



Critical Incident Stress Management Foundation Australia Newsletter

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PRESIDENTS REPORT *Robyn Robinson*

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Special Points of Interest in the President's Report

- **CISMFA Confer-
ence 2004**
- **Coordinators
Meeting 2003**
- **Feature article:
How CISM Pro-
grams Function in
an Organisation**
- **Adaptation of
CISM model to suit
the workplace**

Planning is underway for the 2004 conference. The focus is on early intervention and our current knowledge of best practice. There is an excellent range of key-note and general speakers including Dr Jeffrey Mitchell, architect of the Critical Incident Stress Management model. The conference committee has tried to develop a format that gives delegates maximum flexibility in choosing those parts of the program they wish to attend. There are two days of pre-conference workshops and the conference itself is also two-days; though the registration allows delegates to attend either or both days. The conference has been moved to a week time slot (rather than weekend) in line with requests from previous delegates. This will not suit all people, however it appears that it will meet the wishes of the majority. We have also decided against individual paper presentation, on a trial basis. Instead, there will be concurrent seminar sessions on both days of the conference. Here, people with expertise will be invited to present a brief 15 minute paper on a specific topic. There will

be 3 or 4 invited papers per seminar enabling plenty of opportunity for discussion at the end of the presentations. A list of seminar topics and presenters will be available from early April.

CISMFA hosted a day seminar at the end of last year for Co-ordinators of Emergency Service CISM programs in Australia. There is a need for people who have responsibility for running staff support programs to share their knowledge with one another, to contribute to important tasks such as the setting of standards and also to support one another when necessary. Ours can be isolated positions. Mr Paul Scott, Manager of Welfare Services with the NSW Rural Fire Service presented an excellent paper on how CISM programs function within an organisational environment. He has given permission for us to reproduce the segment of his paper that focuses on team development and maintenance. He raises important points on the role of organisations in programs that I am sure will be of much interest to many readers.



Indeed, there are many examples of CISM programs that have been changed and adapted to suit particular workplaces. This can be healthy and demonstrates the robustness of the CISM model. However in some circumstances, variations may differ so greatly from the basic principles of the CISM model as to constitute a different approach or even a model which is counter to the CISM one. I have heard people say that they do not follow "the Mitchell model" then describe what they do practice which, to my mind, is the classic CISM model. I have also heard people say that they do follow "the Mitchell model" then give an account of practices that I would definitely see as violations of the CISM approach. This raises the issue of what are the crucial features of the CISM model? It is a tricky question and one that needs to be answered at a variety of levels.

Presidents Report (cont)

"CISM programs can be affected, both positively and negatively, depending on the way that they are structurally integrated into the organisation;"



**CISMFA
Third Conference**

**3rd–6th
August 2004**

**Mark the date
in your
diary now!**

Probably the most obvious level of response is to cite the many texts that describe CISM. Like most successful models, the CISM one has evolved over time, but the basic principles have remained relatively unchanged. Nevertheless, since models of crisis intervention necessarily entail flexibility of applications, in keeping with individuals' needs, differences in CISM practices can and do emerge. What are the acceptable "variations on a theme" in the way CISM programs are administered and executed?

Our challenge in answering these and other questions is not limited to the content areas of CISM (such as the interventions of debriefing, defusing and crisis management briefings) or the training and supervision of service providers (peers and mental health) or the processes of mobilising a response following a critical incident. The CISM model also embodies certain philosophical principles which underpin practices. Examples are the maintaining of a non-political stance with respect to Management and Union and policies and practices around confidentiality.

CISM programs can be

affected, both positively and negatively, depending on the way that they are structurally integrated into the organisation. There are implications according to where they fit on organisational flow charts and determinations that are made regarding role descriptions, accountability and responsibility. The original operation of CISM teams in the US occurred essentially "out-of-hours" and outside of organisational structure, support or hindrance. In Australia, our programs have developed largely within organisational structures and we have needed to come to terms with how various structures can both help and harm programs.

