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Crisis Management and Peer Support

A Thesis Project Report Submitted to

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by

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THE DOCTOR OF MINISTRY THESIS PROJECT ABSTRACT
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This mixed-methods Doctor of Ministry Research Project examined peers' roles during crisis management situations and sought to improve their knowledge, skills, readiness, and confidence during crises. Peers are often the first to see precursors of a crisis or are the first present when a crisis ensues. This was true in the ministry context of a United States Army Reserve unit. A training program was developed to equip participants on crisis precursor identification, prevention, intervention, stabilization, post-intervention, and normalization concepts and techniques. Additionally, ethical consideration, professional resources, and resiliency concepts were trained. The concepts were delivered via an online web-based platform for asynchronous participation. The twelve participants reported improved confidence and knowledge of the presented topics. The participants reported that they better understood how to manage the crisis management cycle and were more confident aiding peers in crisis. The research results improved the local ministry context's crisis management support and can be applied in other contexts.

Keywords: crisis prevention, crisis intervention, crisis post-intervention, stabilization, normalization, peer support

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Abbreviations

MEB	*Maneuver Enhancement Brigade*
TPU	*Troop Program Unit*
UMT	*Unit Ministry Team*
USAR	*United States Army Reserve*

CHAPTER 1: INTRODUCTION

Introduction

Life can present innumerable challenges, many of which can be handled safely, healthily, and without further issues. Often, traditional coping mechanisms and learned resiliency aid in overcoming the stressors and lead to further growth and stabilization.[1] Learned coping mechanisms that are successful are ingrained and relied upon in future stressful events. However, sometimes these challenges bring about seemingly insurmountable stress that overwhelms healthy coping mechanisms. This may be due to the magnitude of the stress, or due to a sudden combination of several significant stressors. Regardless of the root, the challenge overwhelms those learned coping mechanisms, leading to a crisis.[2]

When experiencing a psychological crisis, individuals typically demonstrate reduced rational problem solving and increased involuntary stress reactions.[3] These may include an inability to make safe decisions, a shift to risky or unsafe decision-making, the inability to manage emotions, and damage to relationships due to those psychological shifts. If left unmitigated, poor decision-making could lead to psychological, emotional, relational, or physical distress or damage.

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[1] Charmayne R. Adams, Jillian M. Blueford, and Joel F. Diambra, "Trauma-Informed Crisis Intervention," *Journal of Professional Counseling: Practice, Theory & Research* 49, no. 2 (July 3, 2022): 93.

[2] Megan O'Riordan, Debra Rickwood, and Sonia Curll, "What Is a Crisis? Perspectives of Crisis Support Help-Seekers," *Crisis*, (June 16, 2023): 1.

[3] Ibid., 1.

Often, the individual in crisis requires intervention and may even seek out support from others, such as family members, peers, or mentors. Those individuals may be overwhelmed or unprepared, which could make the crisis worse or lead to secondary trauma. Therefore, it is critical to raise the training and preparedness for those who may be called upon to intervene during a crisis in the lives of others, much in the same way that first aid training is critical for physical emergencies.

Ministry Context

The research project's ministry context is military-connected leaders and peers within the geographical footprint of the 302D Maneuver Enhancement Brigade (MEB), a brigade headquarters within the United States Army Reserve (USAR). Within the US Army Reserve, many Soldiers serve in Troop Program Units, or TPUs. A TPU Soldier in the US Army Reserve typically trains with their assigned unit for approximately two days each month with an extended multi-week training each year. This may fluctuate as individuals and units may mobilize to active duty, but in most circumstances, USAR Soldiers see their subordinates, peers, and leaders for only a few days each month.

Crisis situations, including self-harm and suicidal behaviors, continue to impact members of the United States Army Reserve. This is compounded by the fact that most USAR Soldiers do not live on or have continuous access to an active-duty Army installation for support services. The Defense Suicide Prevention Office reports that year over year there has been an increase in suicide completions, and 2022 is trending towards similar results.[4] Suicide prevention efforts are

[4] U.S. Department of Defense Suicide Prevention Office, *Department of Defense (DoD) Quarterly Suicide Report (QSR) 1st Quarter, CY 2022* by Liz Clark, (Washington, DC, 2022).

critical to reduce these numbers, and veteran crisis lines help support that effort.[5] Individual and group training for crisis warning sign recognition and intervention delivered to Soldiers is often conducted once each year on a battle assembly weekend, lasting approximately one hour.

A Maneuver Enhancement Brigade (MEB) is a multifunctional brigade headquarters and subordinate battalions that provides command and control to enable commanders to take decisive actions to succeed in combat operations.[6] A Maneuver Enhancement Brigade will be organized depending on the assigned mission and often includes a combination of senior staff officers and multifunctional Soldiers to carry out a variety of engineering, maneuver, protection, security, and command and control operations. The 302D MEB is a USAR MEB headquarters stationed at Westover Air Reserve Base in Chicopee, Massachusetts. Subordinate battalion headquarters are located in New Hampshire, New York, and Pennsylvania.

The 302D MEB has served in a variety of missions in the previous decade, which has resulted in continuous shifts in mission, planning, training, and organization. The 302D MEB served in several roles as a part of Task Force 76 in the Defense Support to Civil Authorities (DSCA) mission. As that mission approached its end, the brigade reorganized. In 2020, COVID-19 brought additional stressors and ambiguity to members of the brigade. In 2021, the brigade executed an extremely short-notice mobilization to serve as the headquarters for Task Force McCoy as part of Operation: Allies Welcome. The short-notice mobilization and short-notice demobilization caused significant stress and crises amongst many members of the unit and resulted in significant turnover in leadership and manpower.

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[5] Claire M. Hannemann et al., "Suicide Mortality and Related Behavior Following Calls to the Veterans Crisis Line by Veterans Health Administration Patients," *Suicide and Life-Threatening Behavior* 51, no. 3 (June 2021): 596.

[6] Department of the Army, *Maneuver Enhancement Brigade,* FM 3–81 (Washington, DC: Department of the Army, 2021), 1.

This author's personal relationship with the unit has been serving as the first and current brigade chaplain for the headquarters. Prior to that, he served as a battalion chaplain in a subordinate unit within the brigade and developed pastoral relationships with members of the various units. Focusing on a ministry of presence, he has developed strong pastoral connections with many Soldiers and has conducted suicide interventions, family crisis interventions, and other related crisis interventions.

Since the COVID-19 pandemic, there has been an increase in psychological crises within the unit. Specifically, and exacerbated by the COVID-19 pandemic, there has been an increase in substance abuse, behavioral health concerns, familial crisis, and financial crises. These crises have all negatively impacted the quality of life of the Soldiers, with several leading to suicidal ideations, attempts, and completions.

Many of the Soldiers in the subordinate battalions are young. Many have not experienced a combat deployment, and their current unit is their first unit in the US Army Reserve. Compared to subordinate battalions, there is a stronger mix of senior leaders and junior Soldiers at the brigade headquarters. The younger Soldiers typically are serving in their first enlistment contract and may not have built up the resiliency and support structures that more experienced and connected members of the units have.

Most of the junior Soldiers do not identify strongly with a specific religious tradition, with many having "No Religious Preference" as their religious identification. Following "No Religious Preference," the next largest group identify as "Protestant" without a denominational affiliation. Some Soldiers come from various disparate faith groups, including but not limited to Muslim, Jewish, Buddhist, Wiccan, Norse Pagan, and Atheist. Many Soldiers in the unit self-report being spiritual but not identifying with a specific religious group. This reflects general

societal trends in the geographic area of units.[7] For those that are religious, most of their religious support occurs with their civilian religious group, although worship services are available during training events.

The geographical footprint of the 302D MEB includes people from Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, Delaware, Virginia, and Pennsylvania. Each of these states contains a unit within the 302D MEB. Most of the Soldiers within the 302D MEB live within this geographical footprint, but several do not. Several commute to or work within the footprint while residing outside of it. Many Soldiers do not live near other USAR Soldiers or major military installations. This results in support requirements that are dependent on the civilian community, family relationships, peers, and civilian occupations.

Many phone lines and web services are available to individuals experiencing a psychological crisis. These include Military One Source and the Department of Veterans Affairs Veteran Crisis Line. Although these are generally well-known by service members, their availability and offering may not be well known by non-military interveners of a crisis. Further, the individual in crisis may not be acting rationally during the crisis and may not remember these resources exist. As such, the importance of peer-connected intervention training is critical.

The term “military-connected” was chosen to include those connected to the military community specifically. For example, they may be prior-service or actively in the service. They also may have never served in the military but still have a connection to the military community through relationships. This may include family members, friends, colleagues, and civilian leaders

[7] Pew Research Center, *Religious Landscape Study: Adults in the Northeast*, 2022, https://www.pewresearch.org/religion/religious-landscape-study/region/northeast/.

from within the community. As these individuals are connected to the military, they may be exposed to or aware of the unique challenges military service creates and may be exposed to a service-member in crisis.

A military chaplain provides religious, moral, ethical, and behavioral support in addition to their religious service support. These efforts are most often directed to supporting members of the chaplain's assigned unit. The role of a chaplain also includes ministry to Department of the Army (DA) civilians and family members as requested.[8] The Department of Veterans Affairs also employs chaplains to provide pastoral support to veterans and service members. Therefore, the efforts of a chaplain are not limited to currently serving service members and can be made available to qualified individuals connected to the military community.

Individuals in crisis may not limit their coping resources to a specific profession. Therefore, it is important to consider non-military individuals who may be critical in reducing or preventing crisis responses. Similarly, due to the infrequent contact of USAR Soldiers with one another, there is a substantial chance that a Soldier in crisis may not be within the vicinity of another member of their unit. However, veteran peers or family members who understand the stressors of military life may be able to intervene. To be successful, appropriate training and preparation is critical.

The rise in crises within the ministry context is the result of several converging circumstances. First, the COVID-19 pandemic dramatically impacted the mental health and mental well-being of those living through the pandemic.[9] The pandemic led to isolation, fear,

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[8] Department of the Army, *Army Chaplain Corps Activities,* AR 165–1, (Washington, DC: Department of the Army, 2015).

[9] Lee D. Mulligan et al., "Acceptability of the 'Crisis Toolbox': A Skills-Based Intervention Delivered in a Crisis Resolution and Home Treatment Team during COVID-19," *Community Mental Health Journal* (April 2, 2022): 2.

anxiety, and conflict. Many faced job changes or job losses, impacting financial well-being. Many lost loved ones or were further separated from loved ones, challenging relationships, and resulting in grieving. The strained relationships further reduced support structures for those in crisis. The members of the 302D MEB were equally impacted, with rises in homelessness, substance abuse, financial struggles, depression, anxiety, and suicidal ideations all warranting concern.

Specifically, the 302D MEB has experienced a high operational tempo. The headquarters transitioned into and out of a Defense Support to Civil Authorities mission, then provided support for COVID-19 missions, completed a very short notice mobilization in support of Operation: Allies Welcome, and is transitioning as a Maneuver Enhancement Brigade into a new mission as per Army doctrine and way-forward visions. The high tempo, turnover, and transition cause stress within the unit and families. Similarly, several units completed challenging mobilizations for combat and non-combat operations within the previous several years. As such, many members of units within the ministry context have experienced, are experiencing, or may experience large surges of stress and conflict, which could lead to crisis if not prevented and managed.

Economic instability and rising inflation caused financial constraints, stressors, and relationship conflicts following the pandemic. Several members within the ministry context lost jobs, homes, and stability as prices increased. Finding new jobs, especially in more rural areas, proved challenging. Civilian non-profit organizations in the ministry context area are stretched due to the increased demand. Therefore, crises continue to increase as Soldiers face increasing and compounding stressors in multiple areas of their lives.

There are efforts to improve the quality of life of Soldiers within the military as an organization, but many of the efforts focus on active-duty Soldiers or on relying on civilian resources or duty availability. For example, the Army has implemented a People First Strategy.[10] The goal of the strategy is to combine several programs that seek to improve morale, stability, resource availability, and recognition of potential crises. However, many of these programs assume routine contact and access between leaders and subordinates. Other programs focus on support during battle assembly weekends or other duty-status events for accountability and safety.

While these programs intend to improve lives and prevent crises, many are only available when a Soldier is off duty and experiencing a crisis. The intent of these programs is noble, and many are in the early stages of development, so their efficacy may be improved. However, they are not, at this time, a replacement for peer-based support systems for US Army Reserve Soldiers and their families.

Problem Presented

A mental health crisis, also referred to as a psychological crisis, is an acute immediate disruption of psychological homeostasis in which the coping mechanisms to function are impaired.[11] A crisis may develop in conjunction with mental illness, but mental illness is not required for the development of a crisis. There is evidence that many, if not most, crises are not the result of an underlying mental illness.[12] Psychological crises have significant financial,

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[10] U.S. Army, "People First," accessed November 8, 2022, https://www.army.mil/peoplefirst/.

[11] Amar Ghelani, "Knowledge and Skills for Social Workers on Mobile Crisis Intervention Teams," *Clinical Social Work Journal* (November 15, 2021): 2.

[12] Craig J. Bryan, *Rethinking Suicide: Why Prevention Fails, and How We Can Do Better* (New York: Oxford University Press, 2021), 36–41.

emotional, and societal impacts that can have secondary ramifications on those exposed to the individual in crisis.[13] Mental health crises are among the leading causes of disability, with one in four adults experiencing a mental health challenge.[14]

A crisis is time-limited and often requires external intervention. The intervener may be a professional, a lay helper, or someone connected to the individual through a relationship, such as a friend, family member, colleague, supervisor, or peer. Often, the intervener is proximal. Ideally, the intervener is trained in the recognition of the warning signs of a developing crisis and how to intervene and stabilize, but this may not be the case if the intervener is a non-professional. This can lead to exacerbation of the crisis, thus adding additional stress to the situation. Similarly, there may be secondary trauma to the intervener if they are not prepared for the emotional response and ramifications of performing a crisis intervention, especially if there is a strong personal relationship.[15]

When experiencing a crisis, an individual's current coping mechanisms are overwhelmed. This often causes dysfunctional behaviors.[16] Coping with a crisis involves managing the cognitive and behavioral efforts in response to psychological stress, which are developed as a

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[13] Sidney H. Hankerson et al., "Study Protocol for Comparing Screening, Brief Intervention, and Referral to Treatment (SBIRT) to Referral as Usual for Depression in African American Churches," *Trials* 23, no. 1 (December 2022): 16.

[14] Sarah Weatherstone and Lorna Dodd, "Experiencing Mental Health When Treating Others: Experiences of Mental Health Workers in Relation to Mental Health Problems: Stigma, Perception, and Employment," *European Journal of Mental Health* 17, no. 3 (2022): 5.

[15] Brian L. Mishara, Louis-Philippe Côté, and Luc Dargis, "Systematic Review of Research and Interventions with Frequent Callers to Suicide Prevention Helplines and Crisis Centers," *Crisis* (January 28, 2022): 2.

[16] Ghelani, "Knowledge and Skills," 2.

result of experience, learned skills, and resource availability.[17] Within the ministry context, several individuals, both military and non-military, experienced a psychological crisis, sought assistance from a peer, leader, or mentor, and that individual attempted intervention. Following those incidents, the interveners expressed frustration over a lack of preparedness and feelings of helplessness. They also were not prepared for the emotional impact of the intervention. The problem is that military-connected leaders in the 302D MEB geographical areas lack the training to recognize and intervene when others experience a crisis.

Purpose Statement

The purpose of this DMIN action research project is to develop and implement a voluntary training program for crisis recognition and intervention for leaders and peers. Training in crisis intervention is critical for military-connected leaders, both military and civilian, so they can recognize a developing crisis and how to intervene and stabilize an individual in crisis. Often, peers and leaders are the first to recognize a crisis before a professional care provider can intervene.[18] The intervention may involve stabilization, referral, escort, and reintegration. There may be post-intervention support required as well. Therefore, training for military-connected leaders can better prepare them for when their peers, subordinates, or family members experience a crisis.

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[17] Anja Gysin-Maillart, Leila Soravia, and Simon Schwab, "Attempted Suicide Short Intervention Program Influences Coping among Patients with a History of Attempted Suicide," *Journal of Affective Disorders* 264 (March 2020): 393.

[18] Pu Cheng et al., "COVID-19 Epidemic Peer Support and Crisis Intervention Via Social Media," *Community Mental Health Journal* 56, no. 5 (July 2020): 786.

