Psychological Early Intervention

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MOOC 1 – Unit 2
Different phases in Early Psychological Interventions: a dimensional crossings paradigm

Chapter 1
New Psychologist Profile Crossing Crisis Phases and Paradigm Dimensions

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Chapter 1: New Psychologist Profile
Crossing Crisis Phases and Paradigm Dimensions

INTRODUCTION

- Grasp the interweaving of the bio-psycho-social dimensions as the basis and guide for Psychological Early Intervention
- If we want to navigate the phases of the 3 dimensions without undergoing them, we must connect to the biopsychosocial structure of the phases themselves
- Because this is the secret of a good intervention in Psychological Early Intervention in different contexts : and so we keep the course in the storm

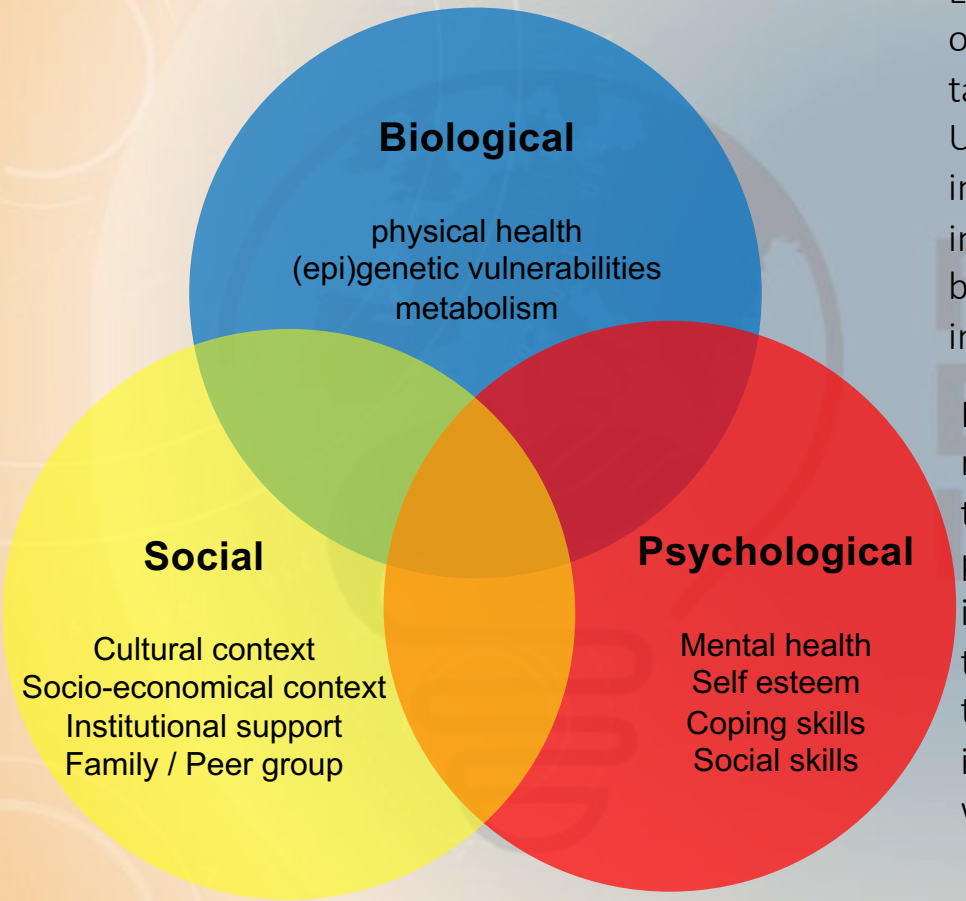
Chapter 1: New Psychologist Profile
Crossing Crisis Phases and Paradigm Dimensions

INTRODUCTION

The objective of this chapter is to describe and emphasize the ability to connect and cross the different types of phases on different contexts and the 6 types of victims on specific context by the psychologist. You will meet the neuronal stress phases in the next unit, and here you'll learn the crisis phases and rescuers intervention phases and crisis management phases (that you deepen in final unit of this Mooc).