To give an example, the increase in litigation regarding Posttraumatic Stress Disorder and work experiences has caused many programs to rethink how details can be given of management's support to employees in a court of law. This can and should be done in ways that preserve the essential nature of confidentiality of these programs and without turning the focus of the CISM program into a vehicle to protect Management from litigation.

On another matter, last years Co-ordinators meet-

ing specifically included members of the clergy in recognition of the important role that pastoral care plays in CISM programs. The second article in this newsletter defines pastoral Crisis Intervention. It is written by Dr George Everly, Co-Founder of the International Critical Incident Stress Foundation (ICISF). I am also delighted to announce that CISMFA is offering a new course in "Pastoral Crisis Intervention". It is accredited both by CISMFA and ICISF. There is only one authorised trainer in Australia to conduct that course, namely Mr Jim Keatch, and we welcome him into our group of trainers. He will conduct a half-day workshop prior to the August conference entitled "Incorporating Pastoral Care into CISM". Details and dates of the two-day course will be announced at a later time.

With just over 6 months until the conference, I would be most grateful if members could assist us by distributing the conference program and bringing this event to the attention of interested parties. Please contact the CISMFA office if you would like more fliers.

Best wishes for the New Year.

REFLECTIONS

When written in Chinese, the word 'crisis' is composed of two characters: one represents danger, and the other represents opportunity.

Developing and Maintaining a Team within an Organisational Environment

*Paul Scott DipCommMgt, MCouns
Manager, Welfare Services, NSW Rural Fire Service*

Editors Note

The following is an extract from a paper titled "Working Within an Organisational Environment" It was presented at a workshop on "Critical Incident Stress Management Programs: Challenges and Future Direction" on 12th December 2003, in Melbourne. The extract is reproduced here with the kind permission of the author. The paper identifies several issues relevant to how CISM is applied within an organisational environment, such as management commitment, program maintenance, policy and the CISD/CISM debate. This extract describes just one of those elements, namely developing and maintaining a team.

Centrally Coordinated and Managed Programme

The CISM function needs to be a centrally coordinated and managed programme to ensure adequate activation, deployment and monitoring capability. A centrally coordinated programme allows for the allocation of the most appropriate resource to the presenting need, the control of logistical resourcing (transport – air and ground, accommodation, meals, radio communications, appropriate forward command briefing, etc) along with welfare assessment of the CISM personnel (Peer Supporters, external consultants, etc).

Clinical Expertise

Not only does the CISM Manager need to be administratively and logistically adept, he/she also needs to be clinically equipped to monitor and supervise all aspects of the programme along the continuum of care. The NSW Rural Fire Service's Critical Incident Support Service (CISS) manager has always had a mental health practitioner background, however the position established two years ago, was formally required to have clinical expertise in CISM, counselling and supervision. Whilst Mitchell and Everly's CISM model does not require this feature, it is I believe, a best practice initiative. Of course, if an agency has the capacity to engage the services of a mental health practitioner on a full-time basis, or have quick easy access to one, this may compliment or override the CISM Manager to have such expertise.

Quite often, CISM teams that rely upon an external provider to ensure clinical supervision, experience a diminished capacity to provide such supervision, often as a result of financial constraint, remote access and availability, and so on. For small operating programmes, this may not be as significant a factor. But for a programme the size of the NSW Rural Fire Service, with in excess of 6,800 hours of activation

over a 12-month period (not including pre-incident education / information), it has been identified that an important component is to have in-house capability allowing for immediacy and proximity.

It is recognised that at times the role of the CISS Manager versus clinical supervisor can conflict, and for this reason we utilise a pivotal team of four of our key mental health practitioners (with a network of a further twelve practitioners, if required) to work closely with the Peer Supporters, to ensure appropriate clinical support is available to them. In this context, it is necessary to emphasise that *supervision* has a different meaning to that in other work settings. Supervision in CISM is not that dissimilar to supervision in counselling, i.e. it is not primarily a management role, in which the CISM Team Member is given directions and allocated tasks, but rather is aimed at assisting the CISM Team Member to work as effectively as possible with the 'client' (Carroll 1988). Hawkins and Shohet (1989) have identified three main functions of supervision in this context. The first is educational, with the aim of giving the CISM Team Member a regular opportunity to receive feedback, develop new understandings and receive information. The second aspect is the sup-



"Not only does the CISM Manager need to be administratively and logistically adept, he/she also needs to be clinically equipped to monitor and supervise all aspects of the programme along the continuum of care."