Further, continuing education models for crisis prevention, recognition, intervention, and post-intervention are limited.[19] The developed training needs to be reinforced and reintegrated based on experiences and lessons. The training should also introduce opportunities to practice specific crisis intervention skills, including empathy, de-escalation strategies, bearing, knowledge, tact, control, and calmness.[20] The crisis intervention training must be relevant, specialized to the context, and practiced before a true crisis occurs.[21]

Those who may need to intervene in a crisis also need to be prepared for the emotional impact the intervention. These emotional responses include feelings of frustration, inadequacy, lack of control, and second-hand trauma.[22] The skills need to be practiced regularly and potential interveners must be taught how to discern when the situation is beyond their capabilities or emotional capacity. Resiliency and recovery skills are critical for potential interventionists.

Basic Assumptions

There are several assumptions underpinning this research action project. The first is that the crisis interventionist's ability to recognize crisis preconditions, intervene, and respond can be improved through developed training. It is assumed that by developing specialized training for leaders, their ability to prevent, recognize, intervene, and reintegrate those who are experiencing a crisis will be significantly improved, thus reducing crises, and providing comfort to those in

[19] Annette S. Crisanti et al., "Beyond Crisis Intervention Team (CIT) Classroom Training: Videoconference Continuing Education for Law Enforcement," *International Journal of Law and Psychiatry* 62 (January 2019): 104.

[20] Ghelani, "Knowledge and Skills," 4.

[21] Crisanti, "Beyond Crisis Intervention Team (CIT) Training," 108.

[22] Mishara, "Systematic Review," 5.

distress. It is assumed that the training will be available to those who want to take it and that it will adequately improve readiness in crisis situations.

It is also assumed that individuals will respond willingly and honestly to pre-training questionnaires and post-training questionnaires. The project will use questionnaires to determine self-reported perceptions of capability and readiness for crisis intervention. It is assumed individuals will be able to reflect thoughtfully on their strengths and weaknesses, communicate those in the form of the questionnaires, and that the questionnaires provide adequate opportunity for skills and readiness improvement measurement.

Another assumption is that there will be an appropriate number of participants. This will be important, as forced attendance could detract from the ability to learn from the material. In other words, if the only way to get enough individuals to participate is to force attendance in a military context, the non-military leaders and the non-military contexts may not be addressed. Therefore, it is assumed that there are enough leaders who will want to increase their training and readiness in this area to justify the time and resource commitments needed to develop the training and implement training events interested people.

It is assumed that those who participate will complete the developed training and provide thoughtful feedback to improve the training. It is assumed the end result of the training is useful and will be made available to additional groups as available and willing. The training seeks to improve the non-clinical opportunities for reducing crises, so it is assumed that the broader the applicability and availability of the research, the better the ability for non-clinical individuals in leadership or relational positions will be able to improve the lives of others.

Given the importance of sacred confidentiality and the role of the chaplain within a unit, confidentiality will be critical. The developed training will be unique in the requirements of the

research project and should be provided as a singular solution. Specifically, participants should be able to provide their feedback in the same system as the training to ensure accurate and timely reflection. There is an assumption that a technological program or platform exists that can provide project information, collect consent, administer the data collection tools, provide the training, and generate a confidential report for the researcher. If this assumption is not accurate, a customized tool may need to be developed that meets those requirements. Alternatively, a combination of available tools may be able to be combined, although that would not be as preferred.

Definitions

This project is primarily concerned with preparing military-connected leaders within the geographical footprint of a specific Army Reserve Maneuver Enhancement Brigade to intervene in developing and stabilizing a psychological or mental crisis. The ultimate goal of the intervention is to stabilize and assist the individual in recovering to a healthy state. This may include prevention, intervention, and post-intervention efforts.

Crisis, Psychological or Mental Health. A crisis, specifically a psychological or mental health crisis, is an acute disruption of psychological stability that results in an individual's coping mechanisms failing to provide resilience, leading to functional impairment and distress.[23] Impaired psychological functioning is the difficulty to perform optimally when carrying out

[23] Ghelani, "Knowledge and Skills," 2.

regular activities or that makes the individual unable to care for themselves or others due to distress in a safe manner.[24]

Crisis Intervention. Crisis intervention is a time-limited intervention of a psychological crisis designed to be an "exit strategy" to remove the individual from the disrupted psychological homeostasis and return them to psychological stability, often through immediate intervention and connection with additional resources for post-intervention support and eventual reintegration.[25] Whereas the act of intervening is time-limited, the long-term recovery and reintegration could take significantly longer time and resources. However, this reintegration and stabilization is critical to prevent relapse.

Gatekeeper and Gatekeeper Training; Interventionist. A gatekeeper is a non-clinical individual within the community that is positioned to recognize an individual in crisis, identify the behavioral warning signs of a crisis, intervene, and refer the individual to professional support and care.[26] The intervention involves identifying the crisis and providing the needed, acute, and immediate support to stabilize and assist the individual, preventing further distress and risk. Gatekeeper training is critical for suicide prevention but often focuses on the crisis of suicide rather than broader crisis intervention and support. Gatekeeper training also focuses on the acute situation, often ending the gatekeeping interventions at referral or handoff, negating the importance of the prevention and post-intervention support. However, gatekeeper training has

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[24] Kehinde Clement Lawrence and Ajibola Omolola Falaye, "Trauma-focused Counselling and Social Effectiveness Skills Training Interventions on Impaired Psychological Functioning of Internally Displaced Adolescents in Nigeria," *Journal of Community & Applied Social Psychology* 30, no. 6 (November 2020): 617.

[25] Cheng, "COVID-19 Epidemic Peer Support," 789.

[26] Jacinta Hawgood et al., "Gatekeeper Training and Minimum Standards of Competency: Essentials for the Suicide Prevention Workforce," *Crisis* (June 30, 2021): 1.

shown increased knowledge, recognition, and comfort in dealing with suicidal ideations, which could be adapted and applied to other situations.[27]

Leader. A leader is anyone who inspires and influences people by providing purpose, direction and motivation by their assumed role or assigned responsibilities.[28] The training is designed for leaders of Soldiers, either in their military, civilian, or relational contexts. During a crisis, individuals often turn to those who they believe can assist, often through influence and potential responses that can alleviate the crisis triggers.

Military-connected. Military-connected is a term used in various contexts and definitions throughout the literature. In educational contexts, it refers to children whose parents are either in the military or recently separated.[29] In academia, schools use the term to refer to currently serving service members or veterans.[30] In an organizational context, a military-connected organization is one that interacts with the military through business relationships.[31] For the purpose of this research project, a combination of the above is appropriate. A military-connected leader is a leader who is either in the military serving in a supervisory role or is a civilian who supervises a member of the military in the civilian context. This definition also extends to family and spouses that are military-connected.

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[27] Sarah G. Ross, Tamara DeHay, and Megan Deiling, "The Suicide Prevention for College Student Gatekeepers Program: A Pilot Study," *Crisis* 42, no. 1 (January 2021): 48.

[28] Department of the Army, *Army Leadership and the Profession*, ADP 6–22, (Washington, DC: Department of the Army, 2019), 1–13.

[29] Kendall D. Moore et al., "Evaluating Behavioral Health Interventions for Military-Connected Youth: A Systematic Review," *Military Medicine* 182, no. 11 (November 2017): 1836.

[30] K. T. De Pedro et al., "Responding to the Needs of Military Students and Military-Connected Schools: Perceptions and Actions of School Administrators," *Children & Schools* 36, no. 1 (January 1, 2014): 18.

[31] Iman Harymawan et al., "Innovation Intensity of Military-Connected Firms," *International Journal of Managerial Finance* 18, no. 2 (March 8, 2022): 365.

Peer, Peer Support. Peer support is a relationship that exists prior to the crisis in which non-professional individuals provide support, comfort, and encouragement.[32] Unlike professional or clinical intervention, peer-support is provided primarily during the prevention and intervention stages of a crisis due to the pre-existing relationship. Although peer-support continues throughout the entire crisis management process, the preventative and intervention support a peer can provide enhances the ability to manage the crisis successfully. This is largely due to pre-existing trust, experience, and the ability to provide support outside of a generalized approach to crisis management personally.[33]

Post-intervention and Reintegration. Post-intervention is the support provided to survivors of a crisis, both the individual and others who were impacted by the crisis, including grieving, understanding, stabilization, normalization, and reintegration.[34] Reintegration, in particular, involves reintroducing the survivor to normal functioning without ostracization, bias, or diminished social relationships. It is important to return to a sense of normalcy following a crisis, even if normalcy is different than pre-crisis daily living.

Sacred Confidentiality. As a representative of a faith group, a chaplain in the US Army provides spiritual, emotional, and behavioral support in addition to the religious and staff support required as a member of a commander's personal staff. In this capacity, members of the unit ministry team provide counsel and communication opportunities that are absolutely confidential,

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[32] Gregory S. Anderson et al., "Peer Support and Crisis-Focused Psychological Interventions Designed to Mitigate Post-Traumatic Stress Injuries among Public Safety and Frontline Healthcare Personnel: A Systematic Review," *International Journal of Environmental Research and Public Health* 17, no. 20 (October 20, 2020): 2.

[33] Rowan Magill, Gabrielle Jenkin, and Sunny Collings, "'Really There Because They Care': The Importance of Service Users' Interpretations of Staff Motivations at a Crisis Intervention Service in New Zealand," *Health & Social Care in the Community* (October 11, 2021): 7.

[34] John R. Jordan, "Post-intervention Is Prevention—The Case for Suicide Post-intervention," *Death Studies* 41, no. 10 (November 26, 2017): 614–15.

known as sacred confidentiality.[35] These confidential communications cannot be revealed to others unless those others are likewise bound by sacred confidentiality. This provides every member of the unit the opportunity to talk to a professional about any topic without fear of repercussion, reprimand, or embarrassment. However, this also limits the ability of the chaplain to provide critical information to others unless that confidentiality is waived.

Soldier. A Soldier is a member of the U.S. Army, serving in one of several components, including the Active Component, Army Reserve, and National Guard.

Unit Ministry Team. Within the United States Army, religious support is executed through the unit ministry team. At most echelons, this team consists of one chaplain and one enlisted religious affairs specialist or religious affairs non-commissioned officer.[36] At higher echelons, the unit ministry team may be augmented with additional members, including religious faith group leaders and chaplains dedicated to specific roles. Within the unit ministry team, all members are afforded sacred confidentiality to ensure proper confidentiality of communications that may occur in and around unit ministry team working areas.

Web-Based Training. Web-based training is training on a topic provided through internet-based services, such as electronic classrooms or resource areas, and are generally available at any time, providing appropriate access and authorization.[37] Web-based trainings are simpler to provide, are cost-effective, and improve accessibility, especially across geographic limitations. Web-based training is used throughout the crisis management literature and is a proven method

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[35] Department of the Army, *Army Chaplain Corps Activities.*

[36] Ibid.

[37] Lisa M. Sansen et al., "Daring to Process the Trauma: Using a Web-Based Training to Reduce Psychotherapists' Fears and Reservations around Implementing Trauma-Focused Therapy," *European Journal of Psychotraumatology* 10, no. 1 (December 31, 2019): 6.

of improving knowledge, readiness, and skills transfer.[38] Web-based training can be either synchronous, asynchronous, or a combination of both approaches. The benefits of each depend on the content, demographics of the participants, and need for flexibility.

Limitations

One limitation within this research action project is the available sample size. A convenient sample is proposed since the ability to interact with all members of the population would be impractical and unlikely to be approved. Further, attaining an appropriate sample size to be statistically generalizable would be a challenge, unless the population is narrowly defined. As such, the available sample of the research will be limited by practicality and limited to a convenient sample of available, willing, and geographically accessible individuals.

There is also the practical limitation of training applications. Although there is a potentially large sample size within the narrowly defined population, the practical ability to train individuals is limited due to training availability and travel restrictions. The training could be adapted to be virtual or asynchronous, or a combination of in-person and individual, but that is beyond the scope of this research project.

Additionally, another limitation related to the sample is that individuals who provide initial responses may transfer, change units, or leave military service before the training is complete. While this is not necessarily a waste of effort, as any trained skills could be useful in practice, follow-up responses and training opportunities would be limited. This can be somewhat mitigated by attempting to address those who do not have plans to leave and who express a

[38] Amanda B. Nickerson et al., "Transfer of School Crisis Prevention and Intervention Training, Knowledge, and Skills: Training, Trainee, and Work Environment Predictors," ed. Kelli Cummings, School *Psychology Review* 48, no. 3 (September 1, 2019): 236.

desire to complete the training, but military transfers and transitions can be unpredictable. If generalized and made available to a wider audience through technology, which has been shown to be useful in crisis intervention training, this limitation could be further mitigated.[39]

There is also a limitation regarding applicability of learned skills. The training will seek to improve the ability to recognize, intervene, and recover someone in crisis. If a crisis does not occur in which a trained individual can intervene, it will be difficult to ascertain the practical and applicable benefit of the training, resulting in a purely theoretical improvement. It would be unethical to introduce a legitimate crisis upon an individual in order to test the results of the training, so practical feedback beyond theory may not be plausible. If this is the case, the research contribution would be limited to theoretical during the time-limited scope of the project, with future investigations and reports needed to supplement the research results.

Delimitations

The primary delimitation is the action project design. The proposed design will involve several phases of effort. First, a skeleton outline of potential training would be developed based on the literature and experiences within the ministry context. Next, a survey instrument would be administered to understand training needs, such as readiness, ability to recognize a crisis, intervention skills, reintegration skills, and related topics. The results of this pre-training questionnaire may influence areas of influence in the training but will not fundamentally alter the training from best-practices and key areas. The training program would be developed and then implemented with the initial audience. After the training, there will be a follow-up questionnaire to measure self-reported improvements from the pre-training questionnaire.

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[39] Sansen, “Daring to Process the Trauma,” 8.

The study will target individuals within the defined scope of the context, with an initial plan of Chicopee, Massachusetts as the training focus. This location is selected out of convenience to the context, as it is a regularly attended location of key brigade leaders and contains generally stable numbers of attendees. It also has adequate local support, including training rooms, technology support, and breakout areas if needed.

The demographics are also a delimitation. The target of this training is military-connected leaders. The initial emphasis is on those who lead Soldiers on a regular basis, such as squad leaders, section sergeants and leaders, platoon sergeants and leaders, and those in similar civilian supervisory roles. Additional training opportunities will be provided as available to those in adjacent positions, such as staff leaders and those who previously led or are identified to lead Soldiers in military or civilian contexts.

Another delimitation identified prior to the project proposal is that the training will focus on practical, observable, and addressable solutions. While societal changes such as greater accessibility to financial and health services or changes in regulatory environments certainly could improve crisis intervention and prevention, those areas are not directly addressable and applicable to the ministry context. Therefore, training will be limited to what the individuals participating can influence and address.

A further delimitation is that the training must be constrained for time. For the purposes of this action project, the training should result in no more than four hours of delivered material. This time constraint matches current training standards within the ministry context. As a result of providing this training and collecting feedback, there may be a desire to expand or reduce the training time further to ensure it is timely, effective, and approachable for all participants. This

time constraint may be modifiable on an individual basis if provided asynchronously, as individuals may move through the training faster or slower than other participants.

Thesis Statement

Specific training relating to crisis recognition, intervention, and post-intervention could enable more effective crisis management and could be developed for the presented problem. The training needs to be evidence-based, focused, maintainable, and relevant.[40] The developed training must also contain modern best practices and required components.[41] After the training, participants should be able to recognize the causes of psychological crises better, how to recognize when an individual is in crisis, how to intervene, and how to provide post-intervention support.

The training should also focus on brief interventions and expectation management.[42] Crisis intervention is brief, time limited, and focused on the immediate crisis rather than longer-term care. The training should also be repeatable and relevant to the ministry context and level of influence.[43] Crisis intervention skills need reinforcement and updates as best practices continue to evolve.

The training should focus on military-related stressors, but given the ministry context of the USAR, the training must also include civilian and non-military contexts. The training, therefore, should be tailored to the unique context of Soldiers who may not have access to military programs and who may experience crises that are rarer for active-duty Soldiers, such as

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[40] Crisanti, "Beyond Crisis Intervention Team (CIT) Training," 108.

[41] Nickerson, "Transfer of School Crisis Prevention," 237.

[42] Mulligan, "Acceptability of the 'Crisis Toolbox," 1.

[43] Mishara, "Systematic Review," 3.

homelessness or job loss. Similarly, the training should not be exclusively provided to military members. It should be available for family members and civilians who would be potential interveners in crisis situations. If military-connected leaders receive training on crisis recognition and intervention best practices, then they will be better prepared to assist others in crisis.

