

Editorial

Five Principles of Crisis Intervention: Reducing the Risk of Premature Crisis Intervention

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ABSTRACT: *Crisis intervention, as it has evolved over the last five decades, has clearly demonstrated its effectiveness as a tool to reduce human distress. Nevertheless, as with any effort to alter human behavior, there are risks associated with crisis intervention. One such risk is that of premature intervention. Premature intervention may not only waste valuable intervention resources, but may serve to interfere with the natural recovery mechanisms of some victims. By clearly defining the nature of the crisis phenomenon itself, premature intervention may be averted [International Journal of Emergency Mental Health, 2000, 2(1), 1-4].*

KEY WORDS: Crisis intervention; crisis; critical incident; disaster; posttraumatic stress

The need for urgent psychological support in the wake of crisis events is evidenced by the high prevalence of traumatic events and the subsequent development of posttraumatic stress disorder (PTSD). For example, it has been estimated that 90% of Americans will be exposed to a traumatic stressor as defined by the American Psychiatric Association (Breslau et al., 1998). Furthermore, recent summaries have concluded that about 9% of those exposed to a traumatic stressor will develop PTSD (U.S. Dept. HHS, 2000). Thus, the need for urgent crisis intervention seems in evidence. Similarly, the effectiveness of crisis intervention programs has also been demonstrated (see APA, 1989; Everly, Flannery, & Mitchell, 1999; and Everly and Mitchell, 1999 for reviews; see also Everly, Boyle, & Lating, 1999; Everly, Flannery, & Eyler, 2000; Flannery, 1999). Despite the best of intentions, combined with both the existence of an empirically demonstrated need and empirically demonstrated tactical effectiveness, criticism has arisen surrounding what some perceive as premature and perhaps even overzealous psychological intervention in the wake of a crisis event. Such is evidenced by articles entitled: "Shamans of Sorrow at Columbine High," and "The Grief Racket," appearing in reputable newspapers such as the Washington Post, as well as a paper entitled "A Surfeit of Disaster" which appeared

in the Economist. Responsibility dictates that the need for urgent psychological support be recognized, while acknowledging that the exposure to a traumatic stressor is a necessary, but not sufficient, condition for the development of disabling posttraumatic sequelae. As noted above, only the minority of individuals will develop PTSD. One might infer the existence of natural healing and recovery mechanisms. It may be further inferred that these natural restorative mechanisms may actually be interfered with by premature or overly aggressive intervention. The purpose of this current paper is to offer some general guidelines for the timing of psychological crisis intervention.

Let us begin with a review of the nature of a *crisis*. A crisis is an acute *response* to a critical incident wherein:

- 1) Psychological homeostasis is disrupted.
- 2) One's usual coping mechanisms have failed. And,
- 3) There is *evidence* of human distress and/or dysfunction.

The crisis response is often confused with the *critical incident* (crisis event). A critical incident is the stressor *event* which initiates the crisis response. More specifically, the critical incident may be thought of as the stressor event which sets the stage for the emergence of the crisis response in those so adversely affected.

Lastly, a review of the term *crisis intervention* may prove of value. Crisis intervention may be defined as the provision of acute psychological support, the goals of which are:

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- 1) Stabilization of the symptoms/signs (evidence) of distress. Here the crisis interventionist asks the question, "What can I *do now* that will keep the victim's distress from escalating?"
- 2) Mitigation of the symptoms/signs (evidence) of distress. Here the crisis interventionist asks the question, "What can I *do now* that will assist in reducing the victim's distress?"
- 3) Restoration of functional capabilities, i.e., "Is this person capable of returning, in an unassisted manner, to home, work, etc.?" If the answer is "yes," then the acute crisis intervention has reached a reasonable endpoint. If the answer is "no," then the fourth goal of acute crisis intervention becomes important.
- 4) Referral to/ follow-up by someone representing some higher level of support/care.

Using these definitions as a guide, potential sources of confusion with regard to the timing of an intervention are now elucidated:

Crisis Intervention Principle #1: Mobilize a crisis intervention team in response to a significant critical incident, then actively *implement* the most appropriate crisis intervention tactics in response to observable signs or reported symptoms (evidence of need) of distress and/or dysfunction. It will be recalled that a crisis is a *response*, not an *event*. This phenomenological differentiation has direct tactical ramifications. Specifically, the direct implementation of crisis intervention tactics is predicated upon evidence of human distress and/or dysfunction, not merely the occurrence of an event (critical incident). As noted above, an inescapable reality is that not everyone exposed to a traumatic event develops PTSD. Clearly some individuals possess a natural resistance to extreme stress. Furthermore, many individuals who are traumatized possess natural recovery mechanisms sufficient enough to preclude external psychological support.

Crisis Intervention Principle #2: Not all signs and symptoms of acute distress are pathognomonic! It is important that those implementing the crisis intervention be cognizant of putative criteria for psychological triage. More specifically, it is important to differentiate the signs and symptoms of acute stress which predict PTSD and those which do not. Everly (1999) has addressed these predictors in a previous paper noting that those acute reactions to a stressor that are consistent with Cannon's (1932) formulation of the "wisdom of the body" are less likely to be predictors of PTSD and subsequent comorbidities than are those

reactions which are inconsistent with classic "fight or flight" reactions.