Developing and Maintaining a Team within an Organisational Environment (cont)



portive role of supervision through which the CISM Team Member can share dilemmas, be validated in his/her work performance and deal with any personal distress or counter-transference evoked by 'clients'. Finally, there is a management dimension to supervision, in ensuring quality of work and helping the CISM Team Member to plan work and utilise resources.

CISM Manager

A major issue facing CISM Managers is the development and maintenance of the CISM team personnel. The Programme manager needs to have superlative leadership skills – particularly in relation to management, coordination, and effective communication across all levels.

Team Composition and Activation

The CISS team within the NSW Rural Fire Service is comprised of the CISS Manager, Assistant Manager, 4 CISS Duty Officers, an Incident Management Liaison Officer, 35 Peer Supporters, a Senior Chaplain, a Senior Family Support Officer, 4 key specialist practitioners and a network of 12 specialist practitioners. Requests for CISS assistance may be made by personnel seeking individual assistance, by Captains, Fire Control Officers or other personnel seeking group assistance, or by referral through other internal welfare programmes. Members make initial contact with our State Operations Division

via a 'freecall' telephone number. An Operator receives a telephone contact number and a first name only, and pages the CISS Duty Officer. The CISS Duty Officer contacts the member, makes an assessment, and deploys the most appropriate resource for the presenting need. In the eventuality that the primary CISS Duty Officer does not respond to the pager notification within 5 minutes, the secondary CISS Duty Officer takes the call. Should there be a failure in this procedure, and contact has not been made with State Operations within 10 minutes, a second pager notification occurs. If this back-up procedure fails, the CISS Manager is activated via pager or telephone.

Appropriate selection, recruitment and training of CISS Peer Supporters

The NSW Rural Fire Service's CISS team has been operating for ten years, and throughout this time there has been five recruitments undertaken. Advertisements for the Peer Supporter positions are published, and applicants are required to provide a written submission addressing specific essential criteria and self-assessment, along with two written references (one from their Fire Control Officer). Following the 'cull' of unsuitable applicants, each person is interviewed by a panel, with a further assessment being made at that time. These appli-

cants are required to undertake psychometric testing / evaluation. The final 'cull' occurs based upon the initial application, the two referee checks, the interview and the psychometric evaluation. The successful candidates are then invited to attend a basic Rural Fire Service CISM training programme – conducted over two, 2-day sessions, with a written assignment to be completed between the two training weekends (five weeks apart). The training programme includes effective communication, organisational and procedural requirements, and the CISMFA accredited basic CISM programme. Candidates are continually monitored and assessed at every stage, by the CISS Manager, Safety & Welfare Manager, and three Peer Supporter Mentors. Not all candidates are guaranteed of progressing the second training weekend, or indeed of continuing onto the Probationary Peer Supporter status. However, those that are successful are invited to join the CISS team as probationary Peer Supporters, and sign an initial agreement, committing to a twelve-month period of availability, continual assessment, and professional development. At the end of the 12-month period, Probationary Peer Supporters may be invited to join the CISS team as Peer Supporters (full members). All members of the CISS team are required to sign

"A major issue facing CISM Managers is the development and maintenance of the CISM team personnel".

Developing and Maintaining a Team within an Organisational Environment (cont)

an annual agreement, committing to all the protocols of the CISS programme. Termination or suspension of members may occur at any time, if an investigation determines breaches of protocol, and the situation warrants this measure.

