

Continuing Education

Crisis Intervention: A Review

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ABSTRACT: *Critical incidents are sudden, unexpected, often life-threatening time-limited events that may overwhelm an individual's capacity to respond adaptively. Frequently, extreme critical incident stressors may result in personal crises, traumatic stress, and even Posttraumatic Stress Disorder. This paper presents a concise, fully-referenced, state-of-the-art review of crisis intervention procedures within the context of Critical Incident Stress Management (CISM; Everly & Mitchell, 1999; Flannery, 1999) [International Journal of Emergency Mental Health, 2000, 2(2), 119-125].*

KEY WORDS: Crisis; crisis intervention; Critical Incident Stress Management (CISM); disaster

The field of crisis intervention is predicated upon the existence of the phenomenon of psychological crisis. Because crisis intervention is the natural corollary of the psychological crisis, this review begins with a definition of the crisis phenomenon.

The Nature of a Crisis

A crisis occurs when a stressful life event overwhelms an individual's ability to cope effectively in the face of a perceived challenge or threat (Auerbach & Kilmann, 1997; Everly & Mitchell, 1999; Raphael, 1986; Sandoval, 1985; Schwartz, 1971; Wollman, 1993). More specifically, a crisis may be thought of as a response condition wherein:

- 1) psychological homeostasis has been disrupted;
- 2) one's usual coping mechanisms have failed to reestablish homeostasis; and,
- 3) the distress engendered by the crisis has yielded some evidence of functional impairment (Caplan, 1961, 1964; Everly & Mitchell, 1999). If a crisis is a response, then what term defines the stressor event?

The term "critical incident" is a term which is frequently confused with the term crisis. Contrary to the crisis response, a critical incident may be thought of as any stressor event

that has the potential to lead to a crisis response in many individuals. More specifically, the critical incident may be thought of as the stimulus that sets the stage for the crisis response.

Of particular importance to emergency mental health (EMH) are extreme stressor critical incidents such as disasters and human acts of violence that may result in psychological trauma and Posttraumatic Stress Disorder (PTSD; American Psychiatric Association, 1994; Everly & Lating, 1995; Flannery, 1994, 1995). Traumatic crises or critical incidents may occur in the face of actual or threatened death, serious injury, or some other threat to the victim's physical integrity. Individuals may also be victimized by witnessing these events occurring to others (American Psychiatric Association, 1994). Crises may also emerge as the result of a contradiction to some deeply held belief (Everly & Lating, 1995).

Frequently, victims of these traumatic events experience disruptions in reasonable mastery of the environment, in caring attachments to others, and in sustaining a purposeful meaning in life (Butcher, 1980; Flannery, 1994; Raphael, 1986; Sandoval, 1985; Wollman, 1993). Victims may also experience the common symptoms of hypervigilance, sleep disturbance, intrusive recollections of the event, and a tendency to withdraw from full participation in daily activities (Butcher, 1980; Flannery, 1994, 1998; Mitchell & Everly, 1996). The impact of traumatic events may be profound and may last until death if these events are left untreated [See this journal, Continuing Education Series: *Psychological trauma and Posttraumatic Stress Disorder: A review* (1999, 1, 135-140)

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for a complete discussion of these matters].

Crisis Intervention: A Definition

Over the years, crisis intervention has proven an effective, front-line intervention for victims of all types of critical incidents, especially the extreme stressors that may result in psychological trauma (Everly, Flannery, & Mitchell, 2000; Everly & Mitchell, 1999). Crisis intervention is defined as the provision of emergency psychological care to victims as to assist those victims in returning to an adaptive level of functioning and to prevent or mitigate the potential negative impact of psychological trauma. (Everly & Mitchell, 1999).

Crisis intervention procedures have evolved from the studies of grieving conducted by Erich Lindemann (1944) in the aftermath of a major nightclub conflagration, from the military writings of Kardiner and Spiegel (1947) on the three basic principles in crisis work—immediacy of interventions, proximity to the occurrence of the event, and the expectancy that the victim will return to adequate functioning—and Gerald Caplan’s emphasis (1964) on community mental health programs that emphasize primary and secondary prevention.

