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Building a Foundation for Crisis Intervention in Eastern Europe

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ABSTRACT: *The principles of Critical Incident Stress Management for assisting individuals and groups are applied to an Eastern European crisis event. This case study demonstrates the importance of understanding the cultural context where crisis events occur and the value of developing a network of local relationships as a step toward gaining credibility when working cross-culturally. I recount experiences over the past 13 years working in Eastern Europe as a clinical psychologist, consulting and intervening in a wide variety of critical incidents. There is a great need to raise the awareness of depression, anxiety, trauma, abuse, and addictions among health professionals, educators, clergy, and the general public. By combining the practices of community and clinical psychology, traction has been gained in developing counseling and crisis response initiatives led by both non-professionals and mental health personnel in Eastern Europe.*

Key words: *Crisis intervention, critical incident, Eastern Europe, community psychology, critical incident stress management*

I received by mail in 2003 a seminar notebook on Critical Incident Stress Management (CISM) (Mitchell & Everly, 2001) from a professional colleague in the United States. I was discussing with him my work of intervening and responding to crisis events across Eastern Europe and Eurasia when he suggested I look at the CISM material. He added, "Maybe this is something you might find helpful in your work there." When I received the live CISM training for individual (Everly, 2006) and group (Michell, 2006) intervention, I already had years of experience working with groups and individuals more effectively because of the CISM model.

In this brief case study, I recount the process of moving from a western, American mindset to a growing understanding and appreciation of the life, history, and culture of Eastern Europeans. A critical element of effectiveness in mental health work is credibility. Arriving in Hungary in 2001, I was met with deep suspicion by neighbors and acquaintances. I obviously lacked important elements of credibility that were going to be necessary for me to work in a cross-cultural context. I would need to overcome the perception and historical fact that psychologists were a part of the former oppressive regime, used to break political prisoners and extract false confessions from innocent victims.

THE CULTURAL CONTEXT

I was working in the emergency room of the Detroit Receiving Hospital in 1993 when a call went out through the unit, "Can anyone here speak Serbo-Croatian?" A non-English speaking patient had arrived in a state of shock. While I did not speak Serbian, I did participate in assessing the patient. His face was tight and drawn; he stared blankly into space. He was malnourished and underweight, wearing threadbare clothes. Even though he was reportedly 40 years old, he appeared at least 20 years older. The hospital had an increased number of refugees coming to Detroit, Michigan from the Balkans, people fleeing the Bosnian War and the Croatian War of Independence.

Since 2001, I have been living and working in Hungary providing mental health services to religious and humanitarian organizations,

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as well as the national churches in Eastern Europe and throughout Eurasia. Helping people traumatized by war and political unrest has been a regular and ongoing aspect of my work. But psychological injury caused by war is just one of the many sources of trauma in this region.

Tragedy often finds a way into people's lives through the impact of suicide. Lithuania, Slovenia, Hungary, Latvia, Belarus, Ukraine, Croatia, Russia, Moldova, and Poland are European countries that lead the world in suicide (World Health Organization, 2014).

In Eastern Europe, alcohol use often starts early in the teen years and leads to an increased risk of violence, illness, and suicide (Felson et al., 2011; Alström & Österberg, 2005; Landberg, 2008). According to the World Health Organization (Lynch, 2014), the countries with the highest annual consumption of alcohol among those 15 years old and older consume more than the twice the world average of 6.2 liters of pure alcohol. Of the top ten alcohol consuming countries, eight are members of the Former Soviet Union and comprise a large part of Eastern Europe.

1. Belarus 17.5 liters
2. Moldova 16.8 liters
3. Lithuania 15.4 liters
4. Russia 15.1 liters
5. Romania 14.4 liters
6. Ukraine 13.9 liters
7. Andorra 13.8 liters
8. Hungary 13.3 liters
9. Slovakia 13 liters
10. Portugal 12.9 liters

It has been my experience in meeting people from throughout this region that almost every family, village, and city has its own story of struggle, hardship, and tragedy. As I began to know Eastern Europeans on a personal level, they willingly shared their family's story of the suffering. Individuals suffered for multiple reasons, besides the obvious harm caused by war and political unrest. Some

encountered abusive teachers, religious persecution by school administrators, police harassment, deportation, sexual abuse, and loss of jobs and property. Others experienced daily verbal abuse, discrimination, and hatred by people from different ethnic groups who all shared the same roads, stores, factories, and schools.

