ESSENTIALS OF PSYCHOLOGICAL CRISIS INTERVENTION, PEER SUPPORT, AND THE CRITICAL INCIDENT STRESS MANAGEMENT SYSTEM (CISM)

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Caveats and Disclaimer

The following guidelines are provided as general recommendations only and are not intended to be clinical prescriptions, nor are they intended to be used by those other than individuals qualified to do so.

Important!

During the course of the discussion of human trauma and disasters, it is natural that some material may be revealed that some may perceive as distressing. While this is not by intention or design, exposure to affect-laden information should be expected and those who read this material or attend trainings based upon this material are hereby warned of that possibility.

To Andi, Peter, and Ella

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CHAPTER ONE

THREE ARCHITECTURES OF INTERVENTION

Fundamentally speaking, there are three core architectures, or frameworks, through which both acute and subacute psychological support may be studied and applied: 1) psychological crisis intervention, 2) peer support, and 3) critical incident stress management (CISM), including disaster mental health response. This volume is an introduction to those fundamental architectures, and as such, it represents a "primer" to the complex field of emergency psychological support. By necessity, and as befits an introductory text, many topics are reviewed at a basic, rather than advanced, level. In order to make the conveyance of information most expeditious, some topics are written in almost outline form, whereas other topics, which require greater explanation, are elaborated upon in more traditional prose.

SETTING THE STAGE

Mental health is the cornerstone of an effective society. Anything that threatens mental health threatens the core fabric of society itself (United Nations, 2020). In 2025, as this text is being written, it's safe to say the world finds itself in turmoil:

1. The COVID-19 global pandemic persists, with new variants emerging each year.
2. The credibility of the World Health Organization (WHO) and the United States Centers for Disease Control and Prevention (CDC) has suffered from revelations of perceived ineffective management of the COVID crisis.

3. Wars in Gaza and Ukraine continue. The authoritarian government in Syria has collapsed.
4. The major shipping lanes in the Red Sea continue to be under constant threat and periodic attack.
5. Partisan politics have slowed socioeconomic progress and threatened national security, while "clueless incompetence" appears to be evident within the leadership ranks of many governmental and private sector organizations (Everly, 2023).
6. Major urban centers in the United States struggle with homelessness and crime, with some major cities referred to as "lawless" by their own leaders, indicating abject failures in leadership.
7. There is a loneliness epidemic, with over 20% of millennials and GEN Z saying they have no close friends and 60% saying they are lonely.
8. Immigration crises exist in the United States and many European and Middle Eastern countries.
9. Social civility seems to have declined, in general.
10. Colleges and universities, traditionally centers of tolerance and innovative thought, seem plagued by intolerance, censorship, lower standards of academic performance and rigor, and policies spawning adverse and unintended consequences. The coddling of America appears to have weakened its social capital and psychological infrastructure, according to some authors.

In addition, evidence would suggest emergency services professionals are at extraordinary risk for psychological injury. For example, consider the following from the Substance Abuse and Mental Health Administration (SAMHSA) and others (SAMHSA, 2018):

1. Thirty percent of firefighters develop mental health concerns, vs 20% in the general population.
2. Fifty percent of firefighters report binge drinking.
3. Forty-nine percent of firefighters have considered suicide over their lifetime, vs 14% of the general population.
4. Seventy-five percent of law enforcement officers (LEO) are exposed to a trauma during the course of their career.

5. Between 7% and 19% of LEO develop reactions similar to PTSD, vs around 6% of the general population.
6. Recruitment and retention remain challenges for many law enforcement departments following "defund the police" movements, placing extraordinary stress on understaffed departments.
7. Prevalence of PTSD among firefighters is as high as 37% (Obuobi-Donkor et al., 2022).
8. According to Violanti et al. (2016), a 40-year police cohort of 2,593 officers had a mean life expectancy 21 years shorter than the general population (see also Violanti, et al., 2021).
9. A 2018 systematic review documented the following prevalence among first responders: anxiety (15%), depression (15%), PTSD (11%), and general psychological distress (27%) (Petrie et al., 2018).
10. The proportion of deaths attributed to suicide among emergency medical services (EMS) clinicians (5.2%) is more than twice the general population's (2.2%) (Vigil et al., 2019).
11. A 2024 systematic review of EMS clinicians found evidence of burnout reaching over 80% in a selected sample (John Hopkins, 2025, unpublished).
12. Psychological support for emergency responders and healthcare professionals in particular must adopt nontraditional methods to meet current demands, according to the United Nations (2020).