The scientific literature shows the evolution of knowledge in all sectors involved in the management of crisis situations, precisely because experience has shown that interdisciplinarity permits links of knowledge and makes any intervention more effective and efficient. If in general only 4 types of victims are considered, the classification into 6 categories makes all operators more attentive to specific problems of patients, and this new attention has conditioned the implementation of intervention and organization methodologies. The interdisciplinarity today takes into account a more widespread systemic methodology since half century: the century of the biopsychosocial paradigm in the clinical, operational and managerial field.

INTRODUCTION



Each of these 3 paradigmatic dimensions has a dynamic impact on others at any level of intervention, creating circularity that takes into account positive and negative priorities. Understanding this flow of influences helps the quality of interventions and their efficiency with a positive return, not only in terms of mental and physical health of patients and rescuers, but also in economic conditions and energy flow of interventions

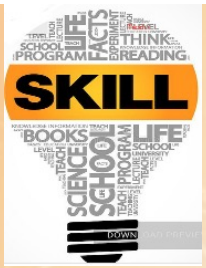
Knowing individually all the peculiarities of each dimension is not the right methodology since it excludes the specialization of trades and scientific research underlying the Western system of professional organization. The capacity for dialogue and interconectivity are appropriate because they take charge of the human aspects of professional relationships, the longer times intersectoral and specialist evolutions, and the intersection between science and politics as we have seen worldwide in relation to the Covid-19 pandemic .

§ 1.1 The bio-psychosociological paradigm and crossing levels

- While **anticipation** is central to the effectiveness and efficiency of each rescue intervention methodology, it remains evident in the role of the psychologist in crisis situations. Anticipation is not only central when it comes to the specific crisis event, but also with respect to the biopsychosocial **phases** that are emerging in every individual and community.

- The phases linked to the body and its close survival. Those linked to the psyche and its ability to keep and overcome stress and trauma. The social phases linked to the family and friend and professional groups, to the organization of aid interventions, support and care that must therefore be able to address all categories of victims – rescuers and communities included – taking charge the three dimensions under analysis.

- In the acute phase the **psychological support** of early psychological intervention is not "professionalized", and responds to specific primary needs that all rescuers must be able to offer in a direct and empathic way. But it becomes more and more specific according to the phases of the rescue and the type of victims. Certainly the first adaptation of psychological help (or not) is related to the type of crisis contest, which determines a priori and in a singular way any type of phase of the crisis.



§ 1.1 The bio-psychosociological paradigm and crossing levels

- The skills that the psychologist must develop in order to fluidly apply this principle of **transversal anticipation of the biopsychosocial phases and dimensions and contexts of crises** are multiple, but their basis lies **in empathy** as a perceptual ability **to grasp individual differences and anticipate them in different contexts, linked to their specific phases**. We've dedicated an unit in MOOC 2 to Empathy, but you'll find simple directions and exercises below to practice and test yourself.
- Having in mind the 6 types of victims, the 4 crisis phases that victims go through in crisis situations and remembering that individuals, groups, organizations and communities express themselves holistically in the 3 dimensions of the biopsychosocial paradigm of human reality, allows to empathically anticipate the recognition of the global functioning of the patient or victim who is in charge, even just for a first psychological support. [*** Jeffrey T. Mitchell , 2014,2003)
- When this methodology will be clear enough, don't forget that you have to get rid of and remake it as a new methodology for every context because in practice every context is new, with new specific community territory, new kind of resources, new people's problems. You just wait the same and the unknown and try to match with your experience and professionality and that of all the others. **Please don't forget that you are also in development when you're coming as a rescuer !!**

