without controversy. Well-intentioned but methodologically flawed efforts to assess the effectiveness of group crisis interventions such as critical incident stress debriefing (CISD) led to the rise of many misconceptions and inappropriate conclusions regarding early psychological crisis intervention in general, and "debriefings," in particular (British Psychological Society, 2015; Dyregrov & Regel, 2012; Everly & Mitchell, 2000). The misconceptions, often cited in sometimes unreliable secondary and tertiary sources, seemed self-sustaining and reached the stature of urban mythology according to Atle Dyregrov and Stephen Regel (Dyregrov & Regel, 2012), as well as others (British Psychological Society, 2015; Hawker et al., 2010; Tuckey, 2007). According to Dyregrov &

Regel (2012), much of the misunderstanding and subsequent debates around CISD/PD are based on two studies, summarized in the Cochrane Review (Rose, Bisson, Churchill, & Wessely, 2002). These studies have subsequently been challenged, if not discredited the minds of some, in that they employed inappropriate samples and used interventions that lacked internal validity: "Both studies have since been demonstrated not only to have methodological flaws, but also not to have given adequate training to those carrying out the PD interventions…. This inevitably has caused significant confusion not only in terminology, but also in the areas of research, practice, and policy. This lack of clarity and understanding in the terminology surrounding early interventions has subsequently influenced the literature on what works best and for whom, and confusion in this area has reigned for over a decade" (Dyregrov & Regel, 2012, p. 272).

The findings of the British Psychological Society (2015) echo the aforementioned:

> The debriefing debate has been raging ever since the publication of the Cochrane Review. As has been argued cogently by colleagues in the chapters above, it seems that the findings of this review are fundamentally flawed. There is a problem with holding up RCT evidence as the gold standard in the hierarchy of evidence when the RCTs utilized have not used optimal sampling or methodology to examine the issue in question. There are further problems with extrapolating the findings to make recommendations which exceed the findings on which they are based. In this case, it is now very transparent that a procedure that had been designed to improve the social cohesion of emergency workers that have trained together, worked together and expect to face trauma together, was misapplied and used in situations for which it was never intended and administered by people who had never been intended to administer it, delivering it in ways in which it was never intended that it should be delivered. No wonder, then, that these studies produced the results that they did, no wonder that the Cochrane Review's findings reported what they did, and no wonder still that the misleading press coverage and knee jerk responses that led to the blanket bans on its use that emerged subsequently (p. 70).

Despite the fact that subsequent publication of data from randomized investigations with higher internal validity were highly supportive of CISM (Boscarino et al., 2005, 2011) and group crisis intervention, specifically CISD (Adler, Bliese, McGurk, Hoge, & Castro, 2009; Adler et al., 2008; Deahl et al., 2000; Tuckey & Scott, 2014), misconceptions lingered (see Regel & Dyregrov, 2012, for a thorough discussion).

To make matters even more problematic, CISM is commonly confused with terms and concepts such as "debriefing," critical incident stress debriefing (CISD), and "psychological debriefing" all of which represent various tactical interventions that may or may not be applied within a strategic continuum of care such as CISM (Robinson, 2007; Tuckey, 2007), but clearly are not synonyms for the CISM-like continua of care which reviews generally recommend (Jacobson, Paul, & Blum 2005; Regel, 2010). In 2017, CISD was recognized by the U.S. Substance Abuse and Mental Health Administration (SAMHSA) as a promising evidence-based intervention.

Psychological First Aid

A brief review of current literature on crisis intervention and disaster mental health reveals differing points of view on the methods that should be employed, however (Raphael, 1986; NIMH, 2002). Nevertheless, there appears to be virtual universal endorsement, by relevant authorities, of the value of acute "psychological first aid" (American Psychiatric Association, 1954; DHHS, 2004; Institute of Medicine, 2003; NIMH, 2002; Raphael, 1986; WHO, 2003).

In 1944, a curriculum was developed to implement PFA in the US Merchant Marine (Blain, Hoch, & Ryan, 1944). This was the first known widely used curriculum in PFA. In 1954, the American Psychiatric Association published the monograph titled *Psychological First Aid in Community Disasters* (APA, 1954). That document therein defined and argued for the development of an acute mental health intervention in the "Cold War" era. This early exposition noted,

> In all disasters, whether they result from the forces of nature or from enemy attack, the people involved are subjected to stresses of a severity and quality not generally encountered…It is vital for all disaster workers to have some familiarity with common patterns of reaction to unusual emotional stress and strain. These workers must also know the fundamental principles of coping most effectively with disturbed people. Although [these suggestions have] been stimulated by the current needs for civil defense against possible enemy action… These principles are essential for those who are to help the victims of floods, fires, tornadoes, and other natural catastrophes (APA, 1954, p. 5).

This document delineated three important points:

1. The constituents of PFA consist of the ability to recognize common (and one might assume uncommon) reactions post-disaster.
2. The constituents of PFA further consist of the fundamentals of coping.
3. That ALL disaster workers should be trained, not just mental health clinicians.

More recently, the Institute of Medicine (2003) has written,

> In the past decade, there has been a growing movement in the world to develop a concept similar to physical first aid for coping with stressful and traumatic events in life. This strategy has been known by a number of names but is most commonly referred to as psychological first aid (PFA). Essentially, PFA provides individuals with skills they can use in responding to psychological consequences of [disasters] in their own lives, as well as in the lives of their family, friends, and neighbors. As a community program, it can provide a well-organized community task to increase skills, knowledge, and effectiveness in maximizing health and resiliency (IOM, 2003, p. 4–5).

Raphael, in her seminal clinical treatise (1986) suggests that PFA consists of the following:

1. Comfort and consolation.
2. Physical protection.
3. Provision of physical necessities.
4. Channeling energy into constructive behaviors.