CHAPTER 2: CONCEPTUAL FRAMEWORK

An individual experiencing a mental health crisis suffers from an acute disruption of psychological functioning which overwhelms usual coping mechanisms.[1] This is evidenced as distress and functional impairment, negatively impacting various aspects of living, including relationships, physical health, employment, and rational decision-making.[2] While everyone can experience a mental health crisis, military members often face additional and unique stressors, often putting them at elevated risks. Crisis intervention seeks to stabilize the individual in crisis, connect people with additional resources to mitigate the causes that led to the crisis, and introduce new coping mechanisms to improve resiliency in future crisis situations.[3]

Literature Review

Humans have experienced crises throughout history. Crisis intervention is a time-limited intervention that seeks to stabilize those in crisis, help them attain the resources they need to overcome the distress, and return to a healthy quality of life.[4] Crisis intervention emerged as a distinct field of clinical practice in the 1940s.[5] However, non-clinical resources staffed by volunteers designed to provide crisis support significantly predate clinical practices. Often, this

[1] Ghelani, "Knowledge and Skills," 2.

[2] Lawrence, "Trauma-focused Counselling," 617.

[3] Cheng, "COVID-19 Epidemic Peer Support," 789.

[4] Ibid.

[5] Magill, "Really There Because They Care," 2.

crisis intervention was provided by community professionals within the community that were trusted and received evidence-based training focused on crisis intervention.[6]

As crisis intervention became more focused on mental health support, the non-clinical resources, aside from phonelines, became scarcer, resulting in support options largely being limited to emergency hospital departments and law enforcement crisis teams.[7] Although hospitals and law enforcement resources may be appropriate for severe cases in which threat to self or others is present, there are barriers present for lesser crises. The stigma of involuntary hospitalization may prevent seeking emergency medical assistance, especially as the COVID-19 pandemic influenced the availability of healthcare services.[8] Additionally, those in crisis may not have the rational decision-making capability to recognize they need emergency health services, therefore leading to law enforcement being a primary avenue of intervention.

The role of law enforcement as primary responders for those in crisis arose in the 1970s and 1980s, partially as a result of the movement to deinstitutionalize those with a mental health crisis.[9] Often, law enforcement personnel receive generalized training, such as the Crisis Intervention Team (CIT) model.[10] However, interventions that are not tailored to the specific situation and intervention are not as successful, leading to less effective stabilization and outcomes.[11] The use of law enforcement as the first-line response for psychological crises also

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[6] Hankerson, "Study Protocol," 1.

[7] Ghelani, "Knowledge and Skills," 2.

[8] Elizabeth Siantz et al., "Peer Respites: A Qualitative Assessment of Consumer Experience," *Administration and Policy in Mental Health and Mental Health Services Research* 46, no. 1 (January 2019): 1.

[9] Ghelani, "Knowledge and Skills," 2.

[10] Crisanti, "Beyond Crisis Intervention Team (CIT) Training," 104.

[11] Mishara, "Systematic Review," 3.

stretches an overwhelmed law enforcement force. Some law enforcement agencies report spending more time managing mental health related incidents than on traffic accidents, assaults, and burglaries.[12]

Crisis intervention services have undergone dramatic changes recently.[13] Since the COVID-19 pandemic, mental health crises have increased, and many frontline health care workers were unprepared for the mental health challenges they would experience.[14] The COVID-19 pandemic has placed significant demand on urgent care providers for mental health, stressing overwhelmed systems and increasing the need for brief and effective interventions.[15] There have been calls to examine how society responds to those in crises, especially as a result of the pandemic, as there are significant gaps in understanding how best to intervene, who should intervene, and what the long-term impact of the pandemic on mental health may be.[16]

The COVID-19 pandemic also increased the reliance on peer support for crisis mitigation and management, especially in isolated or vulnerable populations.[17] As professional support was overwhelmed and mental health challenges grew, individuals relied upon each other and peer-support groups. However, many of these groups took on greater responsibility than they were

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[12] Crisanti, "Beyond Crisis Intervention Team (CIT) Training," 104.

[13] Mulligan, "Acceptability of the 'Crisis Toolbox," 1.

[14] Cheng., "COVID-19 Epidemic Peer Support," 787.

[15] Mulligan, "Acceptability of the 'Crisis Toolbox," 1.

[16] Jennifer D. Runkle et al., "Real-Time Mental Health Crisis Response in the United States to COVID-19: Insights from a National Text-Based Platform," *Crisis* (October 22, 2021): 2.

[17] David Best et al., "Delivering Peer-Based Support in Prisons During the COVID Pandemic and Lockdown: Innovative Activities Delivered by People Who Care," *International Journal of Offender Therapy and Comparative Criminology* (August 11, 2022): 1.

trained, which could lead to potentially harmful situations and awareness, both for those in care-seeking roles and in care-providing roles.[18]

Given the need for additional crisis intervention resources and the overwhelmed healthcare and law enforcement services, additional tools are needed. Both formal and informal peer-support programs show promise in providing needed crisis intervention, management, and post-intervention success.[19] However, training is required for potential community and peer-based interventionists, especially in recognizing the precursors of a crisis and how to intervene ethically, safely, and effectively to aid those in crisis.

Precursors to Crises

Craig Bryan, a leading suicidologist, board-certified psychologist, and researcher affiliated with Ohio State University explains that a crisis may develop as a result of a single or prolonged exposure to a stressor that overwhelms a person's ability to cope, handle, and respond functionally to the stress.[20] Stressors could be related to mental health conditions, such as depression, anxiety, or related mental illnesses. However, a pre-existing mental illness is not required for a person to enter a crisis state as a result of an event. Bryan explains that the often-cited statistic that 90% of suicide completions are comorbid with mental illness is very likely to be wrong by a significant amount.[21] A common theme in the multitude of precursors to a crisis is

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[18] Hannah L S Day, "Exploring Online Peer Support Groups for Adults Experiencing Long COVID in the United Kingdom: Qualitative Interview Study," *Journal of Medical Internet Research* 24, no. 5 (May 20, 2022): 1.

[19] Karlen R. Barr, Michelle L. Townsend, and Brin F. S. Grenyer, "Using Peer Workers with Lived Experience to Support the Treatment of Borderline Personality Disorder: A Qualitative Study of Consumer, Carer and Clinician Perspectives," *Borderline Personality Disorder and Emotion Dysregulation* 7, no. 1 (December 2020): 1.

[20] Bryan, *Rethinking Suicide*, 36–41.

[21] Ibid., 30.

a sudden exposure or event that leads to a loss of hope in improvement, overwhelming the ability to handle the exposure healthily.[22]

Mental health conditions such as depression, anxiety, post-traumatic stress disorder, prior suicidal ideation, and dysfunctional psychological arousal can result in the development of a psychological crisis.[23] Depression is a leading precursor to crisis and one of the leading causes of disability in the United States.[24] The prevalence of mental health challenges and crises is significantly high with wide-ranging negative consequences on many sectors of society.[25] A history of depression and suicidal ideation significantly increases the risk of future crisis situations, especially when maladaptive coping mechanisms such as self-blame, self-distraction, and behavioral disengagement were used during previous crises.[26]

Thomas Joiner, a leading expert on suicide and affiliated with Florida State University, examined the fundamental question of why people die by suicide.[27] His continued research identifies many different correlated with increased suicidality, including a loss of hope, loss of connection, loss of identity, and reduced protective barriers. As these losses and reductions become stronger, a psychological crisis is increasingly likely.

A psychological crisis could lead to suicidal ideation or attempt, especially if no other resources appear available. It is important to note that suicidal ideations and attempts may be

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[22] Magill, "Really There Because They Care," 9.

[23] Anderson "Peer Support," 2.

[24] Hankerson., "Study Protocol," 16.

[25] Rachel Richardson et al., "Mental Health First Aid as a Tool for Improving Mental Health and Well-Being," ed. Cochrane Common Mental Disorders Group, *Cochrane Database of Systematic Reviews* 2023, no. 8 (August 22, 2023): 1.

[26] Gysin-Maillart, "Attempted Suicide Short Intervention," 393.

[27] Thomas Joiner, *Why People Die by Suicide* (Cambridge, MA: Harvard University Press, 2007).

viewed as antipredator defensive reactions.[28] The defensive reaction triggers simultaneous psychological arousal and "shutdown" processes that lead to a sudden switch from passive or submissive behaviors correlated with depression and anxiety to more aggressive, approach-based responses. A psychological crisis could trigger a sudden shift from previously displayed mental health symptoms of depression to suicidal violence.

Similarly, social isolation can result in a loss of hope, loss of connection, and development of a psychological crisis.[29] The COVID-19 lockdowns contributed to increased reports of isolation and distress.[30] Although it is currently unknown what the exact long-term consequences of the social isolation enacted during the lockdowns will entail, the predictions are for long-term negative impact of mental health, resulting in higher levels of depression, anxiety, and poorer well-being.[31] Social isolation, loss of work relationships, and strained extra-familial contact are all potential precursors to mental health challenges, which if prolonged could trigger a loss of hope and psychological crisis.[32]

Social isolation and mental health struggles may also lead to increased substance abuse.[33] Maladaptive coping strategies such as substance abuse can lead to, prolong, or exacerbate a

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[28] Craig J. Bryan, Michael Kyron, and Andrew C. Page, "BIS Sensitivity, BAS Sensitivity, and Recent Suicide Attempts," *Personality and Individual Differences* 191 (June 2022): 3–5.

[29] Lawrence, "Trauma-focused Counselling," 617.

[30] Mulligan, "Acceptability of the 'Crisis Toolbox," 2.

[31] Katrina Lloyd et al., "A Mental Health Pandemic? Assessing the Impact of COVID-19 on Young People's Mental Health," *International Journal of Environmental Research and Public Health* 20, no. 16 (August 9, 2023): 1.

[32] Jean M. Twenge and Thomas E. Joiner, "Mental Distress among U.S. Adults during the COVID-19 Pandemic," *Journal of Clinical Psychology* 76, no. 12 (December 2020): 2172.

[33] Runkle, "Real-Time Mental Health Crisis Response," 2.

psychological crisis.[34] Aside from the impact on physical and financial health, substance abuse inhibits rational decision making, exacerbating risk during a psychological crisis.

There are many precursors to crises that do not involve mental health. Arguably, many precursors to psychological crisis and suicidal ideation are not the result of mental health disorders.[35] Craig Bryan and M. David Rudd state that under a functional model of understanding crisis behaviors, the behaviors are understood as the result of how a psychological event is experienced by the individuals rather than a psychological process itself.[36] These precursors are event-based triggers that may cause an almost immediate crisis response. The risk of an event triggering a psychological crisis is increased if there is a dramatic conflict with self-identity or a perception that there is no relational support for handling the event.

One potential triggering event is a financial catastrophe. Homelessness, hopelessness, and financial hardships can contribute to a psychological crisis, especially if combined with isolation or lack of relationship support.[37] Aside from the material needs that can no longer be met, a financial hardship introduces several additional psychological challenges, including devalued self-worth, lowered sense of purpose, and a challenged career identity. Self-esteem and pride may be negatively impacted, increasing feelings of hopelessness.

Relationship problems and family violence can also lead to a psychological crisis.[38] A terminated relationship is especially dangerous if the individual tied their views of self-worth and

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[34] Anderson "Peer Support," 2.

[35] Bryan, *Rethinking Suicide,* 80.

[36] Craig J. Bryan and M. David Rudd, *Brief Cognitive-Behavioral Therapy for Suicide Prevention* (New York: The Guilford Press, 2018), 5.

[37] Lawrence, "Trauma-focused Counselling," 617.

[38] Ghelani, "Knowledge and Skills," 5.

identity to that relationship. Similarly, if the loss of a relationship results in a loss of financial or social support and resources, the risk of a psychological crisis is significantly higher.

It is important to recognize that simply removing the triggering event may not have an impact on mitigating the crisis. In a systems-model view of suicide, the influences that alleviate the crisis may differ significantly from the influences that precipitated the crisis.[39] This is akin to slowing a moving vehicle; pressing the accelerometer adds fuel which speeds up the vehicle but to slow down quickly, pressing the brake is more effective. While removing the fuel will eventually slow the vehicle, it may not do so in order to avoid a crash. The braking system would be more effective. Similarly, in a psychological crisis, simply removing the precipitating issue may not alleviate the crisis, and instead a different approach may be required, depending on the situation.

Ideally, those experiencing a crisis will seek help from a properly trained professional. One of the primary reasons individuals in crisis may not seek help from a professional is related to the perceived stigma of mental health challenges.[40] The stigma includes beliefs that they will be socially rejected, devalued as a member of society, or stereotyped. The stigma often also includes concerns regarding employability and career success. The stigma becomes internalized, and the individual, although suffering, considers the current pain to be better than the perceived stigma attached to receiving assistance. Nearly two-thirds of those experiencing precursors to a crisis or actively experiencing a crisis are reluctant to disclose their situation, often due to stigmatization.[41]

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[39] Bryan, *Rethinking Suicide,* 108.

[40] Siantz, "Peer Respites," 16.

[41] Weatherstone and Dodd, "Experiencing," 5.

Similarly, military members reported concerns about career impacts and mandatory referrals if they were honest about their mental health or suicidal ideations.[42] They believed that they would be involuntarily hospitalized and their careers in the military would be jeopardized if they sought assistance. When the disclosure was confidential, they were more likely to report their mental health crises and ideations.

That stigma can be reduced through mental health literacy and demonstrated mental health acceptance amongst peers.[43] If peers demonstrate a concern for mental health and reduce the stigma, those experiencing challenges are more likely to seek help. However, mental health literacy remains low, and the stigmatization of a psychological crisis remains as a barrier to assistance.

An individual in crisis that does not seek help will therefore either recover using maladaptive coping mechanisms and exit the crisis, develop helpful coping mechanisms and exit the crisis, or potentially attempt or complete suicide. Individuals in crisis may view suicide as a strategy to escape from their current suffering, even though suicide would be a dysfunctional strategy.[44] If other coping skills fail to provide relief, suicide may be viewed as the only potential relief.

Ideally, a crisis can be prevented by ensuring that individuals experiencing precursors have the resources and coping skills to handle them appropriately. However, when in crisis, rational decision-making may be limited. It is critical for others in connected social support systems to understand the precursors of a crisis, recognize when someone may be experiencing a

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[42] Melanie A. Hom et al., "'Are You Having Thoughts of Suicide?' Examining Experiences with Disclosing and Denying Suicidal Ideation," *Journal of Clinical Psychology* 73, no. 10 (October 2017): 1382.

[43] Richardson et al, "Mental Health," 8.

[44] Gysin-Maillart, "Attempted Suicide Short Intervention," 384.

precursor to a crisis, and be able to intervene and respond to mitigate the crisis and restore stability.[45] As Bryan notes, creating lives worth living is one of the most effective mechanisms to prevent crises.

Crisis Intervention

It is important to remember the primary goal and purpose of crisis intervention. Crisis intervention is a brief intervention designed to stabilize, recover, reconnect, and encourage post-crisis growth in an individual experiencing a psychological crisis.[46] Providing hope, connection, and validation to those in crisis, especially if through shared living experiences and authentic relationships, greatly aids in recovery and stabilization.[47] Often, those in crisis primarily want emotional support and the re-establishment of hope and connection.[48]

Lawrence and Falaya emphasize that taking care of the immediate psychological needs of those in crisis is critical as part of the stabilization.[49] This is often the focus of government and law-enforcement-provided interventions. Reconnection and post-crisis growth are not emphasized and may lead to a relapse or future crises if not provided or available.

As part of the post-crisis growth, developing new coping strategies for future crisis mitigation is fundamental. Gysin-Mailart, Soravia, and Schwab, experts in psychiatry and medical sociology, define coping as the process through which cognitive and behavioral efforts

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[45] Ghelani, "Knowledge and Skills," 4.

[46] Cheng, "COVID-19 Epidemic Peer Support," 789.

[47] Barr, "Using Peer Workers," 10.

[48] Hom, "Are You Having," 1389.

[49] Lawrence, "Trauma-focused Counselling," 617.

are made to manage the psychological stress.[50] The success of the coping is directly dependent upon the type of stress and the unique circumstances of the individual. Coping skills can be learned and adapted.

According to Bryan, those in acute or severe crisis often discard newly discovered coping skills, falling back on dysfunctional coping skills.[51] Reinforcement of learned skills, and external reminders about the importance and success of those skills, aids in reducing the severity and scope of the crisis. Unfortunately, those in crisis may have their rational thinking capabilities reduced, so simple external connections or reminders help reinforce when in crisis.

There are many approaches and programs available to crisis interventionists. Being aware of the available approaches, planning and preparation for how to intervene, receiving appropriate training, and rehearsing the learned skills are critical for those who may respond to an individual in crisis.[52] Brief therapy and brief interventions are often the preferred approaches, as they focus on the immediate situation.[53] This is beneficial, especially if there is not necessarily an underlying psychological or mental impairment that would require longer, professional clinical therapy. By focusing on brief interventions, the ability to intervene is increased as the commitment is more limited.

