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Chapter 23.

TRAINING PROGRAMS FOR BUILDING COMPETENCE IN

EARLY INTERVENTION SKILLS

by

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1.0 INTRODUCTION

Each disaster requires emergency response specifically for its survivors. Early interventions that seek to prevent or minimize psychosocial and mental health consequences of exposure to potentially traumatic events do so by promoting resilience and coping. This chapter offers a plan for training groups of helpers to integrate this perspective into early interventions following trauma. Three vignettes are used to exemplify the training processes and interventions that may follow from this new competency.

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1.1 Vignettes: The events

1.1.1 A coach accident in Scandinavia

One dark and rainy evening a coach with 32 football fans was returning from a sports event and was hit by a car heading in the opposite direction. The coach slid off the road and tipped over. Although all the coach passengers were thrown out of their seats none incurred serious injuries, however, three passengers in the car were killed instantly. Police and a crisis team from the local hospital emergency unit arrived on the scene within ten minutes.

1.1.2 War in a Bosnian town

In the midst of war, a group of Bosnian mental health professionals attended a two-days course on crisis intervention and disaster preparedness. Delegates complained their work was tiresome and they felt exhausted. Although no shelling of the town had taken place for three weeks most of the helpers, their families and clients struggled with the ongoing psychosocial consequences of war. They lived with an unrelenting fear that the violence could start again at any time. Indeed, two days later a bomb killed a group of teenagers and injured others. The group of mental health professionals who joined the course hurried to assist survivors.

1.1.3 Abduction in a Sudanese refugee camp

Sudanese refugees have lived in camps inside Uganda for more than 17 years under constant threat from rebels. A community based mental health program trained paraprofessional refugee counselors to assist in their own communities. One night a settlement was attacked and a group of twelve children abducted. From previous experiences, the refugees knew these boys would be forced to become child soldiers
and the girls taken as “wives” for the rebels. Community leaders tried to console the families of the abducted and called the counselor for assistance.

2.0 TRAINING EARLY INTERVENTION SKILLS

Our global media reports traumatic events daily. Though there is a need for research to prove effectiveness, the knowledge of how to provide mental health assistance to those involved has grown exponentially in recent years (Ursano et al. 1996). It is already a significant task to integrate the existing new knowledge into daily best practice and into training programs to build the competence of helpers in early intervention skills.

Implementing a training program requires numerous dimensions. Consideration for who should be trained, what should be the content of the training and how do we ensure the quality, sustainability and continuity after the training is essential. Different resources in the “developed”, “developing” and so-called “countries in transition” define different possibilities. Essential is the level of sustainability and continuity of the competence achieved after the training. Therefore, each training program from the beginning must build capacity to sustain helping efforts though the existing crisis and for future crises. This is effectively done through a “cascading approach” (de Jong 1995, 2002, Fairbanks et al. 2002, Baron et al. 2002). In this approach, each trained group has its capacity raised to the point where it can train another group and multiple trained groups cascade together to provide comprehensive help. This is especially important due to the extensive needs for training in large-scale disasters.

Within this chapter, the design of training courses and curriculum are outlined through the use of 3 phases of early intervention.
3.0 THREE PHASES OF EARLY INTERVENTION

Practical early interventions can be organized into 3 phases:

Phase 1: Needs Assessment Leading to Emergency Response,

Phase 2: Preventive Brief Interventions and

Phase 3: Early Clinical Interventions.

The training curriculum is then adapted to the specific skills needed to provide assistance in each phase:

3.1 Phase 1: Needs Assessment Leading to Emergency Response

It is essential to make a correct assessment of individual and group needs before initiating any intervention in any context. This can be done quickly and is crucial to ensuring that from the onset interventions address the actual needs of service users. To collect the needed information and create an immediate overview of the priorities, helpers compassionately interact with the survivors and offer emotional support as they collate the needed information. Based on the Needs Assessment they coordinate the “here and now” efforts and begin to meet the practical needs of the current emergency. As this is happening, plans can be formulated to deliver other early intervention services at later phases of the crisis.

3.2 Phase Two: Preventive Brief Interventions

The goals of Preventive Brief Interventions are to minimize exacerbation of emotional and practical problems caused by crisis situations. Target populations served can be survivors and their families, witnesses, emergency workers and whole communities. These early interventions comprise of activities intended to be in place within days of completing an initial needs assessment and are provided once or over an extended time.
During these early brief interventions, participants are encouraged to openly share information, experiences and feelings evoked by the traumatic events. Early intervention activities seek to reduce or dissipate emotional distress, advise participants about how to cope emotionally and practically with crises and promote resiliency through family and community support. During these early interventions, helpers try to identify survivors who are more deeply distressed and require onward referral for additional care.