Therefore, in sum, intervention should be the natural corollary of the nature of the given problem. As such, the term “crisis intervention” should parallel the conceptualization of the term crisis. Consistent with the formulations of Caplan (1961, 1964), crisis intervention may be thought of as urgent and acute psychological intervention. The hallmarks of these first interventions are:

- 1) immediacy,
- 2) proximity,
- 3) expectancy, and,
- 4) brevity.

Furthermore, the goals of crisis intervention are:

- 1) stabilization, i.e., cessation of escalating distress;
- 2) mitigation of acute signs and symptoms of distress; and,
- 3) restoration of adaptive independent functioning, if possible; or, facilitation of access to a higher level of care.

Crisis Intervention: Basic Principles

While there is no one single model of crisis intervention (Jacobson, Strickler, & Mosley, 1968), there is common agreement on the general principles to be employed by EMH practitioners to alleviate the acute distress of victims, to restore independent functioning and to prevent or mitigate

the aftermath of psychological trauma and PTSD (Butcher, 1980; Everly & Mitchell, 1999; Flannery, 1998; Raphael, 1986; Robinson & Mitchell, 1995; Sandoval, 1985; Wollman, 1993).

1. INTERVENE IMMEDIATELY. By definition, crises are emotionally hazardous situations that place victims at high risk for maladaptive coping or even for being immobilized. The presence onsite of EMH personnel as quickly as possible is paramount.

2. STABILIZE. One important immediate goal is the stabilization of the victims or the victim community actively mobilizing resources and support networks to restore some semblance of order and routine. Such a mobilization provides the needed tools for victims to begin to function independently.

3. FACILITATE UNDERSTANDING. Another important step in restoring victims to pre-crisis level of functioning is to facilitate their understanding of what has occurred. This is accomplished by gathering the facts about what has occurred, listening to the victims recount events, encouraging the expression of difficult emotions, and helping them understand the impact of the critical event.

4. FOCUS ON PROBLEM-SOLVING. Actively assisting victims to use available resources to regain control is an important strategy for EMH personnel. Assisting the victim in solving problems within the context of what the victim feels is possible enhances independent functioning.

5. ENCOURAGE SELF-RELIANCE. Akin to active problem-solving is the emphasis on restoring self-reliance in victims as an additional means to restore independent functioning and to address the aftermath of traumatic events. Victims should be assisted in assessing the problems at hand, in developing practical strategies to address those problems, and in fielding those strategies to restore a more normal equilibrium.

Crisis Intervention: Agents of Change

Although the beneficial outcomes in crisis intervention may be due to traditional agents of change such as group cohesion, catharsis, imitative behavior, and the sharing of information (Yalom, 1985), authors who study crisis intervention procedures (Busutill et al., 1995; Everly & Mitchell, 1997; Flannery, 1998; Pennebaker, 1990, 1993, 1999; Raphael, 1986; Shalev, 1994; Tehrani & Westlake, 1994; Wollmann, 1993) have proposed with remarkable unanimity three factors considered important as agents of change in

crisis procedures: ventilation and abreaction, social support, and adaptive coping.

An ability to share the negative emotional impact of a traumatic event is seen as an important step in recovery. Being able to share the horror of these critical incidents permits the victim to share the fear, understand the impact of the event, and begin the process of independent functioning. Similarly, social support networks provide victims with support, companionship, information, and instrumental assistance in beginning again. Adaptive coping is the third likely agent of change, and includes both cognitive and behavioral skills with an emphasis on information gathering, cognitive appraisal, reasonable expectations of performance, and skill acquisition.

These three agents of change may be attained in the five principles noted above, and should guide the efforts of EMH practitioners.