A popular and generalizable crisis intervention technique is the Crisis Response Plan CRP).[54] The CRP is a stand-alone intervention aimed to reduce the short-term risk of crisis behaviors by reinforcing reasons to continue to live, reestablishing hope, reestablishing

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[50] Gysin-Maillart, "Attempted Suicide Short Intervention," 393.

[51] Bryan, *Rethinking Suicide*,119.

[52] Nickerson, "Transfer of School Crisis Prevention," 237.

[53] Gysin-Maillart, "Attempted Suicide Short Intervention," 393.

[54] Bryan, *Rethinking Suicide*, 134.

connection with peers, and aiding those in crisis to remember to respond functionally. The plan consists of several key components. The first component is to recognize precursors and warnings signs. Next, when recognized, use simple strategies to reduce the stress, distract from the emotion, and remember resources and connections. Finally, the plan requires contact with resources that can assist in alleviating the situations that led to the crisis.

There are clinical interventions as well. As Bryan notes, dialectical behavioral therapy (DBT), cognitive behavioral therapy for suicide prevention (CBT-SP), and attempted suicide short intervention program (ASSIP) all show promise as treatments for crises and suicidal behavior.[55] These interventions and therapies target the crisis and the suicidality itself instead of trying to focus on other psychological impairments. Specifically, focusing on the crisis as the primary issue rather than symptoms shows promise in relieving suffering.

Unfortunately, those in crisis often report that the available crisis intervention services and psychological health services fail to meet their needs and did not assist in their recovery.[56] Not all interventions are equally efficacious or beneficial. The primary influences that negatively impact intervention success include not focusing on the brief nature of the intervention, not tailoring the intervention to a specific situation, not following best practices, and the intervener not feeling prepared emotionally or practically.

Interventions that are brief are most effective, especially when there is not an underlying illness needing treatment.[57] Interventions that try to focus on long-term therapy often overwhelm the available resources and intimidate the individual in crisis. Hom et al. found that one reason

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[55] Bryan, *Rethinking Suicide,* 127–28.

[56] Magill, "Really There Because They Car," 1.

[57] Mulligan, "Acceptability of the 'Crisis Toolbox," 1.

military members did not report their mental health concerns was fear of long-term involuntary treatment, especially when they felt they did not have a mental illness.[58] Had it been made clear that an intervention could be brief and narrowly focuses on the immediate crisis, the individual in crisis may have been more willing to seek intervention.

Interventions that are not tailored to a specific individual are less effective.[59] Therefore, local resources that are integrated within the culture produce stronger recovery results. The more familiar the interventionist is with the specific situation, the more likely a successful intervention will occur. If the intervention is overly general, it may not address the acute causes of the specific crisis and could make the crisis worse. As Bryan found, simply changing the causes of the crisis may not remove the crisis.[60] The best approach to solving the immediate crisis is to focus on the crisis, understand the individual circumstances, and address the influences that are most likely to reduce the immediate suffering.

Crisis plans also frequently lack recommended components such as primary prevention strategies and differentiated responses based on the nature of the crisis event.[61] The specific crisis intervention approach and technique will depend on the experience of the interventionists, the relationship they have with those they will serve, and the available training resources. Although there are standardized models such as the Crisis Intervention Team (CIT) model,[62] the Zero Suicide model,[63] and the Prevent, Reaffirm, Evaluate, Provide, and Respond, and Examine

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[58] Hom, "Are You Having," 1382.

[59] Mishara, "Systematic Review," 3.

[60] Bryan, *Rethinking Suicide,* 108.

[61] Nickerson, "Transfer of School Crisis Prevention," 237.

[62] Crisanti, "Beyond Crisis Intervention Team (CIT) Training," 104.

[63] Ghelani, "Knowledge and Skills," 5.

(PREPaRE) model,[64] each approach is dependent upon context. If a different model is developed, it must be sure to include best practices germane to the context in which it is likely to be applied. It must also be reviewed regularly for efficacy and improvements.

Similar to the reasons that those in crisis do not seek help, there are several reasons observers may not intervene once aware of a crisis. Lisa Sansen, an expert psychologist who focuses on trauma therapy, notes that a lack of training and negative attitudes toward trauma are the significant reported reasons stated for not intervening.[65] This can be mitigated through preparation and training, if provided and available. However, another reason cited for not intervening is a lack of available resources.[66] Therefore, it is important that local community resources are identified, trained, and made available. Often, the first people to recognize a crisis are peers, and therefore preparing peers for crisis recognition and intervention could mitigate some of these failings.

The Role of Peers

During the previous twenty years, law enforcement has become the de facto crisis interventionists for non-clinical crisis that are not able to be handled at the family or typical social support system level.[67] Unfortunately, this typically leads to a generalized intervention strategy designed to de-escalate the situation and connect the individual in crisis with clinical resources. This may or may not be successful in preventing future crises, as this typically involves hand-offs from one organization to another, with little follow-on support. The hand-off

[64] Nickerson, "Transfer of School Crisis Prevention," 238.

[65] Sansen, "Daring to Process the Trauma," 1.

[66] Cheng, "COVID-19 Epidemic Peer Support," 787.

[67] Crisanti, "Beyond Crisis Intervention Team (CIT) Training," 104.

to clinical support is likely to focus on clinical treatments of the crisis, even if there is minimal correlation between the crisis and mental illness.

When professional clinical intervention is complete, the individual typically returns to their previous environment, which may not have been changed. They may have received some coping skills training or learned functional mitigation strategies, but those skills may not be tailored to the unique circumstances of the crisis. If the precursors of the crises are not addressed, recovery is limited. The cycle may continue, as individuals who experience a crisis and seek out treatment are more likely to reach out again, which may overwhelm resources.[68]

Ideally, law enforcement and crisis response centers should only respond to acute crises that have no other support options.[69] Although often considered the primary intervention option, in practice they would be more efficient if considered the last option. Instead, local services within the immediate peer group, family group, and support systems would be a more effective approach to mitigating crises.

Often, the local support structure consists of peers, such as friends, families, mentors, and direct supervisors. These resources are often referred to as gatekeepers, as they are likely to be the first points of contact in daily living for those who are in crisis.[70] These community and peer-support resources are critical to crisis mitigation.[71] Aside from being more readily available and aware of the specific circumstances that may lead to a crisis in the individual, there are several critical facets of peer-support in crisis intervention.

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[68] Mishara, "Systematic Review," 1.

[69] Ibid., 6.

[70] Sarah G. Ross, Tamara DeHay, and Megan Deiling, "The Suicide Prevention for College Student Gatekeepers Program: A Pilot Study," *Crisis* 42, no. 1 (January 2021): 48–55.

[71] Hankerson., "Study Protocol," 17.

The most effective crisis intervention support is visible and proximal.[72] The best support will often come from local volunteers, professionals, trained peers, and local organizations. The effect of community resources on crisis mitigation and recovery is significant. As Bryan acknowledges, crisis response requires a community responsibility that supports growth and encourages the development of lives worth living.[73] Social support structures and opportunities are among the best mediators of crisis precursors.

The role of reducing suicide and crises is the responsibility of everyone in society, especially at the local level where change is most proximal and visible. Therefore, the responsibility of reducing crises begins at the peer support level. Anderson, head of faculty and a dean at Thompson Rivers University, defines peer support as the supportive relationship between individuals who have experienced adverse events and those who provide emotional support, social support, encouragement, and hope.[74]

Often, the local support systems provide the best mitigation of precursors due to the proximal nature and availability of contact. As both Bryan and Joiner noted, the loss of connection and hope both contribute significantly to crisis development. The local support structure and peer groups provide the unique opportunity to reestablish or strengthen sense of connection, and thereby increase senses of hope.

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[72] Magill, "Really There Because They Care," 7.

[73] Bryan, *Rethinking Suicide*, 198.

[74] Anderson "Peer Support," 2.

Social support also provides a buffering effect on stressors and events that mitigates future crises and can aid during a crisis.[75] Supportive social relationships through peers are pivotal to physical and mental health.[76] During a crisis, the support of peers is directly tied to resilience, in part due to the proximal nature of the peer support.

In addition to being proximal, crisis response is strongly enhanced through contextualization, preparation, and timing.[77] Crisis response problems and solutions are often poorly defined. However, local and peer support can have the benefit of contextualization within the community or through relationships. With proper preparation and training, crisis responders who contextualize the response with creativity, and have the competency to improvise the response based upon local conditions, can more effectively manage the phases of the crisis.[78]

These capabilities are backed through several research studies. Mishara, Cote, and Dargis found that initiating regular contact with those in crisis or experiencing precursors to crisis reduces the reliance on emergency response teams and interventions.[79] Hom also found that each outreach attempt to those potentially in crisis represented an opportunity for the extension of social support and reduction in suicide risk.[80] Liu, Rim, Min, and Min also found that surprise

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[75] Håvard Haugstvedt, "'With a Little Social Support…': Assessing the Moderating Effect of Social Support on Risk Factors and Mental Well-Being among Youth," *European Journal of Social Work* 26, no. 6 (November 2, 2023): 2.

[76] Guro Engvig Løseth et al., "Stress Recovery with Social Support: A Dyadic Stress and Support Task," *Psychoneuroendocrinology* 146 (December 2022): 1.

[77] Pietro Romano et al., "Facing the 'During' Phase in Crisis Management: An Incremental Adaptive Launching Process," *Safety Science* 155 (November 2022): 1.

[78] Ibid., 4.

[79] Mishara, "Systematic Review," 6.

[80] Hom, "Are You Having," 1390.

contact by others improves morale, psychological well-being, and appreciation.[81] Combined, it is clear that even minimally trained peers can reduce crises simply through authentic presence and contact.

There have been attempts to formalize peer support services into systems known as peer respites. Pelot and Ostrow note that peer respites have demonstrated significant opportunities for successful crisis mitigation, stabilization, and coping skill development.[82] Peer respites are recovery-focused systems in which individuals who have experienced a shared-living experience related to psychological crises or mental health trauma provide support to individuals who are currently experiencing, or recently experienced, a crisis. They are controlled by trained staff, but the primary feature of a peer-respite program is the home-like environment shared with others who have had similar experiences. The peer-connection and support opportunities allow skill-sharing and restores a sense of connection, which may mitigate future crises.

Further, Barr, Townsend, and Grenyer note sufferers of crises experienced increased feelings of hope when interacting with others who have recovered from similar crises.[83] The peer-respite model normalizes mental health crises, improving stabilization and resiliency, partly due to the increased hope.[84] Bryan, referencing work completed by Joiner, found that hope and improved quality of life both contribute significantly to improved suicide prevention and care.[85]

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[81] Peggy J. Liu et al., "The Surprise of Reaching out: Appreciated More than We Think.," *Journal of Personality and Social Psychology* (July 11, 2022), 1.

[82] Morgan Pelot and Laysha Ostrow, "Characteristics of Peer Respites in the United States: Expanding the Continuum of Care for Psychiatric Crisis," *Psychiatric Rehabilitation Journal* 44, no. 4 (December 2021): 305.

[83] Barr, "Using Peer Workers," 2.

[84] Siantz, "Peer Respites," 13.

[85] Bryan, *Rethinking Suicide.*

There is increasing concern about the emotional toll placed on crisis interventionists, especially for non-clinically trained interventionists.[86] In post-intervention debriefings with mobile crisis team members, Mishara found that they often reported feeling emotional drain, frustration with the overwhelming complexity of the crisis situation, feelings of resentment, burnout, and lack of understanding.[87] While empathy largely remained strong, feelings of burnout reduced empathy which increased frustration and generalization of strategies. These responses are stronger for those who lack training, self-care skills, or preparation.

This lack of self-care and high levels of stress are prevalent in non-professional intervention strategies. Barr, Townsend, and Grenyer found that those who care for others in crisis or with mental health challenges, including peer support, often lacked the proper tools for self-care, which could lead to burnout and crisis in the intervener. Further, if the interventionist appears burnt out, lacks empathy, or is perceived to lack knowledge and skills, the individual in crisis may regard the interventionist as lacking credibility, as found by Siantz and others.[88]

Along with self-care, formalized training reduces burnout, compassion fatigue, and negative emotional responses to crises for crisis interventionists.[89] Therefore, education and training are plausible mechanisms that may mitigate the adverse emotional responses experienced by interventionists. However, formalized training is most often offered to those who are in pre-identified roles, such as law enforcement and mobile crisis intervention teams. Peers

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[86] Christopher J. Noullet et al., "Effect of Pastoral Crisis Intervention Training on Resilience and Compassion Fatigue in Clergy: A Pilot Study.," *Spirituality in Clinical Practice* 5, no. 1 (March 2018): 1.

[87] Mishara, "Systematic Review," 2.

[88] Siantz, "Peer Respites," 15.

[89] Noullet, "Effect of Pastoral Crisis Intervention," 2.

may not receive formal or informal training, leading to lack of skills and preparation for the emotional weight of the crisis.

The reality is that a number of people who struggle with vulnerability to mental health difficulties is increasing world-wide, leading to a need for new interventions with peer-support.[90] Peer interventions are proving to be effective means of mitigating crisis vulnerability and risk. Increased training, support, and awareness amongst peer populations can help mitigate the growing mental health challenges at both local and societal levels.

Training and Education Related to Crises

To recognize, intervene, and aid in the recovery of those in crisis successfully, specific skills are required. These skills need to be trained and practiced through skills-based training. skills-based training is crucial for assisting those in crisis.[91] Skills related to crisis intervention span prevention, intervention, and post-intervention phases of a crisis.

Skills may be viewed as belonging to specific phases of a crisis, although many skills have varying levels of application in multiple phases. In the earliest phases of a crisis, skills relating to prevention and recognition are critical. Many crises can likely be prevented by improving quality of life and taking steps to create lives worth living, requiring that those interested in reducing crises and suicidality make explicit efforts to improve life in general first.[92] While this may include larger political and sociological changes, localized relational improvements are effective as well.

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[90] Chalotte Heinsvig Poulsen et al., "A Community-Based Peer-Support Group Intervention 'Paths to EvERyday Life' (PEER) Added to Service as Usual for Adults with Vulnerability to Mental Health Difficulties – a Study Protocol for a Randomized Controlled Trial," *Trials* 23, no. 1 (September 2, 2022): 1.

[91] Bryan, *Rethinking Suicide,* 143.

[92] Ibid.

However, life is often wrought with stressful incidents that cannot be prevented in all cases. Often, they are overcome through coping techniques and resources, but this may not always be the case. A key skill for those who want to reduce crises in the lives of others is being able to recognize warning signs and address them before they lead to mental distress.[93] These include recognizing when someone is in a financial hardship, a relational shift, a major stressful life milestone such as retirement, or experiencing a traumatic event.

Often, it is those closest to the individual who recognize the precursors to a crisis. Assessment of precursors to a crisis, such as newly introduced acute stressors, enables peers to recognize that a crisis may be developing.[94] Peers who recognize the crisis can take streps to reduce their effects, such as refer to resources or remind the individual of support. Simply being present and being available may be helpful in improving mental well-being.[95] Often, simple acts of caring and support, though underappreciated by the giver, are substantially helpful for the receiver.[96] Small, regular contact and support may mitigate some crises. However, if the crisis is not or cannot be prevented, intervention skills will be important.

When an individual is in crisis, the intervener needs to be a positive, stable, and present source of comfort and guidance. Critical skills to exhibit during the intervention include talking in a calm and non-confrontational tone, maintaining physical distance, unless safe to approach, using a lower volume of speech than the individual in crisis, providing a sense of self-control and autonomy for the individual in crisis, and reminding the individual about community or

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[93] Ghelani, "Knowledge and Skills," 4.

[94] Noullet, "Effect of Pastoral Crisis Intervention," 2.

[95] Liu, "Surprise," 1.

[96] Amit Kumar and Nicholas Epley, "A Little Good Goes an Unexpectedly Long Way: Underestimating the Positive Impact of Kindness on Recipients.," *Journal of Experimental Psychology: General* (August 18, 2022): 1.

relational resources and support.[97] It is critical that the intervener maintains composure and stability without conveying any sense of judgment. It is also important to establish rapport, as that is a key reason individualization and peer intervention is more effective than generalized interventions.

In the midst of a crisis, an individual may have reduced rational functioning and may exhibit signs of emotional and physical distress. This can include self-harm, emotional outbursts, violent outbursts, and escape strategies including substance abuse. De-escalation strategies are critical for reducing injury and death.[98] De-escalation involved intervening in the situation in a calm, present, and helpful manner to reduce the emotional burden on the individual and remove capabilities for self-harm or harming others. If this cannot be done safely, additional resources such as law enforcement may be required.