Assessment of Specialist Consultants

A written *curriculum vitae* is required from all specialist consultants prior to their engagement. The CISS Manager conducts an interview with each consultant, and makes an assessment against specific essential criteria, which also includes a 'cultural fit' component, along with a willingness and capability of becoming knowledgeable in the aspects of the NSW Rural Fire Service. Acceptable specialist consultants undertake a Rural Fire Service induction component and are directly observed in their interactions with fire-fighters on the fire ground. Satisfactory consultants are invited to meet with the CISS team, who provide a 'peer review' of the candidate. Professional skills must be maintained, written reports supplied, and other protocols met. The key team of consultants are members of the CISS team and are required to abide by legislated policy, and sign an annual agreement.

Adequate and Appropriate Ongoing Training

The CISS team undertakes a minimum of two ongoing training sessions per year – comprising of two

full days and one evening session. Other forms of education and training are identified and recommended to Peer Supporters to undertake. Some financial assistance can be provided for this vital area. Skills maintenance and assessment of competency is conducted at these training sessions to ensure that all personnel are competent to provide the CISM work for which they are responsible.

Reporting Methodology

It is a requirement of the CISS programme that all activations must be verbally reported on, to the CISS Manager or CISS Duty Officer within 24-hours of their occurrence. Written statistical summary reports are required to be forwarded to the CISS Manager within 7 days. Although this is a centrally coordinated programme, Peer Supporters may at times receive direct requests for assistance. Our protocols require that this activation is reported to the CISS Manager or CISS Duty Officer as soon as is reasonably practicable.

Adequate Referral Network

In keeping with Mitchell's CISM model being a continuum of care, it is important that CISM programmes not only cater for the early / crisis intervention requirement, but should also ensure adequate provision of treatment based initiatives. To this end, the NSW Rural Fire Service has established a significant network of mental health pro-

viders that can receive referral for psychological assessment and treatment in the short-term. Prolonged situations may require referral to providers under the workers' compensation / rehabilitation programme (external to CISM).

Maintaining Confidentiality Boundaries

No-one would argue that a CISM programme must ensure that the strictest confidentiality is maintained. NSW Rural Fire Service members often want to know that their dealings with the CISS team and the content discussed will be kept confidential. (Although CISS Peer Supporters operate under confidentiality guidelines, they actually have no exemption under law to withhold information when called upon by a court of law). The belief systems of well-intentioned line managers often include their conviction that they have a 'need' or a 'right' to know about a member who is accessing the CISM programme. They may also wish to know whether the said person is fit and proper to perform their duty as a fire-fighter. It should be noted that the responsibility to determine an individual's fitness to work rests with their supervisor / manager. To divulge any such information would be regarded as a clear breach of confidentiality. Not only would this be ethically improper, but it would also jeopardise the reputation and integrity of



"In keeping with Mitchell's CISM model being a continuum of care, it is important that CISM programmes not only cater for the early / crisis intervention requirement, but should also ensure adequate provision of treatment based initiatives."

Developing and Maintaining a Team within an Organisational Environment (cont)

the CISM programme.

One of the key ethical questions that can arise in the day-to-day practice of CISM within an organisational environment is that of CISM team member accountability. On whose behalf is the CISM team member working? Is the CISM team member only the agent of the 'individual or group client', therefore only acting on behalf of the 'client'? Or can there be other people who have legitimate demands on the allegiance of the CISM team member?

Conflict between the fidelity to the 'client' and other demands on the CISM team member can occur according to Wise (1988), and are often referred to as 'third-parties'. In these situations, the CISM team member may be paid or employed by an (the) organisation of which he/she

is a CISM team member, and may in fact be viewed by the organisation as being primarily responsible to it rather than to the 'client' (Bond 1992). There may be both overt and subtle pressures on the CISM team member to disclose information about the 'client', or to ensure that the CISM assistance provided arrives at a predetermined outcome that best suits the organisation.

Sugarman (1992), makes a number of recommendations (which were originally formulated with reference to the provision of counselling in workplace settings, and have therefore been adapted by the author for the purpose of CISM practices), concerning the maintenance of ethical standards in workplace settings:

- Discover the objectives the organisation is attempting to fulfil by pro-

viding the CISM service.