§ 1.1 The bio-psychosociological paradigm and crossing levels

- Understanding the person who addresses you as psychologist, sometimes to tell you, for example, about how things go wrong in the nurses' group, of which he may not even be a part, can be a way of asking you for help personally and without that group having a real problem. Or the opposite, a doctor who complains to you about delays in supplying basic materials **is perhaps the only way he is experimenting to ask for support that he does not know he can afford**. Neuroscience is helping us validate support systems as old as humans, but it remains the task of disseminating, organizing, suggesting them, recommending them, witnessing them, animating them, and always without invading the people and in respect of intimacy, who otherwise receive the message as infantilizing and impractical, if not clearly violent .
- An example of this can be the measures taken to accompany covid-19 patients to die away from their loved ones and without direct contact with them, but at least by phone or video, with drawings, objects, letters, music, to allow everyone, sick, nurses, medical corps, rescuers, families and the whole community not to dehumanize, reducing the traumatic impact of the event. There are thousands of stories about these events that everyone has been able to let flourish. **Sometimes the violence of urgency makes us forget how belonging and its expression is a sure shield to the violence of trauma.**

§ 1.2 Assessment of victims typology in this paradigm

The concept of victim is complex, at the same time historical, socio-economic, legal, police and psychological notion. The one we are interested in here is related to its pragmatic function of psychodiagnostics in relation to early rescue interventions, almost to help victim recognize the normalcy of most stress reactions to the disasters, crisis and violence. This function aims at the preservation of the entire population exposed/affected directly and indirectly to a danger and a threat to life, to allow the prevention of the emergence of « Extreme "peritraumatic" stress symptoms (i.e., those symptoms which occur during or immediately after the traumatic disaster experience) include [all] (…) reactions if they are of sufficient intensity to cause significant impairment in reality orientation, communication, relationships, recreation and self-care, or work and education.»*
This prevention is equally effective for acute stress disorder (ASD) and post-traumatic stress disorder (PTSD)

Although the majority of the guidelines related to the early psychological intervention speak of 4 types of victims, we suggest the division into 6 categories** which better describes the phenomenon, now acquired by psycho-traumatic literature, of the vicariant trauma (by proxy) typical of indirect victims that the phenomenon of empathy can convey [cf. Unit 1 Mooc 2]. This hexagon criteria is used in CISO orientation management [cf. here Unit 4]

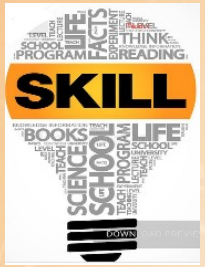
*[DMHS, page 20] **(Taylor, Frazer 1981)

§ 1.2 Assessment of victims typology in this paradigm

VI TYPES OF VICTIM**

- Victim of I° type: who directly suffers the impact of the event
- Victim of II° type : relatives or loved ones of the deceased or survivors
- Victim of III° type : rescuers, emergency/emergency workers /psychologists
- Victim of IV° type : The community involved in the disaster
- Victim of V° type : who, due to pre-critical characteristics, can react by developing a short- or long-term psychological disorder
- Victim of VI° type : who could have been a victim of the first kind or who feels involved for indirect reasons

** (Taylor, Frazer 1981)



§ 1.2 Assessment of victims typology in this paradigm

The skill required for this function is to be able to bear in mind the identification of the symptoms of extreme peritraumatic stress reactions or PTSD, to evaluate all types of victims without neglecting or underestimating indirect victims in prevention processes and protocols, also having in consideration of the mental functioning of each individual, their role and exposure to pain and danger.

In addition, it must be born in mind that victims often hold multiple victim roles: moving from type III to type I, or from type I to Type II and III and IV or V°. This increases the charge of pain and its impact.

It's quite explicit to understand the I° victim type who directly suffers the impact of the event, and also intuitive to see the II° victim type victim as family, relatives or loved ones of the deceased or survivors; but if it's easy to understand the victim of III° type as rescuers, emergency/emergency workers /psychologists, it's not immediately observable, especially for prevention. The same problem appears with the IV° type : the community involved in the disaster.

The rule is "methodological": don't wait for the symptoms to make preventive awareness-raising action and always listen, creating a new adapting setting open to the 6 kinds of victims matching the context.

This translates into the following two types of victims, V° type who, due to pre-critical characteristics, can react by developing a short- or long-term psychological disorder, and VI° type who could have been a victim of the first kind or who feels involved for indirect reasons, in a **very different and specific observation, listening and welcome setting**.