Once stabilized, growth and recovery skills are important. The individual who experienced the crisis may need support in learning and applying healthy coping mechanisms and improving resilience. Teaching healthy coping skills reduces future crises and suicidality.[99] When coming from a trusted or respected peer, these teaching opportunities may be more impactful. Teachable skills include self-care, healthy thinking, presence, mindfulness, and spiritual practices. Self-care and spiritual activities aid in mitigating future crises once beyond

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[97] Ghelani, "Knowledge and Skills," 4.

[98] Ibid., 3.

[99] Gysin-Maillart, "Attempted Suicide Short Intervention," 297.

the initial crisis and help improve general quality of mental health.[100] Spiritual practices in one crisis may mitigate depressive symptoms, anxiety, and distress in future crises or struggles.[101]

Following intervention, and treatment if needed, reintegration reconnects the individual in crisis with social and peer support structures, attempting to return the individual to normalcy. This is especially important if the crisis was not related to a medical condition requiring further treatment, as there may be a concern regarding stigma.[102] Once the crisis has passed, establishing a return to normalcy is important. Peer interaction and support is critical for reintegrating and debriefing.[103] Reintegrating and providing social support is fundamental for recovery and preventing relapse of crises.[104]

The return to normalcy is often anticipated as a stressful and challenging event, but support from a trained peer can help this return to progress healthily. Follow-up contact after reintegration significantly reduces relapse, reestablishing connection, and reinforcing support structures.[105] In fact, reaching out significantly improves general mental health and reinforces connection.[106] The simple act of providing continued contact and reminders of support mitigates future crises and suicidality and reestablishes normalcy.

One popular set of skills related to crisis intervention is grouped into a program called The Crisis Toolbox. The Crisis Toolbox incorporates nine skills related to crisis management and

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[100] Noullet, "Effect of Pastoral Crisis Intervention," 2.

[101] Lisa Miller, *The Awakened Brain* (London: Penguin Books, 2022).

[102] Hankerson, "Study Protocol," 3.

[103] Crisanti, "Beyond Crisis Intervention Team (CIT) Training," 108.

[104] Lawrence, "Trauma-focused Counselling," 618.

[105] Gysin-Maillart, "Attempted Suicide Short Intervention," 398.

[106] Liu, "Surprise," 2.

is a standard for basic crisis intervention strategies.[107] Specifically, The Crisis Toolbox emphasizes distress tolerance, problem solving, distraction techniques, self-soothing, surfing the urge, sleep hygiene, grounding, and worry management. Each of these techniques are useful for prevention and intervention and learned mitigation skills aid in post-intervention reintegration. The Crisis Toolbox was relied upon heavily during the COVID-19 pandemic, although it had limitations in generalization.[108]

Learning these important skills and concepts requires specialized and dedicated training. Training develops available interventionists and resources for prevention, intervention, and post-intervention support. Currently, suicide and crisis-focused treatments are difficult to find due to poor training and poor perspective from professionals.[109] In other words, many professionals and non-professional leaders do not learn crisis-related skills, focusing on their own domains or understandings, which leads to a lack of available resources for those in crisis. Unfortunately, even in peer-respite centers, intentional training was rarely required.[110]

Even professionals conducting crisis intervention did not always use best practices during crisis intervention, often citing insufficient training and a preference of individualized treatment over generalized training and treatment.[111] Generalized training and intervention is less effective, and the lack of available training on how to individualizes crisis interventions reduces the efficacy of the techniques. There is a significant lack of focused training for professionals that

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[107] Mulligan, "Acceptability of the 'Crisis Toolbox," 2.

[108] Ibid., 7.

[109] Bryan, *Rethinking Suicide*, 142.

[110] Pelot, "Characteristics," 306.

[111] Sansen, "Daring to Process the Trauma," 2.

are not dedicated crisis interventionists but are in adjacent fields. This is exacerbated for leaders in non-clinical fields that may be called upon to intervene.

Similarly, continuing education is critical to ensure skills remain relevant and ready, even though continuing education is lacking.[112] In fact, many crisis intervention trainings are one-time events, so skills that are learned begin to weaken over time. Training must be kept up to date and reinforced at regular intervals to remain relevant.

Many individuals in a leadership position are sought out during a crisis to provide intervention, even though most have not received specific formalized crisis intervention training.[113] Improper training and preparation lead to burnout and secondary traumatic stress for the interventionist.[114] Equally problematic is that improper training and preparation can significantly increase the risk of crisis escalation instead of stabilization.

However, crisis prevention, intervention, and post-intervention skills can be trained. The training, if developed and implemented according to best practices and administered to those who desire to receive the training, can be rewarding, effective, and lifesaving. Training design, trainee characteristics, and training environment contributed substantial variance to outcomes from the training.[115] The modality of the training does not appear to be statistically influential on training outcomes either. Web-based training is simple and effective.[116] Web-based peer training

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[112] Crisanti, "Beyond Crisis Intervention Team (CIT) Training," 104.

[113] Noullet, "Effect of Pastoral Crisis Intervention," 1.

[114] Ibid., 5.

[115] Nickerson, "Transfer of School Crisis Prevention," 246.

[116] Sansen, "Daring to Process the Trauma," 2.

and web-based support programs for interventionists and those in crisis are likewise proving successful in mitigating and stabilizing crisis and post-crisis traumatic stress.[117]

Training Delivery

Training may be delivered through a variety of modalities. The best training modality will likely depend on the specific context of the training, such as the target audience and the content of the material. Since the COVID-19 pandemic, there has been an increased transition to distributed online learning environments across disciplines.[118] For crisis management skills, web-based delivery is an effective approach, especially if contextualized and personalized for the specific environment.

Peer support training delivered through electronic platforms asynchronously is often received favorably by participants.[119] Knowledge retention is correlated with participant motivation and attention. Asynchronous delivery allows participants to dedicate time to the training according to their own schedules, reducing the need for coordination and life interruption. Asynchronous delivery may also allow the participant to revisit concepts and materials for reinforcement or clarification, especially as additional concepts are introduced.

Asynchronous web-based training can be powerful and effective. However, the training must be accessible, usable, meaningful, and reliable.[120] To be accessible, there should be

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[117] Cheng, "COVID-19 Epidemic Peer Support," 788.

[118] Rachael Lewitzky and Kari Weaver, "Developing Universal Design for Learning Asynchronous Training in an Academic Library," *Partnership: The Canadian Journal of Library and Information Practice and Research* 16, no. 2 (February 3, 2022): 1.

[119] Kyle Possemato et al., "Web-Based Problem-Solving Training With and Without Peer Support in Veterans With Unmet Mental Health Needs: Pilot Study of Feasibility, User Acceptability, and Participant Engagement," *Journal of Medical Internet Research* 24, no. 1 (January 13, 2022): 1.

[120] Lewitzky, "Developing," 1.

minimal barriers for participants to attend the training. A well-designed platform that provides a holistic solution for enrollment, learning, advancement, and testing ensures that the participants can easily proceed through the training. Further, if delivered asynchronously, the training may be accessible regardless of time of day, allowing for more flexibility in scheduling.

The training must also be usable.[121] Usability ensures that the training can be received and ensures that it is useful in the lives of the participants. If the training is appropriately accessible, participants will retain more learning if they deem the content is relevant and useful. The use of vignettes and practical applications can enhance perceptions of usability within crisis management training. Usability is closely related to meaningfulness in that if the content is useful, and the training is relevant, it will likely be considered meaningful to the participants.

Finally, the training must be reliable. Aside from accessibility concerns related to reliability, the training must be provided from a source with expertise.[122] If the training is not presented professionally, participants may not consider the knowledge to be reliable. All four of these themes influence each other and must all be considered to deliver an effective web-based training program.

There are several barriers related to web-based training environments. First, there is an environmental dimension to web-based learning that must be considered.[123] Individuals who do not have access to the web-based platform, either at home, through community, or through organizational resources, will not be able to participate. Therefore, if the training must reach

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[121] Lewitzky, "Developing," 1.

[122] Ibid.

[123] Azarias Mavropoulos, Anastasia Pampouri, and Konstantina Kiriatzakou, "Adults' Motives and Barriers of Participation in Mixed and Asynchronous Learning Training Programs*," Journal of e-Learning and Knowledge Society* 17, no. 1 (June 22, 2021): 36.

individuals with environmental limitations, a web-based solution may not be appropriate as the only modality of the training.

Further, not every participant will learn in the same manner. Self-discipline is needed to manage time and progress. If the training is open-ended, the participant may not prioritize training advancement. Therefore, one way to mitigate the time-management and self-discipline considerations is to provide a due date for completion of the training. Within that timeframe, self-determination and scheduling may still be provided to the participant.

By its nature, Web-based training features less human contact than in-person training modalities. This reduction in contact is prevalent from enrollment through training completion, with some training programs featuring virtually no human contact. There is a concern about enrolling participants with minimal human contact, however it is feasible if approached with thought and consideration.[124] For crisis management training, human interaction is preferred to reinforce learning and skills practice.

Therefore, combining asynchronous and synchronous training modalities often mitigates concerns about the lack of human contact. For example, a training program could feature predominantly asynchronous training with synchronous "check in" sessions throughout the program. Alternatively, most of the training could be asynchronous with one final optional training session conducted in-person or via web-based conferencing technologies.

The online environment facilitators must also be equipped and motivated to deliver the training appropriately and effectively.[125] Facilitators should be experts in the material they are training in order to ensure reliability and usability. This often involves "train the trainer" training

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[124] Possemato, "Web-Based," 1.

[125] Mavropoulos, "Adults," 29.

events in which facilitators experience the training as a participant and then provide the training in a controlled environment. Following successful completion, the facilitators will have improved confidence and expertise in the content.

Within a distance training environment, there are unique ethical considerations. One consideration is the relevant availability of support for those who experience a serious risk of harm, trigger, or other emotional distress.[126] This can be mitigated by providing consistent resource information. For example, during a crisis management training program, participants could be presented with contact information for professional care givers if they begin to experience emotional distress. This may also be mitigated through regular synchronous "check-in" sessions.

There are also concerns about participants failing to complete the training, either through emotional distress related to the training or life circumstances preventing completion of the training. Automated follow-ups provided through electronic platform substantially increased responses and learning from the training.[127] If a follow-up is not responded to, additional contact attempts may be appropriate to ensure participant safety. However, this is challenging in anonymous training platforms and is a risk to consider when using an anonymous training modality.

Ethical and Legal Considerations

Aside from ethical considerations related to training modalities, the ethical ramifications of peer-crisis interventions also must be considered and incorporated into training programs. The

[126] Poulson, "A Community-Based," 7.

[127] Possemato "Web-Based," 1.

ethical implication of an intervention includes legal, jurisdictional, competence, and moral obligations or constraints. When training for crisis intervention, it is important that the trainer and trainee both understand and consider these ramifications.

A shared understanding of the ethical responsibilities of those in crisis intervention groups is critical.[128] Developing an ethical charter, guideline, or code of conduct can help trained lay leaders navigate the ethical conflicts that may arise. Examples of ethical guidelines include the desire to do no harm, keep strict confidentiality in line with licensure and law, follow training and professional competencies, do not exceed capabilities, and focus on short-term intervention rather than long-term therapy.

There is a significant responsibility to acknowledge professional competency, capabilities, and legal limitations. It is important that peers do not present themselves as patient-professional relationships and avoid presenting their interventions and support as treatment.[129] Strictly, social support is generally viewed as non-clinical and therefore no licensure is required. However, clinical licensure is likely required if clinical interventions are involved, and a patient-professional relationship is established.

It is critical to limit the responsibility the peer support system takes on, especially if the peer support structure lacks relevant training.[130] Ethically, any peer support group must recognize when they are exceeding their capabilities to reduce risk to participants. Peer support should be augmented by professionally trained providers whenever possible. If none are

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[128] Possemato "Web-Based," 1.

[129] Ibid., 789.

[130] Day, "Exploring," 1.

available, professional contacts should be provided to the group, and peers should hold each other accountable to recognize when the scope of their support is exceeded.

Theological Foundations

The theological underpinnings of this research project span all of revelation, beginning with the introduction of sin into creation and concluding with the development of the church on earth. The purpose of this project is, ultimately, to reduce the likelihood or impact of crises, which if experienced cause human suffering. Human suffering occurs as a result of the separation of humanity from God, which began in the book of Genesis.

Separation, Sin, and Revelation

In the book of Genesis, the title of which is derived from בְּרֵאשִׁית meaning "in the beginning," the story of God's creative works is described, resulting in the creation of man in the Garden of Eden.[131] However, willful disobedience as the result of the temptation led to a "fall from grace" in which man was separated from God (Gen. 3:17–19). Through the fall from grace when Adam and Eve disobeyed God, creation was cursed, and pain and hard work was introduced into daily life. Suffering is a product and consequence of the fall of humanity and the result of living in a world with sin and a world in which death entered through Adam.[132]

Since the expulsion from God's presence, pain and suffering are facts of life. Crises, both as the result of natural phenomenon and human activity, became a reality of life. Human suffering is found throughout the Scriptures since the fall. Many of God's chosen looked to God

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[131] John D. Currid, *Genesis, A Biblical-Theological Introduction to the Old Testament: The Gospel Promised,* ed. Miles V. Van Pelt (Wheaton: Crossway, 2016), 50.

[132] John Reuman, *Romans,* Eerdmans Commentary on the Bible, eds. James Dunn and John Rogerson, (Grand Rapids: Wm. B. Eerdmans Publishing Co., 2003), 1292.

to alleviate suffering through prayer, following God's will, and understanding His creation both through special and general revelation. Historically, every generation has experienced crises that typified the time period and the people involved, especially as record keeping and data archival maintained memories of these crises for future generations.[133]

There is contention regarding the role of general revelation in human well-being, with some arguing that Christians need only rely on special revelation while others believe that all knowledge is God's knowledge, fit for use and reconciliation. This is critical for understanding how best to integrate secular theories with biblical truth.[134] One popular approach, termed "Spoiling the Egyptians" by Larry Crabb, seeks to reconcile an approach to counseling that uses Scripture as the truth, but takes what is appropriate and useful from secular resources and integrates them together.[135] "Spoiling the Egyptians," while controversial, attempts to utilize general revelation by combining learning and knowledge from general revelation sources, such as designed human intuition and pursuits of knowledge, with the special revelation of Scripture and Christ's ministry. Scripture remains foundational in this approach.

A key consideration is understanding God's revelation in the world of nature.[136] Psalm 19 is a text that emphasizes the revelation of God within creation as general revelation, as compared to Scripture or Christ's ministry as special revelation. In other words, the psalmist proclaims the glory and knowledge of God through nature, with an implication that all of nature, being under

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[133] Erwin Henderson, "A Global Perspective on the COVID-19 Crisis and an Ontological Theology Perspective," *Pharos Journal of Theology* 102 (2021).

[134] Tim Clinton and Ron Hawkins, *The Popular Encyclopedia of Christian Counseling* (Eugene: Harvest House Publishers, 2011).

[135] Larry Crabb, *Effective Biblical Counseling* (Grand Rapids: Zondervan, 2013).

[136] Willem A. VanGemeren, *Psalms*, vol. 5, The Expositor's Bible Commentary, eds. Tremper Longman III and Device E. Garland, (Grand Rapids: Zondervan, 2008), 266.

God's creation, teaches His creation about Him. Natural revelation is without words, is universal, and spans linguistic divisions.[137] It is important to recognize, as previously examined, that sin has corrupted creation and therefore general revelation in and of itself is not sufficient for understanding God. In that context, learning gained through general revelation must be filtered through learning derived as a result of special revelation.

Paul reminds his readers in Rome that God's invisible qualities, such as divine nature, have been accessible and understandable to all since creation (Rom. 1:20). God's creative processes reveal his nature.[138] Studying and learning about His creation reveals more insight into His nature but also into the results of His creative process. Therefore, the study of natural phenomenon, including human psychology, when tempered with special revelation, can provide a better understanding of reality.

This use of secular knowledge through general revelation must be tempered with God's own revelation through Scripture. In the second epistle to Timothy, readers are reminded that all of Scripture is "God-breathed" and useful for teaching, correction, and training (2 Tim. 3:16). Similarly, in the epistle to the church in Rome, Paul reminds the believers to not be conformed to the world and instead be transformed by the renewal of the mind, testing everything against God's will and commands (Rom. 12:2). The "therefore" in Romans 12:1 refers to God's revelation in Romans 11:11–22 and Romans 11:33–36, recognizing that current creation is mired in sin, but instead learning to identify what is good in learning through the filter of worshipping and following God.[139] It is important to recognize that "non-conformance" to the world does not

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[137] VanGemeren, *Psalms,* 267

[138] Reuman, *Romans,* 1285.

