CCAPS NEWSLETTER

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From the Chair -- Fall 2002

The chill of autumn is in the air and the semester is beginning to heat up--October on college campuses! I hope that you had a restful summer and are ready for the challenges of the fall semester.

In July, I participated in ACPA's Summer Leadership Meeting, which was held in Minneapolis,the site of the 2003 Convention. I was impressed by the organization's commitment to strategic planning and including all members in deciding ACPA's future. Also, I think Minneapolis will be a great place for a conference. The convention center is brand new, beautiful, and big, and the hotels are either close by or easily accessible via the Skyway system. And...the Men's NCAA Basketball Midwest Regionals will be in Minneapolis while we're there, for those of you who might want to get tickets.

CCAPS has continued to be active over the last few months. We were at the leading edge of raising questions about the licensing of counseling center psychologists in Wisconsin. We continued with our liaison work with various professional organizations, and are in the process of considering additional liaisons. And our former Chair, Heidi Levine, is a candidate for the Director of Commissions of ACPA. This is a very important role, as the Director of Commissions represents the Commissions' voice to the Executive Council of ACPA. Make sure you vote!

The Commission is facing many of the same challenges that we have on our home campuses. Our Commission budget was reduced this year, requiring a re-examination of our past activities and the creation of new (and cheaper!) ways to conduct Commission business. However, I am confident that, with the active participation of the CCAPS directorate and membership, we will be able to continue to offer many of activities and services that are CCAPS hallmarks.

In addition, similar to many of our campuses, our Commission is examining our policies and practices regarding inclusion. We are aware that our professional siblings in counselor education, social work, and counseling may not feel as welcome in the Commission as those from other professions. I believe that a unique strength of CCAPS is its multidisciplinary nature, and I am committed to expanding our welcome to all who are interested in college and university counseling issues. I thank Directorate Members Wayne Griffin and Chuck Zanone, in particular, for identifying this issue and continuing to remind CCAPS of its importance. In addition, I am hopeful we can continue to find ways to include individuals from diverse demographic groups, as well as further involve the entire Commission membership in CCAPS activity. All Commission members, as well as interested parties outside of the Commission, are invited to participate in our ongoing important discussion regarding inclusion.

In closing, I want to remind you that the Commission for Counseling and Psychological Services IS our membership. Please consider involvement in our many important committees and projects. And please plan to join us in Minneapolis in March!

Sue Stock-Ward, Ph.D.
Chair, Commission for Counseling and Psychological Services
and
Assistant Training Director
Counseling, Testing and Career Center

University of Akron

From The Editor

Welcome to the latest edition of the ACPA Commission VII CCAPS Newsletter. I hope all of you are enjoying happy and productive Fall semesters.

Our feature article for this edition is Early Psychological Intervention and College Personnel Services by Dr. George Everly. Dr. Everly is co-founder and Chairman of the Board Emeritus of the International Critical Incident Stress Foundation. His article provides an overview of early intervention in response to traumatic events, as well as more specific information about critical incident stress management and its applications on college campuses.

This edition also includes Sue Stock-Ward's Chair's column. Thank you as always to Jonathan Kandell who formatted and uploaded this newsletter.

Matthew Torres, Ph.D.
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EARLY PSYCHOLOGICAL INTERVENTION AND COLLEGE PERSONNEL SERVICES

George S. Everly, Jr., Ph.D., FAPM
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The concept of early psychological intervention in response to traumatic events has been a compelling notion since World War I. Based upon observations made in World War I, T. S. Salmon (1919) argued for the value of early psychological intervention noting "…Nothing could be more striking than the comparison between cases treated near the front and those treated far behind the lines…As soon as treatment near the front became possible, symptoms disappeared with the slightest amount of treatment" (p. 994). Similarly, in a now classic study on early intervention, Solomon and Benbenishty (1986) found all of the three foundational principles of crisis intervention, proximity, immediacy, and expectancy (Artiss, 1963) were associated with a higher rate of return to military service during combat. Lindy's (1985) "trauma membrane" theory provides a theoretical basis for early psychological intervention by noting that survivors of disasters and related traumatic events surround themselves with a protective envelope, or membrane, which serves to insulate them from demands in their environment. Unfortunately, as time passes, this membrane may grow maladaptively thicker and less permeable thus effectively isolating the survivor from virtually all external relationships be they friends, family, or more formal support systems. Thus, early psychological intervention may represent a means of providing support and security without the necessity of constructing an impermeable barrier.