Perhaps related to the pandemic, California's San Mateo County Board of Supervisors passed a resolution on January 31, 2024, that declared loneliness a public health crisis and pledged to explore measures that promote social connection in the community. San Mateo County is home to many tech companies and has a median home price over $1.5 million. What does that say about money and happiness?

And let us not forget January 29, 2024, when, just five days before his 54th birthday, the iconic *Sesame Street* character Elmo unwittingly asked his followers on social media, "How is everybody doing?" The question spawned around 200 million views and over 15,000 responses and became an international news story. *The New York Times* asserted the question

opened a "yawning chasm of despair." Thus, it would seem that the timing of this primer is appropriate, if not fortuitous.

Regarding the broader community, reliance upon traditional mental health services has failed to achieve the goal of adequate mental health-related services due to a lack of availability, persistent stigma, long wait times to access professional service providers (several months in some areas), and fewer available crisis and trauma-informed providers.

More specifically, there is an epidemic of severe and acute life stressors, depression, anxiety, meaningless social contacts, anger, and emptiness. The supply of clinicians in selected behavioral health professions will be approximately 250,000 short of the projected demand in 2025, likely worsening thereafter. Access to crisis trained mental health providers is limited in the wake of adversity and disaster, particularly in geographically isolated areas.

Almost 70 years before the United Nations made its 2020 recommendations, 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).

This primer contains three core constructions representing three overarching intervention architectures that are relevant to the study of acute and subacute psychological support and serve as the foundations of this book. So let's examine each architecture of intervention: 1) psychological crisis intervention, 2) CISM, and 3) peer support.

PSYCHOLOGICAL CRISIS INTERVENTION

The first core term and construct is *psychological crisis intervention*. From a historical perspective, the provision of acute emergency psychological care has most often been referred to as "psychological crisis intervention,"

or "crisis intervention" for short. Crisis intervention is sometimes thought of as "emotional first-aid" (Neil et al., 1974). As used in this text, the term *crisis intervention* may be thought of as urgent psychological/behavioral care designed to achieve three goals:

1. To stabilize agitation (or immobilizing depression) through acute de-escalation or grounding interventions;
2. To mitigate the intensity and frequency of symptoms of distress or dysfunction so as to achieve, or approximate, a state of adaptive functioning; and,
3. To facilitate access to continued care, when necessary (see Artiss, 1963; Neil et al., 1974; Caplan, 1964; Everly & Lating, 2022). 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*, not the incident itself. Crisis intervention may be applied individually, in large groups, and in small groups.

Crisis intervention is sometimes confused with counseling and psychotherapy. They represent different skill sets. The PIE principles, derived and currently adapted from military psychiatry (Salmon, 1919; Artiss, 1963), may assist in this differentiation. PIE 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 shown through this analogy: As physical first aid is to surgery, crisis intervention is to psychotherapy.

The most significant of the early major milestones in the development of psychological crisis intervention, and later, disaster mental health, can be found associated with warfare. T.W. Salmon (1919) made a significant contribution to the literature via his recollections and analyses of psychiatric emergencies during World War I. Salmon observed that the English and French medical corps had success in treating various battlefield neuroses by moving their psychiatric facilities to more forward positions than were historically utilized and by employing stabilization and brief therapy procedures. He argued that the American hospitals should do so as well. As a result of these changes, he observed a dramatic increase in the return-to-duty rates achieved by the end of the war.

From Salmon's work, and that of Kardiner and Spiegel (1947), the three principles of crisis intervention—immediacy, proximity, and expectancy—were derived, articulated, and applied (Artiss, 1963; Solomon & Benbenishty, 1986; Solomon, Shklar, & Mikulincer, 2005).