[139] Ibid., 1305.

necessarily require ignorance of the ways of the world, including developments in science and philosophy. Paul uses the philosophy and culture of the time to preach and teach about Christ in ways that the recipients would better understand.

Jesus' Ministry and Resurrection

Although sin and death entered through Adam, through Christ there is hope of a better life and resurrection.[140] Through Christ's suffering and sacrifice, a new hope and community was made available through the Spirit (1 Cor. 15:20–22).[141] Christ's own suffering, crucifixion, and resurrection re-enabled a personal relationship with God, available to all, and strengthened by the church on earth in roles of support and teaching.

There is also the cosmological implications of Christ's resurrection and the resulting impact on humanity. Through Christ's crucifixion, there is a complete reordering of human energy and activity, implicitly demonstrating the need for new relationships, support, and love for one another.[142] Christ's command on earth was for people to love one another as they love themselves, implying a supporting relationship that raises, supports, and heals one another whenever possible. This ministry of caring is reflective of Christ's love and care for His creation, the church, as a representative of Christ on earth, is ordained in part to heal and reduce suffering in a broken, sinful world.

The command, found in all the Synoptic Gospels, is found within the context of Jesus confronting self-righteous leaders within Jerusalem. When the local leaders attempted to trap

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[140] Reuman, *Romans,* 1292.

[141] Stephen Barton, *1 Corinthians,* Eerdmans Commentary on the Bible, eds. James Dunn and John Rogerson, (Grand Rapids: Wm. B. Eerdmans Publishing Co., 2003), 1348.

[142] Ibid., 1349.

Jesus regarding the Law, Jesus responded that the most important commandment is to love God, and the second is to love others (Matt. 22:34–40). This conversation occurred in the midst of four controversial dialogues in which religious leaders sought to trick Jesus and discredit His theology.[143] This is notable in that Jesus made explicit His role as the God of Abraham, the need to give to Caesar, that He is the Son of David, and the relationship creation should have with God and one another. This loving relationship forms a theological underpinning of peer care and support, especially in times of crisis.

It is relevant to acknowledge that these commands were not new or radical interpretations of the Law. Jesus effectively combined the commandment to love God found in Deuteronomy 6:4–5 and the command to love others as found in Leviticus 19:17–18.[144] This combined command, while technically standing as two commands based upon Jesus stating, "the second is like it," formed a central tenet of the early church.

Paul, however, reduced the dual commands to a single command in Galatian 5:13 and Romans 13:9. Which emphasized the importance of the one-another command. While scholars such as Taubes and Spinoza noted the reduction, and viewed it as revolutionary, it is entirely possible that the love of God was seen as fundamental to the new covenant.[145] With a relationship with Christ, loving God is not necessarily needed to be commanded and simply "is" for Paul. Therefore, commanding a love of God would be redundant, so Paul focuses on the

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[143] Iain M. Duguid, James M. Hamilton, and Jay Skylar, eds., *ESV Expository Commentary* (Wheaton, Illinois: Crossway, 2021), 460.

[144] Gideon Baker, "Paul's Reduction of the Dual Commandment: The Significance of Worldliness to Messianic Life," *Political Theology* 21, no. 7 (October 2, 2020): 606.

[145] Baker, "Paul's Reduction," 610.

practicality of living according to Jesus' commands, especially focusing on the relationships with one another.

The commands in the account are in a similar grammatical structure to other commands found in Matthew. In Matthew, most of Jesus' commands were given in second-person plural, indicating that they speak to the disciples and groups in the goal of developing a righteous and paradigmatic society, with God's will and law shaping society.[146] In other words, Jesus was both commanding and demonstrating the way humanity should live, worship, and interact.

This social relationship is also found in Luke. A local religious legal expert confronted Jesus regarding the question of who one's neighbor is, and Jesus responds with the parable of the Good Samaritan (Luke 10:25–37). This is notably found within the context of Jesus' teachings about eternal life, covenantal love, and tightly linked with understanding God's revelation.[147] It is also important to note that Jesus never challenged the questioner's desire to act rightly as someone who takes care of others, and instead only made clear what the scope of the neighborly view would entail.

In this parable, Jesus explicitly made the reasoning for the righteous leaders' willful neglect of the wounded man ambiguous. This is to undercut any reason for anyone, regardless of background or culture, to ignore someone in need.[148] When Jesus asks the legal expert which of the individuals in the parable was the neighbor, the expert responded that it was the one who showed mercy, avoiding the cultural identity of the Samaritan.

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[146] Duguid, *ESV Expository*, 43.

[147] F. Scott Spencer, *Luke, Two Horizons New Testament Commentary* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 2019), 279.

[148] Ibid., 281.

This rhetorical device is important. It demonstrates that there are two aspects to being a "neighbor" in God's creation. Jesus asked which of these were righteous, specifically using τις. This represents the nature of the person as being important, not just the neighborly acts themselves.[149] Jesus ends the conversation with the command to "Go and do likewise," (Luke 10:37). This represents the importance of the action itself. Therefore, being a neighbor and showing mercy requires a state of the heart and requires action.

It is important to note that the parable receives some criticism as not properly fitting with the Lucan context, primarily since it is not explicit in identifying the proper beneficiary of the activity and parable.[150] However, the power of the parable is that it places the interpretation back on the questioner, posing each reader to question who their neighbor is, who should be shown mercy, and who should be shown love. When tied back to Jesus' greatest commandments, it is clear that these two instances of Jesus' teaching require Christians to take care of each other and take care of non-Christians, equally and lovingly. There is now, for the lawyer in the context of the Good Samaritan and within creation as a whole, a reciprocal relationship between humanity.

The Early Teachings and Implications

In the letter to the Galatians, the Christian community is exhorted to balance both individual responsibility and communal support.[151] Each member is responsible for their transgressions, but when in distress there is a communal responsibility to engage and support one another (Gal. 6:2). The community is told that the entire law is fulfilled by the command to love

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[149] Spencer, *Luke*, 282.

[150] Proctor, "'Who Is My Neighbor?' Recontextualizing Luke's Good Samaritan (Luke 10:25–37)," *Journal of Biblical Literature* 138, no. 1 (2019): 205–06.

[151] Beverly Gaventa, *Galatians*, Eerdmans Commentary on the Bible, eds. James Dunn and John Rogerson, (Grand Rapids: Wm. B. Eerdmans Publishing Co., 2003), 1383.

your neighbor as yourself (Gal. 5:14). Christians are not saved through the work of keeping the law, but they are obligated to follow this law of love.[152] While love may entail discipline and correction, it also entails healing, support, and presence. This extends to reconciliation with the community.

Paul is largely speaking to a group of believers, but there is a subtle implication that the love and support commanded is not limited to the immediate group. It is important to understand that all are in Christ in some sense, even if they have not yet accepted Christ as Savior.[153] As created beings of God, Christians must recognize that even non-Christians are deserving of love and support. Through the ministry of love, support, and healing, Christ's love may be reflected as "lights upon a hill," demonstrating Christ's desire that all seek and find Him.

Paul does not limit his guidance to build up, support, and heal others to the Galatians. Kindness, compassion, and forgiveness are expected from all Christians, as Christians are forgiven by Christ (Eph. 4:32). While preparing for Christ's return, believers are told to guard themselves, and guard each other, continuing to demonstrate a sense of communal support for those who may be weak or suffering.

The church in Philippi was commanded to watch out for what is best for others (Phil. 2:4). Further in Philippians, the believers are told to focus their minds on what is true, novel, right, and pure (Phil. 4:4–9). They are commanded to demonstrate their gentleness, or sense of community harmony, to all in support and love towards one another, based in the right mind focused on Christ.[154] The guidance is spiritual and psychological; Paul is addressing the

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[152] Gaventa, *Galatians*, 1383.

[153] Reuman, *Romans*, 1292.

[154] Robert Murray, *Philippians*, The Oxford Bible Commentary, eds. John Barton and John Muddiman, (Oxford: Oxford University Press, 2001).

importance of controlling thoughts, maintaining harmony, and ensuring the proper context of suffering in the light of Christ's resurrection.

The urging of support and healing is not limited to the Pauline epistles. In James, the author writes that those who are not well should pray and seek support from the elders of the faith group (Jas. 5:13–16). There is a sense of responsibility that those within the faith take care of others through accountability, support, and healing. James notes that believers must endure the effects of sin and must rely on each other in doing so.[155] Specifically, James commands the readers to pray and intercede in both suffering and cheerful times, delineating the range of human emotional experience.[156] In suffering, such as in a psychological crisis, spiritual practices and interventions are important responsibilities of the group.

Theodicy, Comfort, Hope

There is no single underlying theology of trauma and multiple approaches, understandings, and contextual nuances are generally accepted.[157] The challenge in developing a theology of theodicy, and the requisite response to trauma and suffering, is contextualizing the discussion based upon the held beliefs and interpretations of both special and general revelation. However, the roots of providing peer, pastoral, or practical theological care can be found in both Scripture and in the works of theologians throughout history.

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[155] Dan G. McCartney, *James.* Baker Exegetical Commentary on the New Testament, (Grand Rapids: Baker Academic, 2009), 239.

[156] Ibid., 251.

[157] Elaine Graham, "After the fire, the Voice of God," in *Tragedies and Christian Congregations: The Practical Theology of Trauma, Explorations in Practical, Pastoral, and Empirical Theology* (New York, NY: Routledge, Taylor and Francis Group, 2020), 14.

Pastoral care and counseling, whether from professional or lay comforters, has undergone many distinct changes in the previous century.[158] Post-modernism substantially altered the theological understanding of a practical theology primarily through two challenges. First, the context of pastoral or practical theology is that of a cultural context in which large groups of disparate individuals from differing culture lack a shared contextual theology for communication. Similarly, the mass devastation technology and science made possible challenges the presence of a just God in the eyes of some, leaving the question of evil in the forefront of practical theological discussions. Pastoral and peer care is not immune from these challenges. In order to provide spiritual care for those in crisis, a theological understanding of why bad things happen, termed theodicy, must be addressed.

The question of theodicy remains prevalent within modern Christian theology. Understanding why there is suffering and pain in a broken world presents a theological challenge.[159] Succinctly, if God is omnipotent, omnipresent, and omniscient, He can choose to prevent suffering. The fact that suffering exists means that either He is not capable of preventing suffering or He has chosen not to prevent suffering. Either of these would severely undercut the Christian understanding of an all-powerful, just, and loving God. However, this is a false choice, lacking the context of human decision making, sin, and a fallen existence.

One notable book of the Old Testament that provides a theological insight into human suffering is Job. In this narrative, Job experiences significant loss, grief, illness, betrayal, and false accusations. Job's peers and family attempted to provide counsel and intervention by being

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[158] Amanda du Plessis, "Contextual Pastoral Counseling: Paradigm Shifts in Practical Theological Development Since the Middle 20th Century," *In die Skriflig* 55, no. 2 (n.d.): 1.

[159] Xolisa Jibiliza, "Pastoral Challenges Experienced by the Biblical Character Job and a Brief 'Theology of Suffering,'" *Pharos Journal of Theology* 102 (February 2021): 1.

present but were also judgmental and ineffective.[160] In other words, simply being present was not sufficient for aiding Job, and the intervention strategies applied did not alleviate pain and suffering. This implies that it is not just important to be present with those that are suffering but knowing what is helpful to aid the sufferer. Despite the unhelpful counsel and interventions, Job maintained a hope in God. Ultimately, Job's faith was rewarded, and his suffering was alleviated.

While Job may not provide an answer for why suffering occurs in general, it does provide theological insights into suffering and human existence. First, it demonstrates that God is aware of human suffering, revealing that God is present and cares about the suffering of His creation. Second, since Job was an outstanding and righteous follower, it reveals that suffering is not inherently tied to righteousness or lack of faith. In other words, suffering can harm even the most righteous followers of Christ and, therefore, suffering should not be seen solely as punishment for sin. Finally, it demonstrates the healing is possible, showing that God wants a restorative response to suffering and faith.

Some theologians, such as Jewish theologian Hans Jonas, have argued that God cannot alleviate pain in the immediate crisis as God empties the Godself into creation, allowing the interplay of chance and natural law to take its course.[161] Similarly but alternatively, Etty Hillesum held that God has handed Himself over to the world, entering the human heart, and therefore it is the responsibility of the faithful to protect that "little piece of… God" within the heart.[162] However, the Christian theology of God is not compatible with these views, as Christ is understood as personal, involved, relational, and present in the lives of His followers.

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[160] Jibiliza, "Pastoral Challenges Experienced," 4.

[161] Christopher Southgate, "'In Spite of All This, We Will Yearn for You," in *Tragedies,* 107.

[162] Ibid., 108.

Being present is a key facet of practical theology. Just as Christ was present with His disciples, and remains present in the lives of His church, believers should be present with those they care for. It should be noted that religious care providers accompanied the earliest militaries within Israel, providing spiritual care, comfort, hope, and counsel to those exposed to trauma.[163] These "proto-chaplains" provided a needed reminder of God's presence, love, and power in the midst of chaos, crisis, and trauma.

When considering a theology of crises, two assertions are often put forward.[164] First, God exists and is personal and relational. Second, God is intentional, and through a relationship with God, meaning and understanding can arise. The previous analysis of theodicy demonstrates both assertions, as God is both personal and intentional, with hope in a better future free of suffering provides comfort.

The divine metanarrative, stemming from the original creation and expulsion of humanity, is to reunite and restore all things.[165] The ontological metanarrative provides hope for the future rooted in a restored existence with God. This hope provides comfort, especially in times of crisis and despair.

Theological Summary

Therefore, the theological context of this action research project designed to enhance prevention of suffering, intervene during suffering, and reintegrate those who have recovered from the suffering, is supported through Scripture. Through rebellion, sin entered the world, introducing suffering and pain apart from God. God did not abandon His creation, however, He

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[163] Hillborn "The Ethics of Disaster Response," in *Tragedies,* 211.

[164] Henderson, "A Global Perspective," 9.

[165] Ibid., 14.

was seen through both His creation in nature and His special revelations, such as through Scripture.

Christ's ministry, suffering, death, and resurrection enabled a return to a relationship with God that is available to all who accept Him. Christ demonstrated love, caring, compassion, and the importance of communal support. This emphasis on love, harmony, and support was a common theme in the writings of the apostles and early church fathers. Followers of Christ, in an effort to become disciples, are to imitate Him as best as possible and live according to His teachings and will.

Theoretical Foundations

Significant research related to psychological crises has been conducted. Research has traditionally focused on clinical interventions and treatments carried out by professionals in a clinical setting.[166] Due to this, the focus of previous research has been primarily on clinical diagnoses and treatments related to mental illness and behavioral health deficiencies. The goal of the clinical interventions focused on psychological homeostasis and stabilization.[167] However, there are significant research gaps, especially in the areas of suicidology and non-clinical interventions.

Clinical Foundations and Spiritual Aspects

One of the primary clinical treatments for psychological crises, behavioral health deficiencies, and mental health disorders including depression, anxiety, posttraumatic stress

[166] Magill, "'Really There Because They Care," 2.

[167] Ghelani, "Knowledge and Skills," 2.

disorder, and other non-medical disorders is Cognitive Behavioral Therapy (CBT).[168] The fundamental concept in CBT is that behaviors and emotions are strongly moderated and influenced by thoughts and perception of an event or trigger. There is scholarly and practical evidence that CBT can be helpful in treatment, mediation, prevention, and coping.[169] With cognitive therapies learned in CBT sessions, participants are taught how to recognize their helpful and unhelpful thought patterns, evaluate their responses to those thoughts, and shift the thoughts and responses, and therefore the behavioral and emotional response, into a healthier approach.

Cognitive therapies are often problem-focused, seeking to solve the problematic thoughts or experience the client is experiencing.[170] Other theoretical approaches, such as solution-focused therapies, focus on the future, finding solutions to suffering, and facilitating hope for a better future.[171] The commonality between these theoretical approaches to treatment is that it is ideal to train the individual how to problem solve, manage their thoughts, and maintain hope in what may be a painful situation. These are often related to a traumatic experience or ongoing chronic condition.

For some treatments, especially when dealing with prior trauma, cognitive treatments are combined with exposure therapies to assist in de-escalating and stabilizing the responses.

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[168] Marina Charquero-Ballester et al., "Effective Psychological Therapy for PTSD Changes the Dynamics of Specific Large-scale Brain Networks," *Human Brain Mapping* 43, no. 10 (July 2022): 3208.