3.3 Phase Three: Early Clinical Interventions

Early Clinical Interventions target individuals, families or small groups in need of more specialized assistance than provided in the Preventive Brief Interventions phase. They seek to address the needs of survivors who are extremely distressed or are so emotionally disorganized that they have been unable to return to normal functioning. Early Clinical Interventions help participants understand their reactions and promote adaptive coping strategies so as to prevent escalation of adjustment difficulties into longstanding or chronic problems.

Whereas Preventive Brief Interventions comprise of activities that seek to resolve distress and promote resiliency, Early Clinical Interventions are like short term counseling sessions with a “here and now” focus on reactions evoked by the traumatic event.

Additionally, a small number of survivors may still need more help than can be provided through these three levels of early intervention. Some may require long-term psychotherapy, especially if a recent event revived memories and reactions to previous traumatic experiences.

In practice, these levels of early intervention may overlap but the framework is useful for systematizing and planning. This framework is used to outline the main themes in the training curriculum to prepare helpers to intervene at each phase. These
themes for training are then illustrated through the development of events in each of the three vignettes.

4.0 WHO SHOULD BE TRAINED TO PROVIDE EARLY INTERVENTIONS?

In the vignettes the traumatic events occurred in three distinct cultural contexts each characterized by significant differences in accessible economic and professional resources. It is therefore essential to begin by addressing the question of who should be trained when seeking to develop early intervention skills appropriate for a particular cultural context:

4.1 In ‘Developed’ countries

The first vignette of a traffic accident in a developed and peaceful country demonstrates how early intervention can be provided with the resources of a well functioning health care system staffed by sufficient numbers of trained professionals who can be mobilized at short notice. In developed countries, survivors and members of the general population expect local professionals to be available to address social, psychological, psychiatric and physical needs that arise after major events. In this context, all potential helpers including police, fire fighters, health professionals, psychiatrists, psychologists, social workers and other emergency volunteers need specialized training in mental health service.

4.2 In ‘Countries In Transition’

A traumatic event in the midst of a war-affected ‘country in transition’ is described in the second vignette. Although some trained professionals are available to provide health, social, psychological and psychiatric care the health care system is not prepared to handle the overwhelming consequences of war. In such situations, often only a few
national professionals have specialized knowledge about how to assist communities with traumatic experiences. The target group for training in this context is similar to that of a developed country but because of the severity and magnitude of the crisis these professionals can be complemented by local police, government officials, community and religious leaders, human rights workers and emergency volunteers. Expertise available within United Nations organizations and international nongovernmental organizations (NGOs), soldiers or peace keepers can also be used.

4.3 In ‘Developing’ countries

The third vignette is set in the context of a refugee camp in a developing country. Community and religious leaders, healers and families are expected to assist those in need by providing emotional and physical support, ritual and prayer. Only a small number of trained mental health professionals are available within most countries and they typically provide services to the national population and are unavailable to refugees. In the developing countries, the target group for training is similar to that for countries in transition. One main difference is that the number of mental health professionals is often limited so the establishment of a trained paraprofessional team is helpful. Cooperative work with community elders, leaders and traditional healers is essential.

5.0 TRAINING CURRICULUM FOR PHASE ONE:

BUILDING SKILLS FOR NEEDS ASSESSMENT AND EMERGENCY RESPONSE

Training given to develop competence in Needs Assessment and Emergency Response encourages participants to take a pragmatic, common sense perspective on acute and early interventions after trauma. In the very early aftermath of an emergency, the imperative is to offer practical interventions at individual, family, group and community levels. Learning how to do a needs assessment is essential to all helpers since the
appropriate practical emergency response will differ as illustrated through the continuation of the vignettes.

5.1 Vignettes of Phase 1 Interventions

5.1.1 The Scandinavian coach accident

A crisis team arrived to assess the situation and the police organized a simple shelter for survivors in which refreshments were served. Brief interviews were conducted with all coach passengers and its driver while immediate needs were addressed. Special attention was given to anyone appearing physically hurt or severely affected emotionally. Relatives were contacted. The team addressed the whole group and expressed the hope that all would cope fine but also explained that nightmares, flashbacks and feelings of anxiety during coming days and nights might be anticipated as natural transitional reactions. They were advised that if these reactions persisted or interfered with daily functioning they could find help at a local psychiatric emergency unit. Details of a follow-up meeting to be held within a week of the accident were circulated. After a brief questions and discussion session all passengers decided to go home to their families and friends. Transport was organized. The team agreed to meet the next day for an operational review.

5.1.2 War in a Bosnian town

The blast was heard all over town. A social worker who lived near the site of the incident contacted members of her previous training group and within minutes they arrived at the scene to form a crisis team. They assessed the needs of survivors and ensured that the injured were transported to the medical emergency room. The team established a focal point for information and made themselves available the next day to offer assistance in a
community mental health center. They prepared a list of the families most directly affected by the attack and sought permission to contact them within a week for follow-up.