Crisis Intervention Principle #3: Tailor the crisis intervention to the needs of the individual(s). The great Johns Hopkins' physician Sir William Osler once said "Where malignant disease is concerned, it may be more important to understand what kind of person has the disease, rather than what kind of disease the person has." Once again it is argued that the most important element of the critical incident — crisis response complex is the person and that person's idiosyncratic reaction to the critical incident. As noted personologist Theodore Millon (Millon, Grossman, Meagher, Millon, & Everly, 1999) has postulated, some individuals are primarily cognitive in their experience-processing orientation, while others are primarily affective in their orientation. Cognitively oriented individuals tend to require emotional distance, information, and assistance in problem-solving and re-establishing control as they recover from a crisis. Conversely, affectively oriented individuals tend to prosper from cathartic ventilation and empathetically-based interventions.

Crisis Intervention Principle #4: Timing for crisis intervention is based upon psychological readiness, rather than the actual passage of time. A useful model for understanding the "timing" of crisis intervention is the model developed by Faberow and Gordon (1981). These authors describe four phases of a disaster:

- 1) Heroic Phase - This phase begins immediately upon the onset of the disaster and may even begin in anticipation of the impact of the event itself. It consists of efforts to protect lives and property.
- 2) Honeymoon Phase - This phase is characterized by optimism and thanksgiving. There is a sigh of relief as the realization of survival is appreciated. Congratulatory behavior is common.
- 3) Disillusionment Phase - This phase, which may begin as early as 3 - 4 weeks post disaster, is replete with the realization that something "disastrous" has really taken place. There is a great deal of "second-guessing" wherein anger, frustration, and even efforts to place blame are revealed. The question, "Why did this have to happen?" is often posed. Religious beliefs may be challenged. Here the mourning process actually begins. The growth and development of individuals and communities is arrested. Stagnation is evident. This

Table 1: Critical Incident Stress Management (CISM): The Core Components
(Adapted from: Everly and Mitchell, 1999)

	INTERVENTION	TIMING	ACTIVATION	GOAL	FORMAT
1.	Pre-crisis preparation	Pre-crisis phase	Crisis anticipation.	Set expectations. Improve coping. Stress management.	Groups/ Organization
2 a.	Demobilizations & staff consultation (rescuers)	Shift disengagement	Event driven.	To inform and consult, allow psychological decompression. Stress management.	Large groups/ Organizations
2 b.	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 a.	Family CISM	Anytime	Either symptom driven or event driven.	Foster support & communications. Symptom mitigation. Closure, if possible. Referral, if needed.	Families/ Organizations
6 b.	Organizational consultation				
7.	Follow-up/Referral	Anytime	Usually symptom driven.	Assess mental status. Access higher level of care, if needed.	Individual/ Family

[From : Everly, G. & Mitchell, J. (1999) Critical Incident Stress Management (CISM): A New Era and Standard of Care in Crisis Intervention. Ellicott City, MD: Chevron Publishing.]

phase may last weeks, months, or even years. For some, the phase never ends. It is the goal of crisis intervention to facilitate the transition from this disillusionment phase to the final phase.

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

The growth of individuals and communities is continued.

While the model described above was developed for understanding the human response to disasters, it will prove useful in understanding how individuals psychologically progress through any crisis reaction. Obviously, the duration of each of these phases may be drastically constricted. Nevertheless, the goal of crisis intervention remains the same whether in response to a mass disaster or an acute, isolated event. From the model offered by Faberow and Gordon (1981), the goal is to facilitate the transition from the disillusionment phase to the reconstruction phase.

Crisis Intervention Principle #5: The final principle of crisis intervention is to select the best crisis intervention strategies and tactics:

- 1)For the specific event,
- 2)For the specific population affected, and
- 3)Implemented at the best respective times.

The Critical Incident Stress Management (CISM)

approach to crisis intervention represents a comprehensive, integrated, multicomponent crisis intervention system ideally suited to meet the demands of numerous and diverse critical incidents, experienced by numerous and diverse populations, anytime a crisis is in evidence (Everly & Mitchell, 1999). Table 1 on the preceding page delineates the multifaceted nature of the CISM system as described by Everly (Everly & Mitchell, 1999; Everly, Flannery, & Eyler, 2000). Everly and Mitchell (1999) have created a virtual intervention manual on multicomponent crisis intervention which may be used as a resource for assisting in the development of flexible, innovative crisis intervention.

Summary

The need for crisis intervention services is clear. Yet the efforts to provide those services must well-timed and well-measured. Crisis intervention services must complement and augment natural recovery and restorative mechanisms. They must not interfere with said mechanisms. This is true for wherever the crisis response is in evidence, whether for individuals, organizations, or entire communities. Consideration of the aforementioned principles may assist the crisis worker in the most effective application of crisis intervention strategies and tactics.

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