Crisis Intervention: Critical Incident Stress Management

A relatively new term that has emerged in the crisis intervention literature within the last decade is “Critical Incident Stress Management.” (CISM; Everly & Mitchell, 1999; Flannery, 1999). CISM is a comprehensive crisis intervention system consisting of multiple crisis intervention components which functionally span the entire temporal spectrum of a crisis. CISM interventions range from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. CISM is also considered comprehensive in that it consists of interventions which may be applied to individuals, small functional groups, large groups, families, organizations, and even entire communities.

As currently evolved, CISM (Everly & Mitchell, 1999) includes numerous core elements: 1) pre-crisis preparation; 2) large scale demobilization procedures for public safety personnel as well as large group crisis management briefings for civilian victims of terrorism, mass disaster, community crises, school system tragedies and the like; 3) individual acute crisis intervention; 4) brief small group discussions, called defusings to assist in acute symptom reduction; 5) longer small group discussions known as Critical Incident Stress Debriefings (CISD; Mitchell & Everly, 1996); 6) family crisis intervention procedures; 7) organizational development interventions; and, 8) referrals for additional psychological assessment and treatment where indicated.

CISM (Everly & Mitchell, 1999) allows the EMH practitioner to tailor the intervention response to individual or organizational needs and is emerging as the international standard of care for victims.

Variations of the CISM model have been adopted by numerous and diverse organizations in a wide variety of workplace settings including the Federal Aviation Administration (FAA), the United States Air Force, the United States Coast Guard, the US Secret Service, the Federal Bureau of Investigations (FBI), the Bureau of Alcohol, Tobacco, and Firearms (ATF), the Airline Pilots Association (ALPA), the Swedish National Police, the Association of Icelandic Rescue Teams, the Australian Navy, and the Massachusetts Department of Mental Health.

Crisis Intervention: Research Findings

Single Interventions

The evaluation of CISM actually began, historically, with a narrowly focused evaluation of psychological debriefings, choosing to extract the debriefing process from the overall multifaceted CISM formulation.

While some studies (e.g., Bisson, Jenkins, Alexander, & Bannister, 1997; Kenardy, Webster, Levin, Carr, Hazzell, & Cater, 1996; McFarlane, 1988) have found either partial or no support for debriefing interventions, many of these studies have had serious methodological research issues. In some studies, the type of debriefing interventions is not clear, the training of the EMH providers is not described, and the tools used to evaluate the effectiveness of the debriefing interventions are inadequate. In some cases, the effectiveness of the debriefing was measured several months after the debriefing was provided, a period of time in which the victims could have been exposed to additional traumatic events. As an addendum, it should be noted that a recent and oft-cited paper, referred to as the Cochrane Review (Wessley, Rose, & Bisson, 1998), has called for the cessation of “mandatory debriefing” as a crisis intervention. It is important to note that 1) the Review actually failed to assess the group debriefing process known as CISD, the evidence cited was based upon “individual” debriefings clearly not the industry standard, and 2) the Review failed to assess CISM or any other multicomponent CISM-like system.

Given these methodological shortcomings, it would be inaccurate to generalize from singular CISD investigations so as to reach any conclusion regarding CISM. Nevertheless,

as recent meta-analytic reviews have demonstrated (Everly, Boyle, & Lating, 1999; Everly and Boyle, 1999; Everly and Piacentini, 1999) when the intervention model is clear, when the EMH personnel are correctly trained, and the assessment procedure for effectiveness is adequate, then even a limited array of crisis intervention procedures are found to be effective in helping victims (Bohl, 1991; Bordow & Porritt, 1979; Brom, Kleber, & Hofman, 1993; Bunn & Clark, 1979; Chemtob, Tomas, Law & Cremmiter, 1997; Flannery, 1998; Hokanson, 1997; Jenkins, 1996; Leeman-Conley, 1996; Nurmi, 1999; Raphael, 1977; Wee, Mills, & Koehler, 1999; Western Management Consultants, 1996). Well controlled studies continue to be sought.

Multiple Intervention Programs: CISM

To date, there is no common agreement on which of the CISM components (Everly & Mitchell, 1999) should be the minimum standard in any multi-component approach, but the following examples demonstrate the versatility of this approach.