Many modern writers point to Eric Lindemann's (1944) account of the November 28, 1942, Coconut Grove night club fire in Boston, wherein 492 people lost their lives, as the beginning of modern crisis intervention theory and practice in civilian sectors. Lindemann's perspective on crisis intervention was the study and facilitation of the grief process subsequent to that catastrophic fire. Lindemann was later joined by Gerald Caplan in the creation of a community mental health program that emphasized community outreach and crisis intervention in the Boston metropolitan area.

Another important development in the early modem era of crisis intervention was the work of suicidologists Edwin Shneidman and Norman Farberow. In the mid-1950s, they created the prototype for suicide prevention centers in the United States in the form of the Los Angeles Suicide Prevention Center.

The field of crisis intervention received a major boost when, in 1963, President John Kennedy called for a "bold new approach" to the delivery of mental health services. The national Community Mental Health Centers' Act was the result of that appeal. This congressional act established a network of community-based mental health service centers wherein a

major emphasis was placed upon crisis intervention services as a form of preventive outreach. Much of the conceptual foundation for this initiative was provided by the work of Caplan (1961, 1964), who delineated the three levels of preventive psychiatry. He defined *preventive psychiatry* as the body of knowledge designed to reduce

> 1) the incidence of mental disorders of all types in a community (primary prevention), 2) the duration of a significant number of those disorders which do occur (secondary prevention), and 3) the impairment which may result from those disorders (tertiary prevention)
>
> (Caplan, 1964, p. 16–17).

As a result of community mental health efforts, the 1960s and 1970s saw a proliferation of walk-in clinics and telephone hotlines. Clearly the heyday of fundamental crisis intervention services saw the following advances:

1. The provision of services within the tripartite continuum framework of primary, secondary, and tertiary intervention;
2. Deinstitutionalization of psychiatric services (sadly contributing to homeless epidemics 50 years later in major cities such as San Francisco, Los Angeles, New York, and elsewhere);
3. Aggressive community outreach (giving rise to the mobile crisis movement);
4. Emphasis on brief intervention services as a viable mental health delivery paradigm; and
5. The use of paraprofessional counselors (sometimes called "peer interventionists," "peer counselors," or even "peer paracounselors" (fostering national peer support and peer paracounseling initiatives, some of which have been recognized by SAMHSA).

As the 1970s ended and we entered the 1980s, enthusiasm for crisis intervention seemed to wane, even though considerable evidence had accumulated as to the efficacy of applied crisis theory and crisis intervention services (Bordow & Porritt, 1979; Bunn & Clarke, 1979; Decker & Stubblebine, 1972; Langsley, Machotka, & Flomenhaft, 1971; Parad & Parad, 1968).

Interest in crisis intervention was restimulated in the late 1980s and 1990s as a direct result of numerous interacting processes:

1. The emergence of the formal diagnosis of post-traumatic stress disorder (PTSD), which "legitimized" crisis events and disasters as threats to both short- and long-term mental health;
2. The 1982 Air Florida 90 air disaster in Washington, DC, which prompted re-examination of psychological support for emergency response personnel. This was the first mass disaster use of the critical incident stress debriefing (CISD), a group crisis intervention that was originally formulated in 1974 by Jeffrey Mitchell (1983);
3. The founding of the International Society for Traumatic Stress Studies (ISTSS), the Green Cross Foundation, and the International Critical Incident Stress Foundation (ICISF), which gained recognition as a United Nations non-governmental organization (NGO) in special consultative status with the Economic and Social Development Office in 1997;
4. The creation of the Red Cross disaster mental health network in 1992;
5. The first Gulf War;
6. The bombing of the Federal Building in Oklahoma City, which once again underscored the need for crisis intervention services for rescue personnel, as well as civilians;
7. The Salvation Army's emotional and spiritual care program for disaster victims;
8. The TWA 800 mass air disaster, which underscored the need for emergency mental health services for families of the victims of trauma and disaster, as well as the subsequent Gore Commission recommendation for the provision of crisis services for the airline industry;
9. The beginning of the modern era of school shootings in 1999, when 14 students, including the two shooters, were killed at Columbine High School in Littleton, Colorado; school-based violence underscores the need for crisis intervention teams for schools and colleges;