Anto Knezevic (2009) writes about growing up in Bosnia, recounting his life of abuse. The beatings started first with his father and then were carried out by his siblings. Even at school, his teachers physically abused him. His perception in childhood was that the abuse was normal. The people who abused him were traumatized themselves in their childhood; everyone seemed to participate in the passing on of trauma. Living in poverty, Anto felt the entire community had given up. No one helped each other, and no one valued human life (Knezevic, 2009).

The breakdown of society and the loss of stability in communities are intimately related to the political structure or the lack thereof. Political unrest has led to a great deal of instability, fear, and hatred in this region. The values, traditions, and relationships that held families and communities together for generations has been torn apart. Jochen Neumann (1991) writes about Eastern Europe, "Values that were binding and predictable in the past are gone without the establishment of new equivalents. In most countries, there is a lack of objects of identification. Fear of poverty and unemployment weigh heavily on many people. The "biologically" strong often dominate the weaker, and the unscrupulous profiteers abuse this time of transition for their own benefit" (p. 1387).

While Neumann's (1991) observation was about a particularly unstable time period in Eastern Europe after the fall of the Berlin Wall in 1989, little has changed since that time in terms of a collective sense of hope or optimism for the future. There is greater political stability in some regions, but ongoing corruption, high taxes, and poor government services eat away at public confidence. Among our friends we hear the repeated story of being taken advantage of in the workplace, such as working 60 to 80 hours a week only to be paid for less than half the time worked, or not paid at all. People are afraid to speak up for fear of losing what little they have. One individual I spoke with believes that instability and fear in the workplace lead to self-protection and the desire to undermine others. She explained the mindset this way, "It is not important whether or not I get ahead. What is important is that you don't get ahead."

The economic situation varies greatly across Eastern Europe. What we see in Hungary is an exodus of friends and neighbors, people wanting to find work, hope, and a future somewhere else. It is not surprising that according to the Hungarian Central Statistical Office 58,000 people left Hungary in 2011, and 72,000 more emigrated in 2012 (Origo, 2013). Across Eastern Europe, people of all ages are leaving every day, looking for a better life in Western Europe, Canada, and the United States. Our neighbor just officially retired after working for 45 years and received his first monthly retirement pension of $250. He lamented, "What am I supposed to do? I either starve or keep working until I die. Those are my choices. I cannot even pay my heating bill with $250."

When working with crisis situations in Eastern Europe and Eurasia, it is essential to appreciate the culture and history of this area in order to recognize how people individually and collectively respond to traumatic events. Having described a few aspects of the culture, atmosphere, and ongoing struggles of the people in this part of Europe, I will briefly outline one model of working with critical incidents that I have recently found effective.

A CASE STUDY

I received a call from a Hungarian minister asking me to come to his church and meet with the leadership team. A church staff member had just killed himself. As I sat down with the leadership, it was clear

that they were struggling to understand what had happened and how to respond. There was no prepared protocol to follow, but I was not expecting that there would have been such a plan. Immediately it was clear that there were a number of decisions that needed to be made, but the leaders were in crisis themselves. Without a protocol to follow, the situation was even more stressful.

One key element of any crisis management response is having a comprehensive crisis response plan in place before a crisis occurs. This plan takes time and energy to develop, and often people in busy organizations do not see this as a high priority. Not having a plan in place creates an additional stress as a crisis event begins to unfold.

The crisis plan should include specific information about who will communicate with the public, and who will communicate with the church membership. The plan needs to address how legal or police matters will be handled and by whom, the description of a team that is trained and in place to work with grieving family and church members, and the designation of who will coordinate community resources such as medical, mental health, pastoral care, and humanitarian aid. The makeup of the death notification team should also be in place, with each member understanding his or her assigned role.

Since my work began in 2001 in Europe, I have yet to respond to a crisis situation at a church, school, NGO, or Christian mission organization where there was a specific protocol already in place to handle the crisis. This means as I enter a crisis there are some basic structural and organizational steps that I outline for the leadership. This simple framework is always well received by the local leadership, except in situations where there is no clear leader or leadership structure. In these situations, I attempt to recruit a co-leader from the organization to work with me to implement a crisis response plan.

The lack of a protocol is highlighted when there is no defined leadership in a group or organization. Often in these situations there are multiple individuals who each consider themselves leaders and decision makers. These self-appointed leaders may even be residing in different countries, yet are attempting to manage a local crisis. In these situations each leader (or committee) believes he is making the final decisions in a crisis event, while other leaders or committees believe their input is the most important. Without a plan and structure in place for how communication takes place, to whom information is communicated, and what part of the leadership structure has final authority in decision-making, the ensuing chaos eventually creates significant stress for everyone involved and results in burnout, depression, and anxiety for those who are trying to manage the crisis.