Everly and Mitchell (1999; Mitchell, Schiller, Eyler, & Everly, 1999) have used the core CISM components in developing a comprehensive approach for the victims of natural and man-made disasters as well as for the EMH staff that render services in these times of community crisis. These multiple components not only provide support to victims and emergency services personnel, but also serve as a screening procedure for individuals who need further assistance (Everly & Mitchell, 1999).

Flannery and his colleagues (Flannery, 1998, 1999) have developed a CISM approach (Everly & Mitchell, 1999) for healthcare providers of child and adult services in emergency rooms, inpatient, outpatient, day programs, homeless shelters, and community-based residents. The model includes individual crisis counseling, CISD (Mitchell & Everly, 1996) group debriefings, staff victim support groups, staff victim family counseling, and professional referral, when indicated. This approach has provided needed support to employee victims and has resulted in sharp declines in facility-wide violence as well as dollar cost savings in terms of less sick leave, less medical and legal expense, less industrial accident claims, less staff turnover, and sustained productivity.

Leeman-Conley (1996) developed a multi-component approach for bank personnel subject to armed robberies. Her approach includes pre-incident preparedness, training managers to support employee victims, individual crisis

intervention, group debriefings, and long-term counseling. Sick leave was reduced by sixty percent, and workers compensation claims were lowered by sixty-eight percent.

Tehrani and her coworkers (Tehrani, 1995) addressed the needs of postal employee victims. Her model includes manager debriefings, individual crisis counseling of employee victims, and long-term trauma counseling, if indicated. Her approach has provided needed support to employee victims in times of crisis.

Busuttil and his colleagues (Busuttil et al., 1995) employed a multi-component CISM-like crisis intervention in the wake of conflict-related trauma and found it effective in reducing PTSD-like symptoms.

Finally, Richards (1999) found the CISM system of crisis intervention superior in the reduction of PTSD-like symptoms in civilian bank employees when compared to CISD alone subsequent to the critical incident of bank robberies.

With specific regard to the multifaceted CISM, empirical reviews both narrative (Everly, Flannery, & Mitchell, 1999) and especially meta-analytic (Everly, Flannery, and Eyler, 2000) suggest CISM to be an effective crisis intervention capable of reducing the acute manifestations of distress associated with crisis. Randomized experimental designs are still unfortunately lacking and are needed. The use of meta-analytic scrutiny of CISM does serve to diminish the limitations of the current quasi-experimental investigations by reducing the likelihood of systematic experimental bias across studies, however. Nevertheless, randomized investigations are still sought.

Each of these programs illustrate the power of CISM approaches (Everly & Mitchell, 1999) to address the emergency mental health service needs of a variety of work site settings. The flexibility of the model permits each crisis response team to employ a variety of interventions based on the current and changing needs of the organization and the crisis event.

Crisis Intervention: Implications

The evidence for the occurrence of critical incidents worldwide is compelling. These emergencies are frequent, and no nation or group of people is exempt from these events. Equally clear from these studies is the intense human suffering, physical injury and death, and accompanying psychological trauma and PTSD in the surviving victims of, or witnesses to, these critical incidents.

This suffering suggests the need for preventive and treatment interventions in the hands of skilled EMH specialists. This review has documented the mounting empirical evidence that the multi-component crisis intervention strategies of the CISM approach (Everly & Mitchell, 1999) do in fact provide the tools for both prevention and corrective treatment.

The need for CISM as well as other EMH teams and for research on the nature and outcomes of these interventions is widespread. Senior managers are needed for the fielding

and evaluation of crisis intervention systems. The potential for disasters and human acts of violence is an ongoing problem as is the cultural denial of the potential for these critical incidents. This attitude is not correct and may consign individuals to unnecessary suffering as victims. Senior managers are in an important position to bolster EMH teams and needed research, and to address the cultural denial. EMH personnel should actively elicit the support of senior managers so that the extent and quality of EMH services that they provide to victims is enhanced.

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