Human Resilience and CISM

By George S. Everly, Jr., PhD, ABPP, FAPA

Co-founder of ICISF; ICISF Chairman Emeritus

The notion of human resilience stands on the cutting edge of public health policy initiatives and psychological services, especially crisis intervention and disaster mental health services. Indeed, many in the field of critical incident response have become enamored with the notion of promoting human resilience as if it were a new concept…it is not. There persists a false assumption that fostering human resilience, clearly an idea, whose time has come, is in contradistinction to Critical Incident Stress Management (CISM)…it is not. Let's explore human resilience from the CISM perspective. In doing so we shall see that CISM and human resilience are complementary. Indeed, CISM may be thought of as a means to achieve the goal of human resilience.

To begin, human resilience may be thought of as the ability to withstand, adapt to, or rebound from adversity. The problem with such a definition is that it aggregates what may be clinically distinct phenomena. One integrative model contributing heuristic value and greater granularity to the construct of resilience is the Johns Hopkins Tripartite Model of Resistance, Resilience, and Recovery (henceforth, the Hopkins Model), which embraces the distinction between proactive protective factors (immunity) and reactive rebound capability (Kaminsky, McCabe, Langlieb, & Everly, 2007). Finally, *recovery* refers to observed improvement following the application of treatment and rehabilitative procedures. Thus using this model, we see that the overarching term "resilience" can be used to describe a continuum of more granular processes and interventions within the rubric of crisis intervention and disaster mental health services.

Using the lens of CISM, we shall focus our attention on the resistance and resilience aspects of the Hopkins continuum. Recovery is well beyond the scope of acute critical incident response interventions as it consists of formal psychological assessment, psychotherapy, psychopharmacological interventions as well as rehabilitative services. We shall see that CISM can be a useful strategic construct from which to promote both resistance and resilience.

So if we see "resistance" as proactive psychological immunity, i.e., the ability to withstand or adapt to adversity, how does one foster "resistance?" Though we know the least about this aspect of the continuum, we do have some understanding of the processes that appear to support resistance. Pre-incident preparation appears to be essential in promoting resistance, and it is a core element of CISM. Pre-incident preparation serves to set appropriate expectations, allows for the preparation of a plan, and allows for rehearsal of that plan. FEMA argues that all communities should have a disaster plan. We agree. We also add the notion that all communities should have a disaster mental health plan designed to explicitly foster psychological resistance.

"Resilient leadership" is another mechanism by which psychological resistance can be fostered. The US Institute of Medicine (IOM; 2013) has recently argued for the creation of a resilient workforce supported by an organizational culture of resilience. One means by which the organizational culture of resilience can be promoted is through the practice of "resilient leadership" (Everly, Strouse, & Everly, 2010). Resilient leadership may be thought of as the leadership practices that promote resilience throughout the organization. The empirically-derived core pillars of resilient leadership practices appear to be active optimism, integrity, open communications, and decisiveness (Everly, Strouse, & Everly, 2010). A pilot investigation suggests that when resilient leadership principles are applied, workers perceive the organization as less stressful. This would seem to be important in an era where organizations are being asked to do more with less.

Using the Hopkins' terminology, resilience is the reactive ability to rebound from adversity. CISM possesses a myriad of reactive tactical interventions ideally suited to promote rebound. Individual crisis intervention (including psychological first aid (PFA), psychological triage, small group crisis intervention, large group crisis intervention, pastoral crisis intervention, and family crisis intervention are all core CISM interventions designed to foster resilience (Everly, 2013; Everly & Mitchell, 2013). Skills in individual crisis intervention (psychological first aid) can be seen as an essential management skill that all supervisors should be trained in. In fact, in a separate report, the IOM (2003) and the World Health Organization (WHO; 2003) advocated training in psychological first aid (PFA) for all disaster workers. The goals of PFA are psychological stabilization, mitigation of acute distress, and facilitation of access to continued care as indicated. A project underway at The Johns Hopkins Bloomberg School of Public Health has been fostering community resiliency through teaching psychological first aid in faith-based communities (McCabe, et al, 2008). From the CISM perspective, the individual SAFER-R crisis intervention model may be viewed as a variant on the theme of psychological first aid, albeit more structured than most PFA models. Defusing's and crisis management briefing may be viewed as a form of group psychological first aid. Pastoral crisis intervention may be viewed as a form of faith-based PFA. From an evidence-based perspective, CISD and variations on the CISD process, when submitted to randomized controlled trials has been shown to be effective with military and emergency services personnel (Adler, et al., 2008; Adler, et al., 2009; Deahl, et al., 2000; Tuckey & Scott, 2013). Thus the goals of reactive crisis intervention tactics such as PFA and CISM are stabilization, mitigation, and facilitation, we should now see the reactive tactics of CISM as a means to promote human resiliency.