Before a city, village, church, mission, NGO, or school can develop a crisis management protocol, significant work needs to be done to raise the awareness of the need for such a plan. At this point in time, very few churches, ministry organizations, towns, or cities in Eastern Europe recognize their need for a crisis management strategy. Education needs to take place at multiple levels of an organization and within society for the groundwork to be laid.

LAYING THE FOUNDATION

As I began to live and work in Eastern Europe, I saw value in providing basic education about mental health to churches, mission organizations, schools, and hospitals. There was very little available knowledge of how mental health problems developed. I presented lectures, seminars, and papers on depression, anxiety, shame, sexual abuse, trauma, family life, parenting, marriage, crisis counseling, addictions, and forgiveness. I currently continue to present this kind of information in hospitals, universities, schools, churches, and at a variety of conferences. As people learn about how the mind and body operate and interact, they often find the words they need to understand their experience and the struggles of others.

Working as a community psychologist providing education and skill training was not a part of my original plan when I came to Eastern Europe. In fact, I had little understanding of community psychology before I began working in Europe. I was trained to work with individuals, groups, and families as a clinical psychologist. But after listening to the stories of many people, I saw the obvious connection between the attitudes and beliefs in society and the individual struggles that people faced. While I did not completely abandon working as a clinical psychologist, I thought it necessary to first help groups of people to recognize and name problems, identify barriers to change, and learn coping skills they could employ that would help them overcome and even prevent problems, which is the goal of community psychology (Durlak & Well, 1997).

I believe that providing this information has opened the door for conversations to take place regarding beliefs, attitudes, past trauma, and personal struggles. The only alternative is to remain silent about what is really happening or even deny the problem altogether. Denial and silence are the two main enemies to personal change in Eastern Europe.

THE CISM MODEL

As I approached the situation in the church where a staff member committed suicide, I followed the basic structure of crisis management outlined in the Critical Incident Stress Management (CISM) model. This model provides a clear outline of what needs to be done in a crisis, when different interventions need to be employed, and how to assist various groups and individuals. According to Flannery and Everly (2000), "CISM is a comprehensive crisis intervention system consisting of multiple crisis intervention components which functionally span the entire temporal spectrum of a crisis. CISM interventions range from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. CISM is also considered comprehensive in that it consists of interventions which may be applied to individuals, small functional groups, large groups, families, organizations, and even entire communities" (p. 121). It should be noted that the CISM model is subject to ongoing critical review, research, and debate. Questions concerning the effectiveness of psychological debriefing after a critical incident, as well as the benefits of psychology debriefing for acutely traumatized individuals continue (Litz, Gray, Bryant, & Adler, 2002). Ongoing research will help answer these important questions.

There are two misconceptions that commonly occur when I begin working with an organization during a crisis. First, people confuse CISM work with doing therapy with traumatized victims of a disaster. CISM is not a therapy approach and is not solely focused on trauma victims. Secondly, there is a misunderstanding between the term Critical Incident Stress Management and the term Critical Incident Stress Debriefing (CISD). CISD is a model of conducting a 1.5 to 3-hour group intervention that contains seven distinct phases (Every & Mitchell, 2000). CISD is just one of the many elements included within the CISM model.

There are four specific goals of doing Critical Incident Stress Management work. These include: 1. stabilization to reduce the distress and keep the situation from getting worse, 2. reduction of the acute signs and symptoms of distress, dysfunction, or impairment, 3. restoration of adaptive independent functioning, and 4. facilitation of access to a higher level of care (Every & Mitchell, 2003).

To facilitate stabilization and reduce distress in individuals, families, groups, and communities, there are eight core components of the CISM model that can be implemented in a flexible manner before, during, and after a critical incident. These key elements are: 1. pre-crisis preparation, 2. demobilizations and staff consultation (staff/rescue workers) and crisis management briefings (community,

school, church), 3. defusing, 4. Critical Incident Stress Debriefing (groups), 5. individual crisis intervention, 6. pastoral crisis intervention, 7. family intervention and organizational consultation, and 8. follow-up and referral (Everly & Mitchell, 1999).

The CISM model has been adopted by many organizations around the world, such as the Federal Bureau of Investigation (FBI), Federal Aviation Authority (FAA), the Swedish National Police, the Association of Icelandic Rescue Teams, and the Austrian Navy (Flannery & Everly, 2000). CISM has demonstrated to have health benefits to first responders as indicated by a reduced risk of binge drinking, alcohol dependence, PTSD symptoms, major depression, anxiety, and global impairment (Boscarino, Adams, & Figley, 2005). Training in the model is available from the International Critical Incident Stress Foundation (www.icisf.org) throughout the year in many locations. In the near future, some of the training will also be available online.