Interest in early psychological intervention may have peaked in the 1960s and 1970s with the implementation of community mental health initiatives representing a belief in the value of outreach. With the end of the Vietnam conflict some interest clearly waned. In the 1990s, early intervention enjoyed somewhat of a renaissance with the advent and proliferation of student assistance programs and peer counseling on college campuses. In the wake of numerous mass disasters, the field of emergency mental health and early psychological intervention is being revisited. Let examine its current status.

STATE-OF-THE-ART

Organizations like the American Red Cross, National Association of Victims Assistance, and the International Critical Incident Stress Foundation have been provided training, consultation, and crisis intervention in the wake of mass disasters and critical incidents for over a decade. Clearly the field continues to evolve beyond its simplistic beginnings.

Originally, early psychological intervention (sometimes referred to as crisis intervention) was conceived of as "psychological first aid." It remains so. That is to say, early intervention is not a substitute for psychological treatment. Rather, early intervention and formal assessment and treatment should be seen as different points on a continuum of care.

Psychological first aid was conceived of as being implemented by mental health clinicians, as well as specially trained "peer" counselors. It remains so. However, we now recognize that specialty training is needed not just by "peer" counselors, but by mental health clinicians, as well. Emergency mental health training is not required to obtain a license as a psychologist or counselor, so the license to practice is in and of itself insufficient to guarantee competency in this specialized domain of practice.

In September, 2002, suggestions for early intervention were published by the National Institutes of Mental Health (NIMH, 2002). Some of the key points are listed below:

1. Expect normal recovery from most persons exposed to the disaster or critical incident.
2. Meet basic needs first within the context of a needs hierarchy (survival, physical health, safety, food, shelter, assessment, triage, outreach, information, psychological first aid, treatment).
3. Services should be provided on an as needed basis.
4. Services should reflect cultural sensitivity and be tailored accordingly.

5. Emergency mental health services should be integrated within the overall response plan.
6. Emergency mental health services, themselves, should represent a phasic, integrated, multi-component intervention system spanning pre-incident preparation through facilitation of access to formal assessment and treatment services.

World Psychiatric Association president Juan Lopez-Ibor offers similar recommendations (Lopez-Ibor, 2002). He notes the importance of pre-incident planning. He suggests that services should be as immediate as possible, integrated, sensitive to situation and culture, and that verbal "debriefing" is an important aspect of intervention. The suggestion that "debriefing" is an important aspect of disaster response is worthy of revisitation, however. The United Kingdom's Cochrane Review (Wessely, Rose, & Bisson, 1998) questioned the value of "debriefing." Close scrutiny of the Review, however, reveals the source of the apparent contradiction. The studies summarized in the Review were limited to randomized controlled trials and pertained only to single intervention one-on-one counseling with medical patients after serious physical injuries or medical procedures. The Institute of Medicine has long recognized the value of quasi-experimental designs in the development of a clinical science. Furthermore, the practice of integrated multi-component early psychological intervention in the United States extends far beyond the singular ("one-shot") one-on-one practice of "debriefing" in the United Kingdom as described in the Cochrane Review. Everly et al. (2001) provide a more positive review of integrated emergency mental health. Flannery's research (2001) on integrated, multi-component crisis intervention suggests such an intervention may indeed be effective. The only randomized controlled trial on such an intervention system is that of Deahl, et al. (2000). Although more limited than a full spectrum system's approach, the results are encouraging. That is not to say that care should not be taken when exercising psychological first aid… obviously it should.