10. Increasing numbers of disasters, terrorist acts, school shootings, and workplace violence.

But perhaps the three disasters that changed the modern world were 1) the terrorist attacks of September 11, 2001, underscoring the power of malevolent acts; 2) the August 2005 Hurricane Katrina, which became one of the deadliest and costliest natural disasters in American history (the public health response and the overall disaster response thereto was vociferously criticized); and 3) the 2020 COVID-19 pandemic, when, adding to its other adverse impacts, the public health response was criticized by some as inept. With these three events, the world was changed forever.

It is crucial to note that crisis intervention as an overarching architecture focuses upon delivery processes rather than prescriptive tactics. While embracing innovative processes such as PIE, crisis intervention lacked a specific procedural rubric, or set of step-by-step tactics, for implementation. Nor did it specify who might deliver such services. Thus, there was, and remains, great variability in its application, and the term *crisis intervention* can mean many things to many people. What most do seem to agree upon, however, is the importance of early intervention.

The Importance of Early Intervention After Trauma

Based on observations during WWII, British psychiatrist William Sargant (1942) noted, "Our most important finding has been the supreme need for immediate first aid treatment of the acute neurosis. . ." (p. 574).

Kardiner (1959) observed during WWII the application of the crisis intervention principle of early intervention (immediacy) and noted, "By and large, the prognosis ... varies directly with the time factor. . . . The great issue ... is not to permit the syndrome to become entrenched. . ." (p. 253). He went on: "The most effective implement is to keep alive the [causal] relation between the symptoms and the traumatic event" (p. 254), as opposed to attributing symptoms to weakness in character.

In the formative years of crisis intervention, as applied to the civilian world, Thorne asserted,

> In our opinion, . . . preoccupation with depth psychology [psychotherapy] has had a very detrimental effect . . . Prophylactically, it is prob-

> able 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. . . .
>
> (Thorne, 1952, p. 210)

Rapoport (1962) agreed, noting, "A little help, rationally directed and purposely focused at a strategic time, is more effective than extensive help given at a period of less emotional accessibility" (p. 30). This is consistent with Jacob Lindy's construct of the "trauma membrane," wherein psychological retreat and numbing may develop as protective processes in those exposed to psychotraumatogenic circumstances (Lindy, 1985). The membrane thickens, becoming harder to permeate with time. While protecting against further psychological injury, such processes may also serve as a barrier to crisis intervention and even counseling.

Supporting these assertions, Campfield and Hills (2001) used a randomized design wherein subjects were randomly assigned to one of two groups: 1) a CISD group intervention conducted within ten hours of a critical incident, in contrast to 2) a CISD group intervention conducted more than 48 hours post-incident. Post-traumatic distress was assessed at two weeks post-CISD. Results indicated that those who received the CISD intervention within ten hours experienced less distress two weeks later than those who received the CISD intervention more than two days later. After the terrorist attacks on the World Trade Center in 2001, Boscarino and colleagues discovered that two to three sessions of crisis intervention achieved maximum benefit and were more effective than multisession counseling (Boscarino et al., 2005, 2011).

Priebe and Thomas-Olson (2013) investigated the value of early intervention (<24 hours post-incident) vs late intervention (>24 hours post-incident) in the application of CISM interventions with healthcare staff. They concluded, "the quantitative data showed an overall trend that the early intervention group had lower mean scores for avoidance, intrusion, and hyperarousal. . ." (p. 39).

Taking the risk of confounding the issue of timing for intervention, an important lesson was learned with the advent of the field of disaster mental health. Simply put, timing is not only a temporal phenomenon, but a psychological one. That is, *timing* not only refers to the passage of time but psychological status as well. In the case of disasters, *early intervention*

might mean up to several months after impact. This was clearly the case in the World Trade Center disaster of 2001, as well as the COVID-19 pandemic of 2020, where acute signs of distress (sudden-onset and severe) persisted months after the origination of the incidents. Chapter Seven exemplifies this notion in the discussion of a phasic approach to strategic planning.