Implementation

As I worked with the church minister and his staff, several elements of the CISM model were implemented. I first began to work with the staff, briefly educating them on their reaction to the crisis. I also provided them with information on suicide and gave a summary of how family and friends may respond to the crisis. We then worked together on planning the large group, small group, and individual meetings that would take place in the days that were to follow. A brief training was provided to help small group leaders facilitate discussions. We assigned responsibilities to each team member for communicating information, relating with the deceased's family, coordinating activities, and interacting with the police. With these steps in place, we then implemented the plan over the following two weeks. Both the community and the church members participated in the group meetings. Discussion groups were held after the main group meetings and individual people, couples, and families were assisted as needed. Referrals were made for people who needed ongoing mental health care.

The CISM model provides a standard for what should be included in the response to a crisis and a structure that helps individuals and organizations respond effectively. For this model to be implemented in Eastern Europe, training needs to be provided in the local language to emergency service workers, mental health professionals, and community leaders. Teams also need to be formed that will be ready to respond to crisis events. Based on the counseling and crisis intervention training that I have provided over the past 13 years, I have already witnessed the development of national initiatives to deliver mental services and crisis intervention in a variety of settings. It is my hope that as I come in contact with the emergency services (police, ambulance, and fire departments), and provide training to ministers, doctors, school administrators, and mental health professionals, that I will be able to encourage national leaders to implement CISM in their country, community, workplace, and church.

REFERENCES

Alström, S., & Österberg, E. (2005). International perspectives on adolescent and young adult drinking. *Alcohol Research and Health*, *28*(4), 258-268.

Boscarino, J., Adams, R., & Figley, C. (2005). A prospective cohort study of the effectiveness of employer-sponsored crisis interventions after a major disaster. *International Journal of Emergency Mental Health*, *7*(1), 9-22.

Durlak, J.A., & Wells, A.M. (1997). Primary prevention mental health programs for children and adolescents: A meta-analytic review. *American Journal of Community Psychology, 25*(2), 115-152.

Everly, G. (2006). *Assisting individuals in crisis* (4th ed). Ellicott City, MD: International Critical Incident Stress Foundation.

Everly, G., & Mitchell, J. (2003). The evolving nature of disaster mental health services. *International Journal of Emergency Mental Health, 5*(3), 109-115.

Everly, G., & Mitchell, J. (1999). *Critical Incident Stress Management (CISM): A new era and standard of care in crisis intervention.* Ellicott City, MD: Chevron Publishing.

Felson, R., Savolainen, J., Bjarnason, T., Anderson, A., & Zohra, I.T. (2011). The cultural context of adolescent drinking and violence in 30 European countries. *Criminology, 49*(3), 699-728.

Flannery, R., & Everly, G. (2000). Crisis intervention: A review. *International Journal of Emergency Mental Health, 2*(2), 119-125.

Knezevic, A. (2009). Childhood traumas and wars: The case of Bosnia. *The Journal of Psychohistory, 36*(3), 260-269.

Landberg, J. (2008). Alcohol and suicide in Eastern Europe. *Drug Alcohol Review, 27*(4), 361-373.

Litz, B.T., Gray, M.J., Bryant, R.A., & Adler, A.B. (2002). Early intervention for trauma: Current status and future directions. *Clinical Psychology: Science and Practice, 9*(2), 112-134.

Lynch, D. (2014). WHO global alcohol report: What kills 3.3 million of us per year and which country drinks the most. *International Business Times*. Retrieved from: http://www.ibtimes.com/who-global-alcohol-report-what-kills-33-million-us-year-which-country-drinks-most-1583391

Mitchell, J. (2006). *Critical incident stress management: Group crisis intervention* (4th ed.). Ellicott City, MD: International Critical Incident Stress Foundation.

Mitchell, J., & Everly, G. (2001). *The basic critical incident stress management course: Basic group crisis intervention* (3rd ed.). Ellicott City, MD: International Critical Incident Stress Foundation.

Neumann, J. (1991). Psychiatry in Eastern Europe today: Mental health status, policies, and practices. *American Journal of Psychiatry, 148*, 1386-1389.

Origo (2013). Egy debrecennyi magyar már külföldön él. Retrieved from: http://www.origo.hu/itthon/20130522-a-ksh-legujabb-kutatasi-a-magyaroszagi-es-az-europai-migraciorol.html

World Health Organization (2014). Preventing suicide: A global imperative. Retrieved from: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/