5.1.3 Abduction in a Sudanese refugee camp

The refugee counselor visited all families whose children were abducted and discussed details of the incident while also assessing the immediate needs of those involved. She educated them about normal psychological reactions they might expect from this traumatic event and established the extent to which support was available from family, elders, community leaders and healers. All were encouraged to seek help if needed. She explained where she could be contacted should they become overwhelmed by distress and promised a follow-up visit within a week. She asked to be informed should the abducted children return and discussed the potential physical and emotional effects for returning children. Since all families lived in fear due to lack of safety in the camp she met with officials to advocate improved security on their behalf.

5.2 Content of training

Each vignette illustrates different emergency interventions appropriate for the three different cultural and situational contexts. Some of the main skills to be included in a training curriculum to prepare helpers for appropriate emergency response include:

5.2.1 Fostering Good Helper- Survivor Dialogues

 Helpers are trained in key skills required to initiate brief, focused and comprehensive dialogues with survivors that foster comfort and trust. These skills build on inherent helping abilities and natural compassion. From the start, helpers need to convey confidence to engender trust that they are responsible people able to provide immediate practical help.
5.2.2  Knowing How to Share Information
Helpers are taught practical methods for collecting and expediently passing on important
information including details of the available sources of further help.

5.2.3  Coordination Skills
Trainees are taught how to establish a comprehensive action plan and a structured
scheme for its coordination so as to decrease fears and misunderstandings among
survivors, relatives and the public.

5.2.4  Meeting Survival Needs
Techniques for assessing and problem solving basic survival needs are taught.

5.2.5  Upholding Human Rights
Helpers are familiarized with basic principles of human rights and to identify human
rights violations. They learn when and where to advocate on behalf of survivors, register
formal complaints and ask for specialist human rights assistance (Buus Jensen 1998).

5.2.6  Mental Health Education
Training is provided to promote understanding of normal reactions to abnormal situations
and how to educate survivors about these to minimize fears evoked by their occurrence.
Helpers are taught techniques that identify those in need of immediate care or onward
referral. They are taught to encourage survivors to ask for support from their families or
social networks, health care systems, religious organizations or other natural sources of
help.
5.2.7 Follow-up to Explore Latent Problems or Needs
Helpers learn that some people appear untroubled immediately after the traumatic event only to require assistance at a later date. They learn follow-up skills to prepare them to contact people days, weeks or months after an event in a respectful way, honoring privacy and offering help only if needed.

5.2.8 Taking Care of Caretakers
Helpers are trained to recognize risks and signs of vicarious traumatization and are made aware of the imperative of establishing appropriate self-support provision and supervision (Saakvitne & Pearlman 1996, Buus Jensen 1996, Friedman et al. 2002). Information is also given about where they can get specialist help if required.

6.0 THE TRAINING CURRICULUM FOR PHASE TWO:
PREVENTIVE BRIEF INTERVENTIONS
Preventive Brief Interventions go beyond the Needs Assessment and Emergency Response to introduce help for individuals, families, groups and communities. Examples of such interventions are given in the following vignettes.

6.1 Vignettes of Phase 2 Interventions
6.1.1 A Scandinavian coach accident
A follow-up meeting was held for some of the survivors a few days after the accident. Such incident review meetings for survivors and their families foster discussion, exchange of information, processing of experiences and feelings plus problem resolution. For many, these early interventions will be sufficient to close the experience so that normal routines can be reestablished. Those requiring more intensive help can also be identified.
6.1.2 War in a Bosnian town

A few days after the bombing a memorial service was organized to mourn its victims. Such community events and collective rituals may have a strong personal impact due to allowing the survivors’ pain and suffering to be symbolically communally recognized and shared.

6.1.3 Abduction in a Sudanese refugee camp

Meetings with the extended families of abducted children were held in the family’s home the day after the incident. The family members shared their fears and actual knowledge about the situation with each other and the counselor. Time was given to mourn their loss, share hopes and mobilize coping resources.

6.2 Content of Phase Two Training

Training for Phase Two early interventions concentrates on skills needed by helpers to assist survivors to process traumatic experiences and provide support, reassurance and problem resolution caused by or exacerbated by the “here and now” situation. Trainees also learn to identify signs, symptoms and reactions for people requiring referral and more intensive follow-up.

The more therapeutic the aim of these early interventions the more important it is for providers to be trained in mental health work. However, adequate skills for Phase 1 and 2 can be taught to all selected helper groups as follows:

6.2.1 Crisis Response in Phase Two

Helpers learn skills for immediate crisis response including how to assess, respond and refer people at risk of suicide, homicide or mental decompensation. They are taught to
take a “here and now” practical focus and to choose the most relevant target group for intervention: individual, family, group or community.