- Identify any points at which the CISM provision might benefit the organisation at the expense of the individual 'client'.
- Identify any points at which the organisation exceeds its right to control aspects of the 'clients' behaviour.
- Negotiate with the organisation about what is to be understood by 'confidentiality', and the conditions under which it will or will not be maintained.
- Discover whether the resources being allocated to CISM are sufficient to do more good than harm.
- Develop a written policy statement concerning the provision of CISM within the organisation.

Further discussion of the issue of accountability in

"One of the key ethical questions that can arise in the day-to-day practice of CISM within an organisational environment is that of CISM team member accountability."

CISMFA Third Conference

CHALLENGES IN EARLY INTERVENTION

3 – 6 August, 2004

Hilton on the Park, Melbourne

Key-note Speakers

Cherie Castellano, MA, CSW, LPC. Program Director, Cop 2 Cop, USA

Moir Kelly, AO. Executive Director, Children First Foundation

Jeffrey T. Mitchell, PhD, CTS. President Emeritus, ICISF, USA

Gary Raymond, APM. Chief Inspector, NSW Police Force

Michael Tunnecliffe, PhD. General Manager, Prime Corporate Psychology.



Developing and Maintaining a Team within an Organisational Environment (cont)

workplace counselling can be found in Carroll (1996) and Shea and Bond (1997).

By having a CISM programme operated by the organisation itself, that is, seen to be an internal element, there often appears to be a perception that it is 'okay' to seek such information. Due to the prevalence of requests for information, the need to provide education and training to supervisory and line management, about the matters of confidentiality in such programmes has been highlighted. Similarly with external EAP providers, there can sometimes be the notion of 'who is the real client' i.e. the organisation, or the individual member. It is important here, as it would be in any other part of the programme, to foster a relationship built on trust and integrity. The emphasis should always be on meeting the needs of the individual member, so that the obligations of the organisation can be fulfilled.

Dealing with Isolation / Remoteness

Organisations operating across a large geographical area, may find that remotely located clients experience access difficulties because of the long distances they may be required to travel to see a mental health provider. The Rural Fire Service CISS programme has identified, and subsequently elimi-

nated this potential problem, by providing for the travel of CISS Peer Supporters (and consultants, as required) to the individual member's location, with all transport (air, road, water), accommodation, meals, and telephone expenses being met from within the CISS budget.

Linkage with Chaplaincy and Family Support

One of the most valuable concepts to emerge from the field of organisational studies has been the idea of the 'open system' according to Katz and Kahn (1978). From this perspective, organisations are seen as consisting of sets of overlapping and interconnecting parts which combine to form an organisational system, according to McLeod (1998). The NSW Rural Fire Service has deliberately separated the Chaplaincy and Family Support programmes from all things counselling and psychological in nature. Although these programmes are separate entities and managed independently, one actually operates as a safety net for the other. Whilst there is a degree of overlap and integration, CISS is focused on operational matters, whereas Chaplaincy and Family Support has a much broader scope.

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"Organisations operating across a large geographical area, may find that remotely located clients experience access difficulties because of the long distances they may be required to travel to see a mental health provider."

"Pastoral Crisis Intervention": Toward a Definition George S. Everly, Jr., Ph.D.



"The process of pastoral counseling, in the generic sense, may be thought of as the utilization of psychological, spiritual, and theological resources to aid persons in psychological and/or spiritual distress."

ABSTRACT

The pastoral community represents a large and often untapped resource in times of crisis. It possesses a unique aggregation of characteristics that makes it uniquely valuable amidst the turmoil of a psychological crisis. In critical incidents such as terrorism, mass disasters, violence, the loss of loved ones, and any events wherein human actions result in injury, destruction, and/or death, the pastoral community may possess especially powerful restorative attributes. Unfortunately, heretofore, there has existed no generally recognized and accepted manner in which the healing factors inherent in pastoral care have been functionally integrated with the well-formulated principles of crisis intervention. This paper represents an initial effort to elucidate how the principles of pastoral care may be functionally integrated with those of crisis intervention. The amalgam shall heretofore be referred to as "pastoral crisis intervention" and is defined herein [*International Journal of Emergency Mental Health*, 2000, 2(2), 69-71].