That means the great alliance between Crisis Management and Clinical Assessment [cf. here §2.2], because **the Victim Assessment starts immediately as simple constant listening that is immediate *soft* therapy although the setting is moving.**

Every time in therapy the assessment starts as a confidential setting : you don't have it immediately in crisis context.

§ 1.2 Assessment of victims typology in this paradigm

- In interview [A] that we attach here, you can observe how a victim of the I° type, because she is sick with Covid-19, finds herself suffering a double role as a victim & infecting people compared to the fact that her community – colleagues and friends – is itself a victim of the disease of which the interviewee was the carrier and cause of contagion (presumed or real), and seems to have reacted by accusing her (or the subject feels such) and blaming her. The awe signals that her first reaction was to 'close in' on herself and she received no outside help other than that relating to the support of an already established personal therapy that she was able to keep at a distance. However, the person interviewed points out that this support was not able to reassure her about the urgency of the COVID-19 crisis where the need for information was fundamental and medical. She suggests that being able to get in touch with other sufferers to share information and symptoms would help her.
- In interview [B] we see the victim type I° who has passed as a victim type II°, and whose needs have completely changed without the person and the family being able to see the legitimacy of these needs and the possibility of taking charge of them. Contact with a psychologist at the hospital where the parents were hospitalized allowed this victim to activate his resources and probably not to suffer a worse course (particularly if the parents did not survive). The patient points out that the brothers would need psychological and medical family support to understand the evolution of the disease and not build archaic defences. The time of the listening seems to be the most valuable element although time is often rare in crisis contexts.

§ 1.3 Crossing the victim typology with crisis phases

« The normative post-disaster biopsychosocial reaction occurring in individuals and communities forms a relatively predictable pattern from the onset of the disaster through the following 18-36 months. This pattern is delineated by four relatively distinct phases. However those phases are variable with regard to their duration, and within each phase, there is significant individual variation in the reaction of survivors. Hence, this "aerial" view is presented as a heuristic so that clinicians who work for "only" a short period of time following a disaster can place their experience into a larger context.»*

CRISIS BIOPSYCHOLOGICAL RESPONSE PATTERN PHASES*

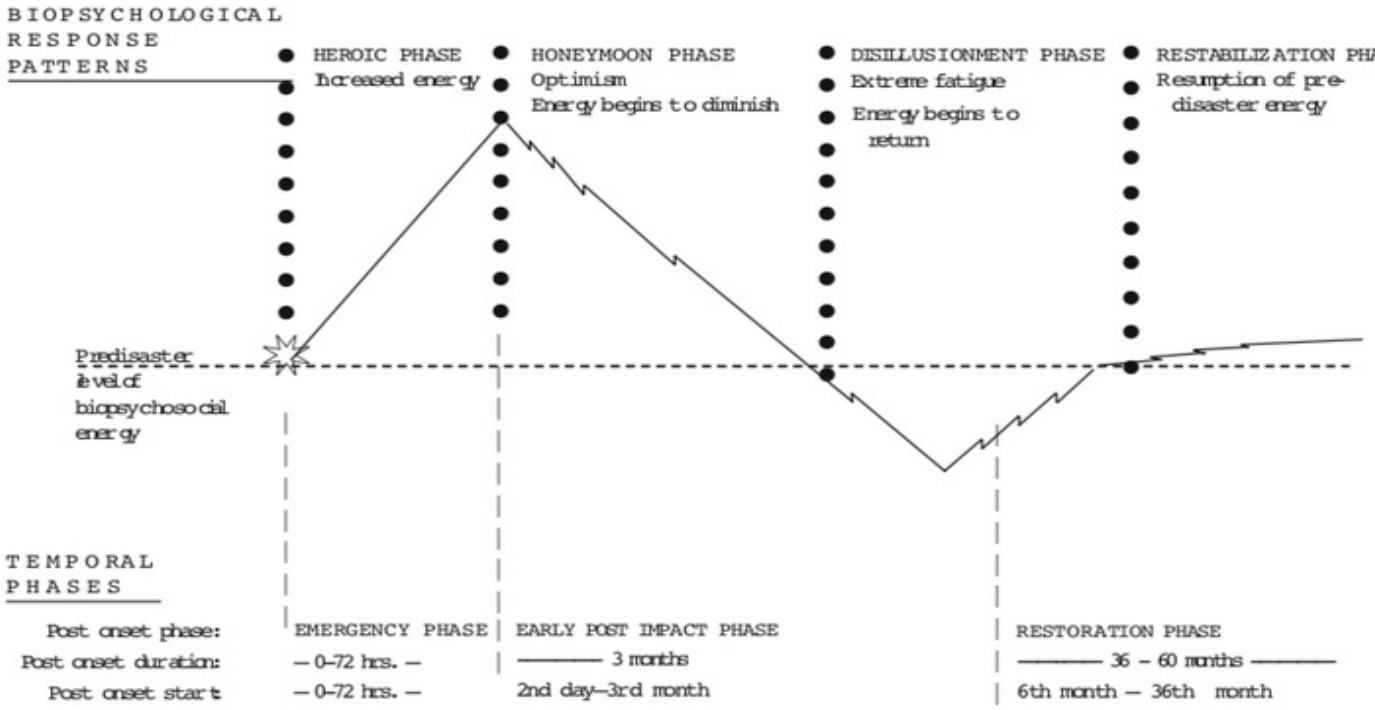
- **Heroic Phase** (from a few hours to a few days): very high energy levels, commitment to rescue activities, help, reception
- **Honeymoon Phase** (from one week to 1 year): optimism of survivors and the community. High influx of resources, media attention, VIP, solidarity
- **Disillusion Phase/Phase of disillusionment** (from 2 months to 1-2 years after impact): sense of betrayal, abandonment, injustice, incompetence, bureaucratic snags. **Symptoms of post traumatic stress intensify**.
- **Reconstruction Phase**: observable changes in long-term calamity-related programmes begin