6.2.2 Basic Counseling Skills

Basic counseling skills of listening, support, attending and questioning are taught along with problem solving and group facilitation skills. Much emphasis is placed on learning how to structure the immediate emotional chaos evoked by disasters and assist survivors in creating a comprehensive narrative of events (Buus Jensen 2001). To avoid unnecessary pathologizing, more is taught about normal vs. abnormal responses to traumatic events and about how to promote natural coping and foster resiliency.

6.2.3 Taking Care of the Caretakers

Helpers are made aware of the importance of attending to their own needs, feelings and stress reactions evoked by listening to survivors repeated narratives or by being a participant observer of unfolding events.

6.2.4 Networking

Training is given in how to mobilize natural helping systems available to survivors with particular emphasis being placed on actively encouraging the organization of collective healing rituals.

7.0 THE TRAINING CURRICULUM FOR PHASE THREE: CLINICAL INTERVENTIONS

After trauma, most survivors cope by drawing on personal resilience and support available through their immediate family or social networks. Early intervention may
therefore be limited to providing some support to those in immediate need, distributing relevant information or practical problem solving and the interventions offered in Phases One and Two. Only small numbers of survivors are likely to need Phase Three early interventions in the form of clinical interventions to promote healing (Baron et al. 2002).

7. Vignettes with Phase Three Interventions

7.1.1 The Scandinavian coach accident
The coach driver developed nightmares and became afraid of sleeping since he would relive the accident in dreams that woke him up in an anxious state. He was unable to return to work due to flashbacks and anxiety attacks evoked by thoughts of once again driving a coach. Preventive Brief Interventions proved insufficient to resolve these reactions so a referral to a psychiatrist trained in the treatment of trauma survivors was arranged. A clinical management plan involving individual short-term psychotherapy combined with medication was implemented.

7.1.2 War in a Bosnian town
Some of the surviving teenage girls developed fainting spells which intensified after they participated in the community mourning rituals. In response, a psychologist set up a support group for these teenage girls that met once a week for ten sessions.

7.1.3 Abduction in a Sudanese refugee camp
The father of one of the abducted children started drinking to excess and was abusive to members of his family. He had previously participated in a Preventive Brief Intervention in which the extended family discussed the abduction but symptoms persisted. The counselor made regular visits to the man and his family to encourage him
to recognize his drinking problem while offering protection and support to other members of this family.

7.2. **Content of Phase Three Training**

Professionals with expertise in mental health work are obvious candidates for training in Early Clinical Interventions since these draw upon the same skills and knowledge used in general mental health counseling and therapy. Special elements in the training curriculum for Phase Three are outlined below:

7.2.1. **Clinical Skills**

A variety of clinical skills can be taught ranging from conducting Critical Incident Stress Debriefing meetings (Mitchell and Everly 1995), short-term crisis intervention and therapeutic approaches that focus on the subjective meanings of the present trauma as rooted in past formative life experiences. Helpers are also trained in techniques of narrative therapy. This technique seeks to bring order to chaos by assisting survivors to reconstruct their immediate trauma story. Examples include the testimony method developed for individuals, families and groups (Cienfuegos and Monelli 1983) or family-oriented narrative methods (White and Epton 1990).

Special training in the use of EMDR (Shapiro 1995) and related techniques are offered if special situations call for it. Use of body oriented therapies are advocated only if therapists have previously acquired skills and experience. (Levine 1997).

 Helpers are also made aware of the importance of self-care and supervision as means of minimizing risks of vicarious traumatization.
8.0 SOME WAYS FORWARD

To ensure continuity of high quality interventions, training programs need to formally establish systems of evaluation that collate data about the success of training, acquisition of skills and resulting interventions (Buus Jensen, 1998, Baron 2002). Furthermore, supervision and follow-up of trainees is essential to building competence since it is a rare situation in which someone learns the skills for Needs Assessment, Brief Preventive or Clinical Interventions in one easy lesson.

It is essential that training programs achieve sustainability and continuity of high quality intervention after the training. The “cascading approach” is recommended. This involves each trained group developing its resources and skills so that it can train and supervise other groups thereby “cascading” their competencies into the broader community.

Throughout this chapter, we have described the training needed to prepare helpers to carry out early interventions with a psychosocial and mental health focus. We have identified groups of potential trainees in different world contexts and outlined main elements in the content of training. In the practical world, these variations have to be translated into pragmatic training courses, which will target the specific group of trainees in their specific context. All courses crossing cultures and contexts will then prepare helpers to effectively deliver relevant interventions to minimize mental health suffering in the short and long-term to any number of survivor groups whatever the crisis situation.
9.0 REFERENCES