KEY WORDS

Crisis intervention; pastoral care; chaplaincy; critical incident; crisis;

Pastoral Crisis Intervention

The term *pastoral crisis intervention* is offered as a term that represents the functional integration of

psychological crisis intervention with pastoral care. This paper shall examine the widely used definitions of both domains and will further seek to elucidate the foundations of functional integration.

Crisis intervention is best understood in the context of the term crisis. A crisis may be thought of as an acute response to an event wherein homeostasis is disrupted, one's usual coping mechanisms have failed, and there is evidence of significant distress or functional impairment (Everly & Mitchell, 1999). The stressor event that precedes the crisis response is commonly referred to as the *critical incident*. The term *crisis intervention* refers to the provision of acute psychological first-aid so as to progressively achieve 1) a stabilization of symptoms of distress, 2) affect a mitigation of symptoms, and 3) restore adaptive, independent functioning, if possible, or facilitate access to further support (Everly & Mitchell, 1999; Flannery & Everly, 2000).

Literally defined, pastoral care may be seen as the function of providing a spiritual, religious, or faith oriented leadership. Pastoral care is typically provided by someone (often ordained, but not always) who has been commissioned or otherwise selected by a faith-oriented group or other organization to provide interpersonal support, assistance in religious education, wor-

ship, sacraments, community organization, ethical-religious decision-making, and related activities of spiritual support. From a more formal perspective, pastoral care is commonly provided by congregation-based clergy (and sometimes formally trained laity), chaplains, pastoral counselors, and clinical pastoral educators, while recognizing that these terms and functions are not mutually exclusive.

One specialized form of pastoral care, which has emerged, is pastoral counseling. The process of pastoral counseling, in the generic sense, may be thought of as the utilization of psychological, spiritual, and theological resources to aid persons in psychological and/or spiritual distress (Clinebell, 1966; Hunter, 1990). The clinical pastoral education movement, beginning in the 1920s with the pioneering efforts of Richard Cabot and others, served as somewhat of a foundation for the outgrowth of the pastoral counseling emergence. In 1963, the American Association of Pastoral Counselors was formed. Thus, the integration of psychological principles and practices with pastoral care appears to be currently manifest in two formalized movements: pastoral counseling and clinical pastoral education.

It seems clear that anyone who serves the function of providing pastoral care will be confronted with the challenge of an acute psy-

"Pastoral Crisis Intervention": Toward a Definition (cont)

chological and/or spiritual crisis. Whether, in a house of worship, a hospital, a nursing home, at the scene of an accident or disaster, a funeral home or gravesite, a battlefield, or even in a formalized counseling office setting, the manifestations of a human being in a state of crisis can be in evidence. The crises may manifest themselves in concrete and tangible concerns regarding safety, security, and general welfare, or they may manifest themselves in less tangible concerns regarding self-identity, affiliative crises, existential, spiritual, or even theological crises (a crisis of faith). But, it is the viewpoint of this paper that, contrary to some commonly held pastoral perspectives, not all crises are spiritually or theologically based (Sinclair, 1993). For those who rise to meet such challenges, a solid grounding in theology, spirituality, and pastoral care is only the beginning. Also requisite will be skills in psychological triaging, basic crisis intervention, and finally, a familiarity with other supportive resources, including psychological, psychiatric, and even other pastoral resources.

This then is the practice of *pastoral crisis intervention*. Simply stated, *pastoral crisis intervention is the functional integration of any and all religious, spiritual and pastoral resources with the assessment and intervention technologies germane to the practice of emergency mental health*

(Everly, 1999). Clearly, as is evident from the definition afforded earlier, crisis intervention is not the same as counseling and psychotherapy (Everly, 1999). Some psychotherapeutic tactics would even be contraindicated in crisis intervention due, in part, to the highly focused and time-limited nature of crisis intervention. Similarly, pastoral crisis intervention is not the same as pastoral counseling or pastoral psychotherapy. Thus, by way of summarial parallelism, as crisis intervention is to counseling and psychotherapy, so pastoral crisis intervention is to pastoral counseling and pastoral psychotherapy.