PEER SUPPORT

The second core term and architecture in this primer is *peer support*. Peer support is the provision of acute crisis (rapid emergent application), subacute (gradual or less intense), and even chronic recovery-oriented intervention services by those other than mental health clinicians and directed toward individuals with key characteristics similar to those of the providers. Peer-support workers—also known as peers—are individuals who share a common bond with others, often with lived experience similar to those they endeavor to assist. Peer support, therefore, is a process through which a person who shares some similar homogenizing experience or characteristic with another provides education, advocacy, and psychological support to them. The shared life experiences and the insights gained from those experiences serve as the foundation for assistance. Peer support is founded on the principles of respect, acceptance, empathy, perspective-taking/mutual understanding, shared responsibility, and awareness of limitations. So peer support may be organized to serve emergency services, the military (current and veteran), student populations, and those diagnosed with PTSD, recovering from addictions, experiencing grief, divorce, etc.

Peers model recovery, promote shared understanding, focus on strengths, offer positive coping strategies, and provide information and resources. Coaching/mentoring, advocating, leading groups, building relationships, and providing subacute and acute crisis support (e.g., psychological first aid), as indicated, are the roles assumed by the peer.

Coaching may take two forms: 1) direct, "content" coaching, and 2) indirect, "process" coaching. The "content vs process" model of consultation was developed by Edgar H. Schein. He is credited with creating the concept of "process consultation," which focuses on the process of prob-

lem-solving rather than just the content of the problem, forming the basis of the "content vs process" distinction.

Key points about Schein's model:

- *Content consultation*: In this model, the client seeks content knowledge and expertise from the coach to solve a specific problem.
- *Process consultation*: This approach emphasizes the collaborative process of identifying and addressing problems, where the coach helps the client understand and improve their own internal processes to find solutions through the use of questions and dialogue.

According to SAMHSA (2023), peer-support services are an integral component of the behavioral health continuum of care—from prevention and early crisis intervention to subacute and even extended support in some instances. But that is not to say peer support is a panacea. As with any form of mental health intervention, there are cautions of which to be aware:

1. Peers must remember the importance of working with professional mental health guidance/support.
2. They should view peer support as only one point on the overall continuum of care.
3. Peers must be sensitive to recognizing when they are "in over their head" (underestimating severity or over-estimating the effectiveness of intervention) when addressing psychological distress in others.
4. Peers must constantly monitor countertransference (over-identification that blurs objectivity).

Evidence-informed and evidence-based training, as well as ongoing monitoring and supervision, are core components of peer-support programs (Bartone, Bartone, & Violanti, 2018; Daniels et al., 2012; Rebeiro et al., 2016). Research reveals that peer support consists of two factors: non-directive and directive support (Kowitt et al. 2017). Peers are well-advised to develop skills in the application of both.

Peer support is an evidence-based process. It has been shown to be effective in reducing hospital admissions and improving hope, self-efficacy, self-confidence, and self-esteem (Ochocka et al., 2006; Ratzlaff et al., 2006; Resnick & Rosenheck, 2008; Salzer, 2002; Trainor et al., 1997; Yanos, Primavera, & Knight, 2001).

A term and construct related to peer support is *peer paracounseling (PPC)*, a term coined by George S. Everly, Jr., and Cherie Castellano (Everly, 2023). PPC is a form of peer psychological support designed to be applied by peer interventionists during the subacute phase of human distress, regardless of its origin. It is intended to foster resilience and empower recovery and growth. PPC is not a form of professional counseling, but is best conceived of as a form of *peer psychological coaching*, which entails integrating the power of shared lived experiences and active listening with non-directive, as well as more directive, guidance interventions. It is similar to aspects of motivational interviewing. While the core skills of PPC are applicable to the acute aspects of human distress, the primary application of PPC is envisioned to be the dysphoric subacute reactions to both traumatic and cumulative stressors.