In 1992, the author was asked to assist in the development of an entire mental health initiative in the State of Kuwait after the Iraqi invasion. Acute distress was evident throughout the country. As the culture would not sustain a "pathological" approach to crisis, it was necessary to employ a resilience approach to foster rebound throughout the nation. CISM was one of the cornerstones of the Kuwaiti project.

Interestingly enough, the original intention of CISM was to support emergency services and disaster response personnel. It may be suggested that these are also "cultures" that recoil from the notion of a pathological approach to intervention, but are more likely to embrace a resiliency-oriented approach. CISM is an approach that seeks to build resistance and resilience, viewing psychological distress as temporary setbacks and as adjustment difficulties requiring minimal, but targeted assistance, in cases where one's ability to function has been temporarily compromised.

Summary

There exists a misconception that the pursuit and support of human resilience, on one hand, and CISM, on the other, are mutually exclusive…they are not! In the wake of the terrorist attacks of September 11, 2001 putative CISM interventions were shown to be effective in assisting resilience, perhaps even more effective than psychotherapy (Boscarino, Adams, & Figley, 2005; 2011). There remains much confusion in the field of disaster mental health (Hawker, Durkin, & Hawker, 2010; Regel, 2007), and much of that confusion may be semantic rather than of substance.

References and Further Readings:

Adler, A., Bliese, PD, McGurk, D., Hoge, CW, & Castro, CA. (2009). Battlemind debriefing and battlemind training as early interventions with soldiers returning from Iraq: Randomization by platoon. *Journal of Consulting and Clinical Psychology*, 77, 928-940.

Adler, A, Litz, BT, Castro, CA, Suvak, M., Thomas, JL, Burrell, L, et al. (2008). Group randomized trial of critical incident stress debriefing provided to US peacekeepers. *Journal of Traumatic Stress,* 21, 253-263.

Boscarino JA, Adams RE, Figley CR. (2005). A prospective cohort study of the effectiveness of employer-sponsored crisis interventions after a major disaster. *International Journal of Emergency Mental Health;*7:9-22.

Boscarino, J., Adams, R., & Figley, C. (2011). Mental Health Service Use After the World Trade Center Disaster: Utilization Trends and Comparative Effectiveness. Journal of Nervous and Mental Disease, 199, 91-99.

Deahl, M., Srinivasan, M., Jones, N., Thomas, J., Neblett, C., & Jolly, A. (2000). Preventing psychological trauma in soldiers. The role of operational stress training and psychological debriefing. *British Journal of Medical Psychology*, *73*, 77-85.

Everly, GS, Jr. (2013). *Fostering human resilience (2nd ed).* Ellicott City, MD: Chevron.

Everly, GS, Jr. (2013). *CISM: Key Papers and Core Concepts.*Ellicott City, MD: Chevron.

Everly, GS, Jr., Strouse, DA, & Everly, GS, III. (2010). *Resilient Leadership*. NY: DiaMedica.

Hawker, DM, Durkin, J, & Hawker, DSJ (2010).To debrief or not to debrief our heroes: That is the question. *Clinical Psychology and Psychotherapy,* Published online in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/cpp.730

Institute of Medicine (IOM). (2013). *A Ready and Resilient Workforce for the Department of Homeland Security: Protecting America's Front Line*. Washington, DC: National Academies Press.

Institute of Medicine (IOM). (2003). *Preparing for the Psychological Consequences of Terrorism.* Wash., D.C.: National Academies.

Kaminsky, MJ, McCabe, OL., Langlieb, A., & Everly, GS, Jr. (2007). An evidence-informed model of human resistance, resilience, & recovery: The Johns Hopkins' outcomes-driven paradigm for disaster mental health services. *Brief Therapy and Crisis Intervention,* 7, 1-11.

McCabe, OL, Lating, JM, Everly, GS, Jr., Mosley, A, Teague, P, Links, J, & Kaminsky, MJ (2008). Psychological First Aid Training for the Faith Community: A Model Currículum. *International Journal of Emergency Mental Health*, Vol. 9, No. 3, pp. 181-192.

Regel, S. (2007). Post-trauma support in the workplace: the current status and practice of critical incident stress management (CISM) and psychological debriefing (PD) within organizations in the UK. *Occupational Medicine*, 57: 411-416.

Tuckey, MR & Scott, JE (2013, in press). Group Critical Incident Stress Debriefing with emergency services personnel: A randomized controlled trial. *Anxiety, Stress, and Coping*, in press

World Health Organization. (2003). *Mental Health in Emergencies*. Geneva: Author.