The mechanisms of action which support pastoral crisis intervention include all of the same mechanisms which support non-pastoral crisis intervention such as social support, problem-solving, cathartic ventilation, and cognitive reinterpretation (Everly & Mitchell, 1999). In addition, the pastoral crisis interventionist benefits from the ability to use, where appropriate, scriptural education, insight, and reinterpretation (Brende, 1991), individual and joint prayer, a belief in the power of intercessory prayer, a unifying and explanatory spiritual worldview that may serve to bring order to otherwise incomprehensible events, the utility of ventilative confession, a faith-based social support system, the use of rituals and sacraments, and in some

religions, such as Christianity, the notion of divine forgiveness and even a life after death. All of these factors may make unique contributions to the reduction of manifest levels of distress (Everly & Lating, in press). Finally, the pastoral crisis interventionist may also prosper from a truly unique ethos (the perspective of theological or divine credibility), as well as, the implicit belief in uniquely confidential/privileged communication exchange.

The two intervention processes closest to the extant definition of pastoral crisis intervention are crisis ministry and crisis chaplaincy. As commonly defined, crisis ministry has as its expressed goals, not only the restoration of functioning within a practical life schema, but also addressing the theological aspects and implications of the critical incident and corresponding crisis response, in all instances (Hunter, 1990). Crisis chaplaincy, in practice, is the closest operational formulation to the notion of pastoral crisis intervention. The greatest difference is perhaps lexical, in that a chaplaincy most often denotes either a specialized form of pastoral care, or more commonly, pastoral care provided to a specialized group or organization, such as law enforcement, fire suppression, hospitals, the military, etc. (Hunter, 1990). In sum, the goals of pastoral crisis intervention, as defined herein, are fun-

"Simply stated pastoral crisis intervention is the functional integration of any and all religious, spiritual and pastoral resources with the assessment and intervention technologies germane to the practice of emergency mental health."



"Pastoral Crisis Intervention": Toward a Definition (cont)

"The pastoral orientation to crisis intervention brings with it a "value added" over and above the traditional non-pastoral approach to crisis intervention."

damentally the same as those of non-pastoral crisis intervention, i.e., the reduction of human distress, whether or not the distress concerns a significant loss, a crisis of meaning, a crisis of faith, or some far more concrete and objective infringement upon adaptive psychological functioning. In the context of this paper, the pastoral orientation to crisis intervention brings with it a "value added" over and above the traditional non-pastoral approach to crisis intervention. This corpus of "value added" ingredients has been enumerated above as mechanisms of change, and appear to be unique to the pastoral perspective as it employs religious, spiritual, and theological resources in an effort to "shepherd" an individual from distress and dysfunction to restoration. As a result of these unique strengths, some form of pastoral crisis intervention option should be integrated within all critical incident stress management teams, community cri-

sis response efforts, and other crisis intervention systems.

NOTE

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17 courses were conducted from 1st July to 31st December 2003 including one in New Zealand and one in Kuala Lumpur

CISMFA Courses July—December 2003

There were 17 courses conducted from 1st July to 31st December, 2003. They included CISM Basic courses, one of which was the first CISMFA course to be run in New Zealand. This was for the New Zealand Fire Services taught by Dr John McEwan. A basic course was also conducted for Malaysian Airlines in Kuala Lumpur and was the second one to be arranged.

Other organisations that held a CISM basic course were Queensland Health; Lifecare Baptist, NSW; South Australian Ambulance Service; Wangaratta Hospital, Victoria; City of Whittlesea, Victoria; Centacare, Queensland and Firecare, Queensland.

Two CISM advanced courses were conducted: one in Melbourne and one in Brisbane.

Finally, a course on Suicide Negotiation was presented by Mr Gary Raymond and received excellent reviews.