[169] Catrin Lewis et al., "Psychological Therapies for Post-Traumatic Stress Disorder in Adults: Systematic Review and Meta-Analysis," *European Journal of Psychotraumatology* 11, no. 1 (December 31, 2020): 10.

[170] Stefan G. Hofmann and Gordon J. G. Asmundson, "Acceptance and Mindfulness-Based Therapy: New Wave or Old Hat?," *Clinical Psychology Review* 28, no. 1 (January 2008): 3.

[171] Jolize Joubert and Tharina Guse, "A Solution-Focused Brief Therapy (SFBT) Intervention Model to Facilitate Hope and Subjective Well-Being Among Trauma Survivors," *Journal of Contemporary Psychotherapy* 51, no. 4 (December 2021): 304.

Exposure therapies, especially when combined with cognitive therapies, have shown the most success in psychological interventions in clinical applications of trauma treatment.[172] One form of exposure therapy that has shown recent promise the use of written exposure therapy (WET).

Written exposure therapy is a form of exposure therapy in which the participant writes about, and therefore re-exposes or "triggers," the traumatic event and attempts to normalize the emotional responses, eventually reducing the emotional response to the stimuli.[173] Written exposure therapy is a brief-therapy, often limited to about five sessions, and may be combined with other treatments. It is notable in that there is little additional effort required by the professional and participant to explore if WET may be effective.

Crisis management, especially in the prevention and post-intervention phases, must consider the spiritual implications. There are several theories related to spirituality and crisis management. Miller, for example, has demonstrated that there is a physical difference in the brains of highly spiritual and non-spiritual individuals, which also correlated with differences between those who suffer from depressive tendencies and those who do not.[174] If humans are biologically tuned to be spiritual, as Miller suggests, then any theory about crisis management and resiliency would be remiss to negate those aspects, however they may be defined in the context. Miller, basing her findings on previous research, suggests that spiritual responses to crises will influence, ideally beneficially, future crisis management and resiliency.

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[172] Kali S. Barawi et al., "A Systematic Review of Factors Associated with Outcome of Psychological Treatments for Post-Traumatic Stress Disorder," *European Journal of Psychotraumatology* 11, no. 1 (December 31, 2020): 2.

[173] Johanna Thompson-Hollands, Brian P. Marx, and Denise M. Sloan, "Brief Novel Therapies for PTSD: Written Exposure Therapy," *Current Treatment Options in Psychiatry* 6, no. 2 (June 2019): 99.

[174] Miller, *Awakened*.

Another theoretical approach to mental well-being is that of mindfulness. In the most general sense, mindfulness is the focus on being present in the current moment, observing one's own thoughts nonjudgmentally with objectiveness, and separating one's identity from one's thoughts.[175] This may include meditative practices, prayer, reflection, and guided breathing exercises. Often, mindfulness supplements other approaches for well-being, and is often offered as preventative tool for stress management and crisis prevention.

Mindfulness may, but does not require, spiritual considerations. This may lead to a disconnect or untreated aspect of a psychological struggle. Sufferers of psychological crises, especially if they go untreated or without intervention, often report struggles with spiritual understanding and religious identity. These include experiencing a loss of faith, feeling of spiritual abandonment or isolation, or a shifted understanding of the nature of reality.[176]

Spiritual and divine struggles with the ultimate meaning of life were positively and significantly associated with increased suicide risk for those in a crisis, even after controlling for relevant demographic and psychological variables.[177] Spiritual struggles include a challenged relationship with God, a challenged relationship with faith in general, and moral injury.

Therefore, any theoretical approach to crisis management must include spiritual aspects. One approach that combines cognitive and spiritual therapies is the Spiritually Integrated Cognitive Processing Therapy (SICPT). This approach is an adaptation of cognitive therapies

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[175] Regina Trammel, "Effectiveness of an MP3 Christian Mindfulness Intervention on Mindfulness and Perceived Stress," *Mental Health, Religion & Culture* 21, no. 5 (May 28, 2018): 500.

[176] Amanda M. Raines et al., "Spiritual Struggles and Suicide in Veterans Seeking PTSD Treatment," *Psychological Trauma: Theory, Research, Practice, and Policy* 9, no. 6 (November 2017): 748.

[177] Ibid., 746.

that differs in several key concepts.[178] First, SICPT specifically targets the moral injury aspect of the trauma. Second, this approach focuses on cognitive restructuring of the interpretations of the events using the client's spiritual resources. Next, SICPT recognizes that moral injury may not always reflect erroneous interpretations, such as feelings of guilt following a purposeful act, and therefore does not rely solely on cognitive restructuring. Spiritual struggles are normalized, and participants are encouraged to remain in or join a religious community reflective of their faith.

Clinical Challenges, Scope, and Peer Interventions

It is important to recognize the limitations of cognitive and exposure therapies, especially if conducted without additional augmentation. These clinical approaches are best handled by trained professionals and often are reactionary to a crisis. In other words, for psychological crises that develop in response to stressors without a prior need for cognitive training and skills development, these will not prevent a psychological crisis. Often, they are not appropriate for peer use, even if the theoretical foundations are incorporated into peer training programs for intervention support.

Additionally, a significant minority of participants in cognitive therapies and exposure therapies do not experience a clinically significant benefit from the therapies.[179] One potential reason for this is that in clinical settings, purely cognitive or emotional therapies may not

[178] Michelle Pearce et al., "Spiritually Integrated Cognitive Processing Therapy: A New Treatment for Post-Traumatic Stress Disorder That Targets Moral Injury," *Global Advances in Health and Medicine* 7 (January 2018): 2.

[179] Daniel J. Lee et al., "The Temporal Sequence of Change in PTSD Symptoms and Hypothesized Mediators in Cognitive Processing Therapy and Written Exposure Therapy for PTSD," *Behaviour Research and Therapy* 144 (September 2021): 1.

adequately address the spiritual aspects of the trauma.[180] Similarly, they may be administered too far from the crisis. In this regard, these critical tools are primarily useful in the prevention and post-intervention stages of a crisis.

With the noted weaknesses of purely clinical interventions, it is important to recognize the broad scope of psychological crises. The prevalence of mental health crises is an international concern, and more research is needed in this area.[181] Little research has been conducted related to the needed competencies of social and peer support in crisis intervention teams, especially those with mixed clinical and non-clinical support.[182]

For example, one of the primary tools for crisis intervention and the theoretical trends of crisis intervention is the Crisis Intervention Team model. However, there is little evidence supporting that the current Crisis Intervention Team model is indeed the best use of resources, is efficacious, or that the approach is not being misapplied. The intervention teams that are formalized with law enforcement often focus on the acute intervention and hand off to clinical providers. This approach does little to impact preventative or post-intervention approached to crisis intervention.

Similarly, there are few evidence-based programs for proactively mitigating crisis and post-crisis stress injuries.[183] Many of the programs focus on stabilization and then clinical treatment, which may not be appropriate. More research is needed related to the role and

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[180] Vincent R. Starnino et al., "Preliminary Report on a Spiritually-Based PTSD Intervention for Military Veterans," *Community Mental Health Journal* 55, no. 7 (October 2019): 1116.

[181] Magill, "'Really There Because They Care," 1.

[182] Ghelani, "Knowledge and Skills," 1.

[183] Anderson, "Peer Support," 2.

effectiveness of peer respites and peer interventions, especially when there is not a medical reason for the crisis such as a mental illness.[184]

One area where clinical support would likely be most helpful is in the post-intervention and rehabilitative phases of the crisis. Ideally, individuals experiencing a traumatic event or psychological crisis will undergo debriefing conversations and sessions in the hours or few days following the event, preferably with others, to help normalize the event and emotions.[185] A combination of clinical therapies, such as cognitive skill development, and peer discussions, such as to enable normalization and shared experiences, would mitigate future crises.

Continued research and education on best practices related to critical stress intervention is also needed.[186] The need for crisis intervention has been exacerbated by recent pandemics and emergency situations, even though there are few, if any, systematic reviews of practices.[187] While studies continue to research treatments for mental illness, since not all crises involve a mental illness, their applicability is questionable. As such, non-clinical, non-medical prevention, intervention, and post-intervention research is needed to reduce human suffering related to psychological crises. The theoretical foundations of these interventions will likely need to combine clinical and non-clinical theories of behavioral support and health.

Appropriate integration and application of theoretical constructs is important. Theoretical underpinnings of the current approaches, such as mindfulness strategies and cognitive therapies,

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[184] Pelot, "Characteristics," 305.

[185] W. Brad Johnson and William Johnson, *The Minister's Guide to Psychological Disorders and Treatments*, Second Edition, (New York, NY: Routledge, Taylor & Francis Group, 2014), 92.

[186] Crisanti, "Beyond Crisis Intervention Team (CIT) Training," 109.

[187] Mulligan, "Acceptability of the 'Crisis Toolbox,'" 1–2.

have been useful if not misapplied.[188] The underlying theories of cognitive theories in crisis intervention have demonstrated strong preventative measures, but as Bryan has demonstrated, simply addressing the cognitive aspects of prevention is at best only partially effective.[189]

Expanding upon this trend, cognitive theories of counseling and support are focused on addressing internally controlled thoughts, which are believed to directly connect to emotional responses and behaviors.[190] This approach and methodology is appropriate if the cause of the crisis is controllable. For example, if the crisis is the result of irrational understanding of a situation or relationship, modifying the perceived thoughts and understanding how the immediate reactionary thoughts influenced emotional responses can be beneficial. However, if the crisis is the result of non-psychological influences, such as a sudden financial crisis, severance of a supportive relationship, or trauma, thought management is only somewhat effective. Cognitive theories are useful for preventing some forms of crises, such as anxiety or suicidal ideations related to faulty reasoning but are often difficult to apply in a crisis intervention setting.[191] Additionally, most cognitive therapies stress a collaborative role between the helper and the individual seeking help, which is fundamental to crisis management best practices.[192]

Cognitive therapies may be supported by solution-focused theories of counseling, in which the individual focuses on potential solutions instead of exploring the underlying causes or

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[188] Thomas Joiner, *Mindlessness: The Corruption of Mindfulness in a Culture of Narcissism* (New York: Oxford University Press, 2017).

[189] Bryan, *Rethinking Suicide.*

[190] A Butler et al., "The Empirical Status of Cognitive-Behavioral Therapy: A Review of Meta-Analyses," *Clinical Psychology Review* 26, no. 1 (January 2006): 17.

[191] Bryan, "BIS Sensitivity," 5.

[192] Elisa Pfeiffer et al., "Does the Therapist Matter? Therapist Characteristics and Their Relation to Outcome in Trauma-Focused Cognitive Behavioral Therapy for Children and Adolescents," *European Journal of Psychotraumatology* 11, no. 1 (December 31, 2020): 2.

past trauma.[193] The goal of solution-focused theories of crisis management tend to focus on future changes and solutions. Like cognitive theories, however, this does not necessarily assist in prevention and immediate intervention. While the approaches may be useful in post-intervention coping skill development to mitigate future crises, they are lacking approaches to crisis management. It should be noted, however, that both cognitive and solution-focused therapies are widely used, applicable, and helpful in other therapeutic contexts and can supplement crisis intervention methodologies.[194]

Synthesis

Therefore, the theoretical underpinnings for this action research project must include an understanding of cognitive approaches to understanding reality, integrate spiritual realities in the context of the individual, ensure that the approaches are individualized and localized, and focus on the three phases of crisis management. There are models of crisis intervention that include individual aspects of the above, but few offer a holistic approach to crisis management. The current models, such as the Crisis Intervention Team, Crisis Intervention Toolbox, and screening-based programs such as gatekeeper training, either address only a few of the needed theoretical areas or lack evidentiary support in the research.[195] Therefore, this action research project will build upon the mentioned crisis management theoretical approaches and seek to synthesize the best practices of each. This approach will also ensure that the spiritual aspects and theological foundations are included.

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[193] Joubert, "A Solution-Focused," 304.

[194] Anderson, "Peer Support," 11.

[195] See Anderson, "Peer Support," and Ghelani, "Knowledge and Skills."

Based upon that synthesis, a theory of crisis management that spans prevention, intervention, and post-intervention that combines the aspects and best practices in the literature will be critical to development. Both quantitative and qualitative approaches to research are used within the research, with qualitative approaches serving supporting roles in understanding individualized circumstances of a crisis.[196] As the training must be contextualized, qualitative approaches for understanding the context will enable the development of a stronger local training to address the current problem. Quantitative tools are approximate for measuring confidence or progress. Therefore, a mixed-methods approach would be theoretically appropriate to the context. This approach has been used in the literature.

Conclusion

Since the Fall, humans have existed in a fallen world with sin and suffering. Human existence consists of struggles, stresses, and crises that can overwhelm natural and learned coping skills. Although creating an environment where crises can be prevented entirely is ideal, this is unrealistic because sin permeates life.

Psychological crises can result from various overwhelming stressors, either as individual stressors or a multitude of smaller stressors occurring simultaneously. The result of either is that an individual experiencing a psychological crisis is in distress, functioning with reduced rational decision-making, and may need intervention to stabilize and reintegrate. That support should be proximal and often results in the needed intervention by families, friends, peers, and trusted leaders.

[196] Siantz, "Peer Respites," 11.

Unfortunately, there is a lack of training available for non-clinical potential interventionists. Training must be theoretically sound, based on best practices, individualized to the context, include all stages of a crisis, and be reinforced. The training prepares the individual not only for how to prevent and intervene during a crisis, but also prepares them for the emotional responses they may experience during a crisis. Without preparation, those called upon to intervene may suffer from secondary traumatic stress and similar psychological stressors.

Within the context of the geographical footprint of the 302D MEB, there have been increases in suffering related to financial, substance, and psychological stressors that have led to crises requiring intervention. When intervening, leaders expressed frustration at the inability to prevent, intervene, and reintegrate consistently and with confidence. The problem is that military-connected leaders in the 302D MEB geographical areas need more training to recognize and intervene in crises. The purpose of this DMIN action research project is to develop and implement a voluntary training program for crisis recognition and intervention for junior leaders and peers.

As such, leaders and peers must be trained to assist one another in crisis intervention and post-intervention. There is a current lack of training, especially among non-clinical professionals and leaders, that enables social communities and relational leaders to assist those in crisis. Through training and practice, akin to first aid training and practice, leaders and peers can identify, intervene, stabilize, and reintegrate those in distress, following the commands to love and support one another foundational to the Christian worldview.

Although some crisis intervention or management training programs exist, training with individualized and contextualized constructs is best when provided regularly. Peers are often in the best position to intervene in a crisis, and the local family and social group is often in the best

position to improve quality of life and prevent crises. Once a crisis is recovered, it is important that the local relational, social, and organizational environments quickly reintegrate the individual that experienced the crisis without bias so as to assist them in returning to normalcy and psychological homeostasis.

Although suffering will not cease in this life, followers of Christ have long since been commanded to love one another, love others, support others, and reduce human suffering as a reflection of God's love for creation. In that relationship with Christ, early church fathers and leaders exhorted the importance of communal support and harmony. Therefore, both Scripture and secular science support the importance of peer support and peer intervention in preventing and mitigating human suffering, aligning with the purpose of this research project. By developing, implementing, and reviewing the results of a new training program targeting the phases of a crisis and best practices, human suffering can be reduced. If military-connected leaders receive training on crisis recognition and intervention best practices, then they will be better prepared to assist others in crisis.

CHAPTER 3: METHODOLOGY

The problem is that military-connected leaders in the 302D MEB geographical areas lack the training to recognize and intervene when others experience a crisis. The geographic areas of the 302D MEB include the states of Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, Delaware, Virginia, and Pennsylvania. The intervention sought to improve crisis recognition, management, intervention, and post-intervention is a new training program that consists of several phases.

The first phase focused on developing the training as outlined in Appendix H. The training was based upon current best practices found in the literature adapted to address the unique circumstances of the ministry context. The training used modern tools and modalities to reach as many participants as possible, including web-based training platforms and surveys, which are used throughout the literature.[1] Additionally, the training was designed to be flexible to fit many different availabilities and time constraints while balancing the importance of collaboration and interaction. In order to ensure that the training was not overly general, several structured interviews were conducted prior to finalizing the training. The results of these interviews provided additional insights and modifications to the training program.

The second phase focused on training the participants with the new training program. The participants were solicited by email and phone conversations using the template in Appendix E. Participation was voluntary and was not coerced by the relationship or rank of the researcher.

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[1] Bryan, "BIS Sensitivity."