IMPORTANCE OF A PLAN

Key recommendations for early psychological intervention call for a plan to be developed prior to a traumatic incident or mass disaster. A simple formula may be utilized to develop or assess a plan for early intervention. The simple formula is:

1. THREAT (designate the nature of the potential incident/ trauma/ disaster)
2. TARGET (designate who will be the recipients of the early intervention services for each credible threat)
3. TYPE (designate the type(s) of psychological interventions that will be used for each recipient group, for each threat)
4. TIMING (designate the timing for the various interventions described above)
5. RESOURCES (perform an audit so as to ascertain the intervention resources available to respond).

CORE COMPETENCIES

The practice of early psychological intervention may be thought of consisting of five core competencies:

1. Differentiating benign from malignant psychological symptoms (including substance abuse)
2. Individual crisis intervention (face-to-face or via telephone)
3. Small group crisis intervention
4. Large group crisis intervention (“town meetings”)
5. Strategic planning using a multi-component tactical intervention system.

MULTI-COMPONENT INTERVENTION

The aforementioned core competencies may be integrated within an over-arching strategic crisis intervention plan for any given college or university. One such formulation, and perhaps the most widely used throughout the world, is referred to as Critical Incident Stress Management (CISM). A prototypic CISM intervention system for colleges and universities might consist of the following components:

1. Pre-crisis strategic planning and tactical training (see core competencies). Train mental health staff as well as peer counselors to provide crisis support.
2. Large group crisis intervention, i.e., the ability to conduct “town meetings” subsequent to a crisis event. These

meetings could be conducted for a dorm (or merely a single floor), a campus organization, or even an athletic team which has been exposed to a traumatic event. Large groups might range from 20 to over 100 persons. The primary purpose of such groups would be information dissemination and rumor control.

3. Small group crisis interventions (defusings or Critical Incident Stress Debriefings - CISD). When small functional groups are collectively exposed to a traumatic event, it may be advisable to allow that group to discuss the event, collectively, but on a voluntary basis. Defusings may be utilized within 8-12 hours and are designed to mitigate the initial adverse impact and/ or triage. The CISD may be used to facilitate psychological "closure" and triage.
4. Individual crisis intervention may be provided via a campus telephone hotline or walk-in crisis clinic. It can also be provided on an as needed basis by dorm resident assistants who have been specially trained.
5. When students have developed a serious illness, been injured, or killed, it is important to provide liaison, advocacy, and crisis intervention services to the student's family.
6. Since students will often reach out to the faith-based community in times of trauma, there may be value in providing pastoral crisis intervention services.
7. Finally, it is imperative that students in intractable crisis have access to mental health clinics and psychiatric hospitals, if needed.

SUMMARY

Early psychological intervention (crisis intervention) is but one intervention concept on a total continuum of mental health care. It is best viewed as psychological first aid. As physical first aid is to surgery, crisis intervention is to psychotherapy. Continued research is clearly needed in this field, as is specialized training. As of this point in time, early psychological intervention should be considered in the wake of mass disasters, traumas, or singular critical incidents (suicides, suicide attempts, serious motor vehicle accidents, accidental deaths, etc). College campuses and the populations they serve are not immune to psychological trauma or even mass disasters. The first line of defense on the psychological level is the college counseling center. Are you prepared?

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George S. Everly, Jr., Ph.D. is co-founder and Chairman of the Board Emeritus of the International Critical Incident Stress Foundation, a United Nations NGO providing consultation and training in the area of critical incident stress management and the emergency services professions. Dr. Everly is also Professor of Psychology at Loyola College in Maryland, and an Associate in Public Health at the Johns Hopkins University. Formerly Chief Psychologist and Director of Behavioral Medicine at the Johns Hopkins' Homewood Hospital, Dr. Everly co-founded the disaster mental health network for the central Maryland branch of the American Red Cross, was clinical and research advisor to the community mental health initiatives in Kuwait, and has actively worked in response to the Oklahoma City bombing, and the World Trade Center attacks. Address correspondence on this paper to Dr. George S. Everly, Jr. 702 Severnside Ave., Severna Park, MD, 21146