*[DMHS, page 17-18]

INTERACTION

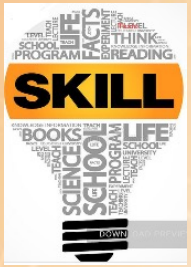
§ 1.3 Crossing the victim typology with crisis phases

Figure 1. BIOPSYCHOSOCIAL RESPONSE PATTERN AND TEMPORAL PHASES OF DISASTER



Disaster Mental Health Services
Stress Reactions of Survivors

[DMHS, page 19]



§ 1.3 Crossing the victim typology with crisis phases

- Even if not all crisis situations follow this typical and known context schema in disaster situations, **the skill that must be developed from this notion of matching between phases** of the crisis and stress phases of individual, group and community evolution, **is that there is a significant interaction in emergency situations between Individual reactions and those of the Group and the Community.** The ability of the psychologist in crisis situation is to know how to anticipate the socio-political repercussions on the individual clinical frameworks by inserting his/her intervention on a larger scale than the present moment alone. The despair has a high price in crisis situations, as well as disinformation.
- **The second skill is correlated**: the internal individual psychic ground matches with the crisis and its phases in specific manner, but the community or group ground works in the same sense and effect. That means/indicates particularly the victims of type IV and V, but also VI.
- At last the psychologists in early intervention have to consider different adaptive kinds of settings and try to put them in contact for an evolutionary synchronization.

§ 1.3 Crossing the victim typology with crisis phases

- In interview [C] you can observe how the psychiatrist responsible for taking charge of psychiatric patients suffering from Covid-19, victims of the I° and V° type, underlines the importance of the relationship between psychiatric patients, their families (victims type II°) and society in general (victim type IV°) to cope with the pandemic. The association between confinement for health measures and psychiatric isolation in the phases of individual psychotic crises, put a strain on the ability of these patients and family members to deal with the pandemic. But his role in the unit where he was assigned was also to support the health workers who arrived as volunteers at the unit (possible victims of type III°). The ability to integrate both the different specific professional intervention groups, and the groups belonging to the community, are the strong points of an effective psychological intervention that the psychiatrist emphasizes as specific to crisis situations. This is because the integration allows a correct and contextualized qualitative dissemination of information and promotes accompaniment and psychological care where necessary.