5. Reuniting victims with friends and family.
6. Provision of behavioral and/or emotional support, especially during emotionally taxing tasks.
7. Allowing emotional ventilation.
8. Re-establishing a sense of security.
9. Utilization of acute social and community support networks.
10. Triage and referral for those in acute need.
11. Referral to sub-acute and on-going support networks.

Everly and Flynn (2005) attempted to provide further guidance into the nature of PFA by defining PFA as a compassionate and supportive presence designed to stabilize and mitigate acute distress. They enumerated the core elements as:

1. Assessment of need for intervention (level one assessment) [Note that the present use of the term "assessment" is not intended to refer to formal mental health assessment per se, rather, it is designed to refer more to an appraisal of functional psychological and behavioral status.].
2. Stabilize—Subsequent to an initial assessment and determination that intervention of some form is warranted, act so as to prevent or reduce a worsening of the current psychological or behavioral status.
3. Assess and triage (level two assessment)—Once initial stabilization has been achieved, further assessment is indicated with triage as a viable option. Assessment of functionality is the most essential aspect of this phase.
4. Communicate—Communicate concern, reassurance, and information regarding stress management.
5. Connect—Connect the person in distress to informal and/or formal support systems, if indicated.

At the Johns Hopkins' Center for Public Health Preparedness (CPHP), the following set of guidelines for the practice of PFA was developed. The model is referred to as the RAPID PFA model (Everly & Lating, 2017). The RAPID PFA model was developed specifically for utilization by individuals with little or no formal mental health training to assist both primary and secondary survivors. The Hopkins RAPID PFA approach has been validated through both content validation and clinical trial (see Everly & Lating, 2017).

The RAPID PFA model, then, is designed to be taught to public health personnel as well as emergency services and disaster response personnel (educators, administrators, and first-line supervisors could also be trained in PFA). These individuals can then be the functional platform for surveillance, stabilization, and triage. More formal mental health services would be applied subsequent to the PFA as part of the over continuum of care. Such a framework will also serve to allow mental health clinicians to attend to those requiring more advanced clinical intervention. The elements of RAPID PFA are briefly outlined below:

1. *R*eflective listening of
    - The event or critical incident
    - Personal reactions sustained
2. *A*ssessment of need (Maslow's hierarchy)
    - Medical
    - Physical
    - Safety
        - Ability to function so as to discharge daily responsibilities
3. *P*rioritize—Triage benign distress versus malignant dysfunctional reactions
4. *I*ntervention—Brief cognitive-behavioral interventions
    - Education: Explanatory (Use "Fight–Flight") and/or Anticipatory Guidance
    - Acute Cognitive/Behavioral Refocusing/Re-orienting
    - Deep Breathing/Relaxation
    - Cognitive Reframing
        - Correction of Errors in Fact
        - Disputing Illogical Thinking
        - Challenging Catastrophic Thinking
        - Instillation of a Future Orientation…Hope
    - Delay Making Any Life-altering Decisions/Changes
    - *Caution! Do* Not Interfere With Natural Recovery Processes
5. *D*isposition: Assess that person can adequately function. If person is unable to adequately function, the interventionist should serve as advocate/liaison for further support using friends, family, community, or workplace resources
    - Identify relevant resources
    - Make initial contacts, as appropriate
        - Follow-up, as indicated.

Research specifically with the Johns Hopkins RAPID model of psychological first aid has shown:

1. Psychological First Aid (PFA) can increase the belief in one's personal resilience and preparedness, as well as enhance community resilience (Everly, McCabe, Semon, Thompson, & Links, 2014; McCabe, Semon, Lating, et al. 2014; McCabe, Semon, Thompson, et al. 2014).
2. RAPID PFA has been shown to reduce acute anxiety (Everly, Lating, Sherman, & Goncher, 2016).

Summary

In this chapter, we have reviewed the concepts of crisis intervention and the most recent variation thereof, "psychological first aid" (PFA). To summarize:

1. From both the acute clinical and public health preparedness perspectives, crisis intervention and its subset of acute PFA represent a potentially valuable skill set that is easily applied, not only in the wake of disasters but also on a daily basis responding to the crises of everyday living. Arguably, wherever there is a need for the application of physical first aid, there can be a need for the application of acute crisis intervention technologies.
2. "[A] acute distress following exposure to traumatic stressors is best managed following the principles of psychological first aid. This entails basic, non-intrusive pragmatic care with a focus on listening but not forcing talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing company from significant others; and protecting from further harm. This type of aid can be taught quickly to both volunteers and professionals" (Sphere Project, 2004, p. 293).
3. Boscarino et al. (2011) found that brief community-based crisis intervention was actually superior to traditional multi-session psychotherapeutic approached when applied after the World Trade Center disaster.
4. At the Johns Hopkins' Center for Public Health Preparedness (CPHP), set of guidelines for the practice of PFA was developed which conformed to the Centers for Disease Control and Prevention (CDC) recommendations. The model is referred to as the RAPID PFA model. The RAPID PFA model (Everly & Lating, 2017) was developed specifically for utilization by individuals with little or no formal mental health training to assist both primary and secondary survivors. Thus it would seem to be almost "ideal" for training "peer support" personnel in high-risk occupations such as law enforcement, fire suppression, emergency medicine, disaster response, and the military.

   The elements of RAPID PFA are briefly outlined below:

1. Reflective listening
2. Assessment of need
   - Medical
   - Physical
   - Safety

   Ability to function so as to discharge daily responsibilities
3. Prioritize—triage by urgency benign distress versus malignant dysfunctional reactions
4. Intervention—brief cognitive-behavioral interventions
5. Disposition: Assess that person can adequately function or assist in accessing continued care. Follow-up, as indicated.

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