It is important to note that peer support as an overarching architecture refers to *who* provides the intervention. Similar to crisis intervention, it does not delineate the processes nor the specific tactics employed, per se (PPC being an exception). Again, similar to crisis intervention, there is great variability in the delivery of peer-support services.

CRITICAL INCIDENT STRESS MANAGEMENT (CISM)

Our third core term is *critical incident stress management (CISM)*. We have seen that the term *crisis intervention* largely describes *processes* for the delivery of emergency psychological support, which differentiate it from counseling and psychotherapy. The term *peer support* largely refers to *who* delivers the psychological support. CISM answers the questions, "*How* do you apply psychological crisis intervention?" and "*What* are the specific tactical interventions that constitute psychological crisis intervention and may be used in peer support?" In that CISM also utilizes peers, mental health clinicians, and anyone else specially trained in CISM, it also answers the question, "*Who* provides interventions?"

CISM is an overarching framework that houses an amalgam of interventions. Structurally, CISM is an integrated continuum of care. More specifically, as defined by Mitchell and Everly (1993), CISM represents an integrated and comprehensive multi-component continuum for the provision of crisis intervention and disaster mental health services.

Caplan's Influence on CISM

The CISM formulation is actually broader and more comprehensive in scope than the historical applications of crisis intervention and is *strategically* more consistent with Caplan's comprehensive (1961, 1964) formulations of preventive psychiatry. Specifically, CISM embodies

1. *primary prevention*, i.e., the *proactive* identification and mitigation of pathogenic stressors and the provision of buffering or "immunizing" interventions such as resilient leadership training and wellness training, such as Psychological Body Armor™ (Everly, 2018);
2. *secondary prevention*, i.e., the *reactive* identification and mitigation of acute distress and dysfunctional symptom patterns through interventions such as psychological first aid, CISD, defusing, crisis management briefing, etc.; and
3. *tertiary prevention*, which includes both subacute and extended interventions, i.e., follow-up PPC (although PPC for subacute distress may be conceived of as secondary prevention, as it bridges the gap between acute and extended service provision) and mental health treatment and rehabilitation services for extended distress. Residential programs such as the On-Site Academy promote resilience, recovery, and growth.

Thus, the specific goals of the CISM program are

- To reduce the 1) duration, 2) severity of, and 3) impairment from critical incidents, cumulative stressors, acute traumata, and disasters; and
- To facilitate advanced follow-up mental health interventions, when necessary.

In the final analysis, the ultimate goal of CISM is the mitigation of acute and subacute disabling psychological dysphoria and discord and the rapid restoration of adaptive functioning in the wake of a critical (crisis) incident or cumulative stressors.

Figure 1.1 displays the reactive CISM adaptation of Caplan's model. The model is divided into three temporal phases: acute, subacute, and extended. The acute phase of intervention contains PFA, the broader-in-scope crisis intervention, and the even-broader-in-scope CISM, all of which may collectively extend for days or weeks, in the case of disasters. The subacute phase contains PPC, which may extend weeks or months. The final phase, the extended phase, routinely is the longest-lasting of the intervention phases. It consists of counseling, psychotherapy, support groups, and residential treatment and support programs. Figure 1.1 introduces interventions that encourage resilience and empowerment.

Time →

Intensity ↓

Crisis-focused Acute Interventions	*Subacute Intervention*	*Extended Interventions*
Psychological First Aid	Paracounseling: 1. Starts with Self-awareness; Self-disclosure while managing countertransference.	Counseling/ Therapy
Crisis Intervention	2. Ongoing monitoring "mental status" (thought, emotion, action). 3. Non-directive Coaching for Resilience	Extended Personal and Professional Coaching
Critical Incident Stress Management Continuum of Crisis Interventions	3. Non-directive Coaching for Resilience	Support Groups
	4. Directive Content Coaching Providing options for resilience.	Residential Programs
GOALS: 1) Self-efficacy, 2) Self-fulfilling Prophecy, 3) Resilience, 4) Attitudes of Optimism and Growth		

Figure 1.1 Interventions for Fostering Resilience and Empowerment