The participants provided answers on a pre-training survey found in Appendix F, conducted an asynchronous training outlined in Appendix H, and then submitted a post-training survey found in Appendix G. The development of pre-training and post-training instruments customized for the specific context to collect responses for subjective reflection is also supported by the literature.[2]

The third and final phase of the intervention focused on analyzing the data from the surveys and monitoring for practical applications of learned concepts. It is not ethical to induce a psychological crisis. Therefore, the practical demonstration of the learning from the training session did not occur. Future contact with the participants is likely, and follow-up contacts and interviews will be conducted when a crisis intervention occurs. Additionally, during this phase, any feedback or improvements to the intervention was collected and considered for future training iterations.

Throughout the intervention development and implementation, the researcher maintained a weekly journal. This helped to ensure consistency and provide context for decisions made during the research project. Interesting insights were collected during the intervention and recorded in the journal. At the conclusion of the research project, a summary of the journal's contents and findings are combined with the results of the intervention analysis to provide both a quantitative and qualitative analysis of the results.

Intervention Design

There were three primary instruments used for data gathering. The first was a structured interview with select individuals who have directly experienced the problem in the ministry

[2] Gysin-Maillart, "Attempted Suicide Short Intervention."

context. Specifically, these individuals intervened in a crisis and expressed frustration, feelings of hopelessness, and a lack of knowledge of what to do. The questions that were asked can be found in Appendix D. These structured interviews involved a more detailed consent form as found in Appendix A. These participants were offered the opportunity to participate in phase two of the intervention but were not required to participate in phase two to participate in phase one of the intervention.

The interviewee had the option of allowing the interview to be recorded or restricting the interviewer to notes. All interviewees requested notes instead of digital recordings. The notes were combined into a list of focus areas prior to completing the generation of the training intervention. The structured interview used a qualitative instrument. Qualitative approaches such as interviews and free-text feedback are germane to understanding and researching peer support in crisis interventions.[3] The results of the interviews assisted in ensuring that the implementation of the training is contextualized and specific to the target audience.

The other two instruments were quantitative surveys provided to participants of the asynchronous training. One version was administered prior to beginning the implementation, as found in Appendix F. A second, slightly modified version of the instrument was administered following completion of the implementation, as found in Appendix G. The pre-training survey collected general demographic data for classification purposes but primarily consisted of several seven-point Likert-scale questions. Likert-scale responses can be concisely compared and

[3] Siantz, "Peer Respites," 11.

analyzed among respondents in an administration of the instrument and for comparison with subsequent administrations of the instrument.[4]

A digital version of the instruments was created so users could provide their information anonymously. A numeric code was provided to the participants to identify them throughout the implementation while maintaining confidentiality. The code was the only data that linked the pre-training responses and the post-training responses.

The implementation design was flexible to ensure accessibility, availability, scope, and reach. One challenge was the unique geographical dispersion of the ministry context. Web-based training is common in crisis management training programs.[5] Therefore, an asynchronous web-based version of the implementation was developed so that participants could participate on their schedules and environment.

Implementation of the Intervention Design

The implementation of the intervention addressed the identified problem was the development of a specialized training program for peer crisis management. The training program is based on best practices and covers several topics. The intervention consisted of thirteen modules that covered the nature of a psychological crisis, precursors of crises, the critical role of peers in crisis management, crisis prevention, the ethics of crisis intervention, crisis intervention skills and techniques, emotional trauma and resiliency for the intervener, stabilization resources, post-intervention support, reintegration, follow-up techniques, and building healthy coping and resiliency skills post-reintegration.

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[4] Katarzyna Lubienska and Jacek Wozniak, "Managing IT Workers," *Business, Management and Education* 10, no. 1 (June 4, 2012): 77.

[5] Cheng, "COVID-19 Epidemic Peer Support," 788.

Crisis management training that is not contextualized to the specific environment is not as effective as specialized training customized for the unique situations of the target audience.[6] Therefore, structured interviews were conducted to better understand specific nuances and shortcomings in current crisis management knowledge and skills. The interviews were prepared, however, the participants were encouraged to speak openly.

Individuals matching the requirements for the structured interviews had been previously identified, as that was part of the impetus for this project. The potential participants were contacted via email or in-person to confirm their interest in participation. The email for interview recruitment was found in Appendix C. They were presented with the consent information and if they agreed, the interviews were conducted. Four structured interviews were conducted. Each participant was offered the opportunity to participate in the next phase of the research implementation, and all agreed to participate.

The results of the interviews provided additional insights into the specific training needs of the program. The summaries of the interviews were analyzed for common trends, common shortcomings, and revelatory insights that were not initially considered in the development of the training plan. After an analysis of the interviews, the training program was updated slightly to ensure there was an increased coverage of reintegration and stabilization.

Once the training program was developed, participation in phase two was solicited. Unlike recruiting for the structured interviews in phase one of the intervention, recruiting for phase two was handled in a way that improved privacy and anonymity. Leaders were made aware of the training and provided contact information for the researcher to interested participants.

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[6] Mishara, “Systematic Review,” 3.

The potential participants could either email the researcher, request someone contact the researcher on their behalf, or visit a provided web address for more information. All utilized the website to participate. Once the participants were interested and on the website, they clicked to continue and were presented with the consent screen containing the information in Appendix B.

Participants received the informed consent information prior to completing the pre-training survey or providing any identifiable information. The IP address of the visitor to the web address was not logged or stored. They were not able to answer any of the survey questions prior to acknowledging the consent. The participants were able to view the consent form at any time.

Upon providing consent, the pre-training survey was administered. When filling out the demographic information, participants were screened. Participants would have been removed from the project if they were not serving in the military, were not a veteran, did not supervise other Soldiers or veterans, or did not have any immediate family members with military service. No participants required removal. A total of twelve participants completed the full training. There were no withdrawals or incomplete participants. The maximum number of participants selected for this phase of the training was approximately twenty individuals.

Participants were provided instructions on how to complete the pre-training survey. They were assigned a unique numeric code that was used to connect their pre-training survey, training progress, and post-training survey. They needed to create a password for that number to prevent accidental access to another participant's data. During the pre-training survey, they were asked to provide general demographic data, such as their connection to the ministry context and their age range. They were next asked to identify their agreement with several statements, as provided in Appendix F.

After completing the pre-training survey, the participants were provided access to the asynchronous training platform. This platform was developed specifically for this research project. The training consisted of several media delivery methods, including video recordings and reading materials, covering the topics outlined in Appendix H. The participants proceeded through the training on their own and had two weeks to complete the training. They had full access to ask the trainer questions or for clarification during and at the conclusion of each module. The training was broken down into modules by topic. Participants were able to save their progress and return to the training at any point.

Table 3.1. Training Module and Actual Video Length in Minutes

Modules and Video Length in Minutes		
1	Introduction and Overview	8:45
2	The Nature of a Psychological Crisis	11:49
3	Precursors of Crises	16:02
4	The Importance of Peers in Crisis Management	13:26
5	Crisis Prevention	26:30
6	The Ethics of Crisis Intervention	17:47
7	Crisis Intervention Skills and Techniques	33:41
8	Emotional Trauma and Resiliency for the Intervener	26:27
9	Stabilization Resources	17:56
10	Post-intervention Support	23:29
11	Reintegration and Follow Up Techniques	21:43
12	Building Healthy Coping and Resiliency Skills	13:10
13	Conclusion and Next Steps	8:38
	Total Time:	240 minutes (4 hours)

After the final module, the post-training survey was distributed. The survey was like the pre-training survey, with several key differences. First, the demographic section was removed, as that information was collected during the pre-training survey and can be linked with the participant code. Second, the language for the instructions was modified to reflect that the training had occurred. The same Likert-scale questions and categories were used. The pre-

training survey and post-training survey were compared to measure perceived changes as a result of the training.

The intervention implementation then proceeded to phase three. Phase three focused on analyzing the results of the surveys to determine if there is a significant perceived change in readiness and knowledge related to the training material. The surveys were compared in two contexts. First, all the pre-training surveys were compared to each other, and all of the post-training surveys were compared to each other. The second context was comparing each participant's pre-training survey with their post-training survey. The results of this analysis were combined with the results of the final session qualitative summary and the journal maintained by the researcher. This provided for a holistic analysis of the intervention.

The training development took approximately eight weeks to complete, including development and recording. The training began on September 18th and was completed by October 5th. All participants submitted both pre-training survey responses and post-training survey responses that provided responses for every question.

To address the problem within the ministry context, several challenges were considered. First, there is a geographic distance that precludes dedicated in-person training. If the intervention is successful and is no longer research, this training could easily be adapted to in-person training to be offered regularly. Second, it is important that pre-existing relationships and power influence are controlled. Similarly, participation must be voluntary, cannot be coerced or influenced, and cannot be seen as influencing a potential professional or pastoral relationship. By ensuring anonymity through asynchronous training and data collection, participants did not report feeling pressure to respond in a specific manner.

By utilizing a phased, mixed-methods, and multi-modality approach, the problem of crisis management within the ministry context may be improved.[7] The completed approach addresses the inherent challenges within the context while providing opportunities for future improvements and changes to fit different contexts. If successful, this intervention could significantly improve the quality of life of the participants, and the participants may be able to provide peer support during a crisis.

[7] According to Bryan in *Rethinking Suicide*, a "wicked problem" is a problem that is distinguished from more conventional problems due to their high level of complexity and unique contexts which makes it especially difficult to understand or solve.

CHAPTER 4: RESULTS

The overall goal for the project was to reduce suffering and improve the quality of life for those within the ministry context by preparing ready and able peer supporters in the event of a crisis. In order to achieve that goal, a new approach to preparation and training was planned, developed, and delivered. Key specific metrics were gathered to understand changes in perceived skills, knowledge, and willingness related to crisis management by the participants of the intervention training.

Data collection was considered from the outset of the project planning. The data was known to be a mix of qualitative and quantitative data broken into two primary collection phases. There were two methods of data collection and recording. The first phase of data collection consisted of typed notes collected during structured interviews conducted before the training program. This data was primarily qualitative. Key quotations, topics, and phrases were compiled between the interviews and a trend analysis was conducted. Recordings were not made of these interviews for privacy purposes. The notes were combined and reorganized to separate the notes from the original per-participant grouping and into grouping by concept and themes. The interviews occurred before the training was conducted and were used to improve or modify the training program. All of the participants in these interviews later participated in the training program.

Second, participants utilized a customized software application available online to participate in the training and provide responses to the research instruments. The software provided login access to users so that the training could be conducted in multiple sessions

asynchronously. Participants provided responses to two survey instruments administered at the beginning of the training sessions and at the end of the training sessions. The data was stored in a relational database and exported for anonymous analysis.

The survey instruments provided three groupings of quantitative data. First, they collected basic demographic data that was used primarily for screening and validation. This data was categorical and nominal. Second, the survey instruments presented several seven–point Likert scale questions asking the participants to identify their level of agreement with the statement. These generated a number between one and seven for each statement and were ordinal. Finally, the instruments asked participants to select one or more topics that they understood well and a list of topics that they did not understand well.

Collective Results

Prior to conducting the training, structured interviews were conducted. The goal of these interviews was to determine if there were specific contextual areas of focus that needed to be added to the training prior to implementation. The interviews were not recorded, but the interviewer took notes.

Each interviewee expressed a desire to learn about long-term support and resources to help those in crisis. Specifically, all participants interviewed at this stage discussed anxiety, concern, and fear for what to do following an immediate intervention. They felt they lacked resources, knowledge, and skills during the crisis. These feelings align with similar concerns for professional care providers, and therefore were expected.[1]

[1] Sansen, “Daring to Process the Trauma,” 2.

Notably, each participant stated that they did not feel they had the required knowledge or skills to provide support to a peer or subordinate in crisis beyond the acute intervention and escort to a professional. When asked what the term “post-intervention” meant to them, none of the participants felt comfortable or confident giving a response. All four participants believed that when a crisis occurred and an intervention enacted, the crisis was over. One participant noted that they felt like they were given clarity on how to serve, “my role if someone is in crisis is to just get them out of the crisis.” On-going peer support after the crisis was stabilized was not an area emphasized in their prior training or experiences.

Each participant had received prior training through mandatory military training in suicide prevention and intervention. However, they felt that the training was “too general” and “lacked practical solutions” to the underlying causes of the crisis. One participant summarized this concern by stating that the provided training “focused too much on just getting out of the current crisis and not enough on preventing future problems.” The provided training was also “generic” and “by the numbers.” Each interviewee expressed a desire to help others before, during, and after a crisis but did not know the best way to prepare. The difference between what a peer could do legally, and ethically what a licensed care provider could do was not clear, so the interviewees expressed an anxious hesitation, as they did not want to experience legal trouble when trying to help.

Based on this feedback, the developed training was modified to provide a stronger focus on prevention, post-intervention, and reintegration topics. There was not any feedback that led to removing existing content of the training, so the topics suggesting a desire for stronger focus were increased in time. Based upon the interviews, the training added nearly an hour of additional training.

Pre-Training and Post-Training Responses

Once the training was prepared and the participants enrolled, entry to the software platform was provided. Participant progress was monitored, although all interactions were anonymized by the software platform. This ensured there was a mitigated risk of violating privacy, a mitigated risk of a power dynamic between the researcher and participants, and that there was an opportunity to provide honest feedback.

Although demographic data was collected, it could not easily be used to identify the participants. With a limited number of participants, it would be possible to speculate on the identity of the participant responses. This would provide little benefit, however, as the results of the surveys demonstrated beneficial experience and knowledge growth. A larger cohort or the removal of demographic responses would further reduce this risk in future applications of the intervention.

Upon completing the informed consent and gaining access to the software platform, the participants were prompted to submit a pre-training survey as described in Appendix F. After completing the survey, participants completed each module. Each training module consisted of a video and a downloadable document for review. After completing the modules, participants were prompted to submit a post-training survey as described in Appendix G.

The pre-training survey consisted of a section of demographic data, several seven–point Likert scale statements, and two multiple-option questions. Based on the responses shown in table 4.1 and figure 4.1, most participants were thirty-one years old or older. This is not surprising, given the seniority of the brigade headquarters.

Table 4.1. Age of Participants

Age of Participants		
18–24	2	16%
25–30	3	25%
31–36	6	50%
37 or Older	1	9%

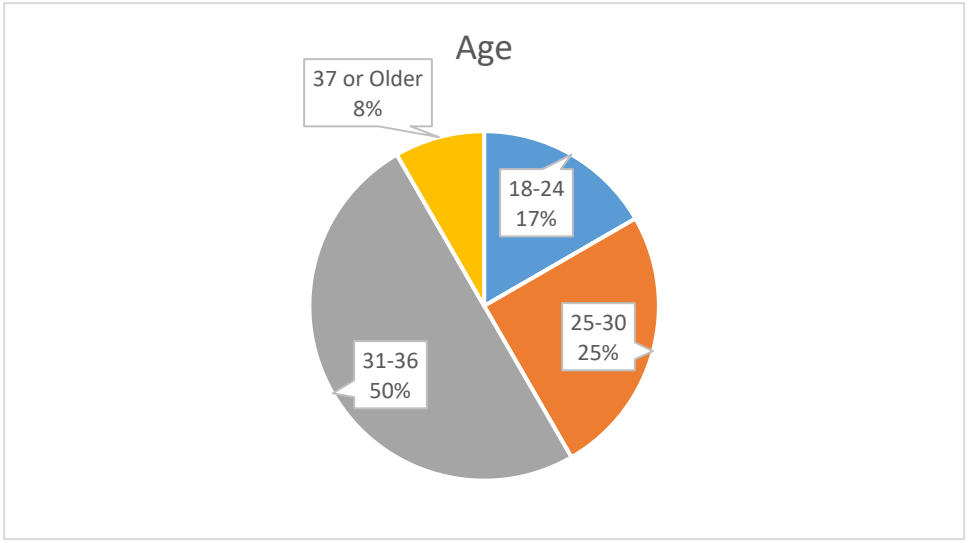

Figure 4.1. Age of Participants.

Similarly, the participants were generally more senior in military rank, as shown in table 4.2 and Figure 4.2. Half of the participants identified as officers and one-third of the participants identified as non-commissioned officers. Like the age proportions, this is not unusual for a brigade headquarters typically commanded by a colonel (O-6) with a command sergeant major (CSM) overseeing the enlisted and non-commissioned officers of the unit. The 302D MEB in specific had a well-developed and resourced senior staff due to its prior missions.

Table 4.2. Rank of Participants

Rank of Participants		
Junior Enlisted (E1–E4)	2	16%
Junior NCO (E5–E6)	2	16%
Senior NCO (E7–E9)	2	16%
Warrant Officer (W1–W5)	0	0%
Junior Officer (O1–O3)	3	25%
Senior Officer (O4–O6)	3	25%
Other	0	0%

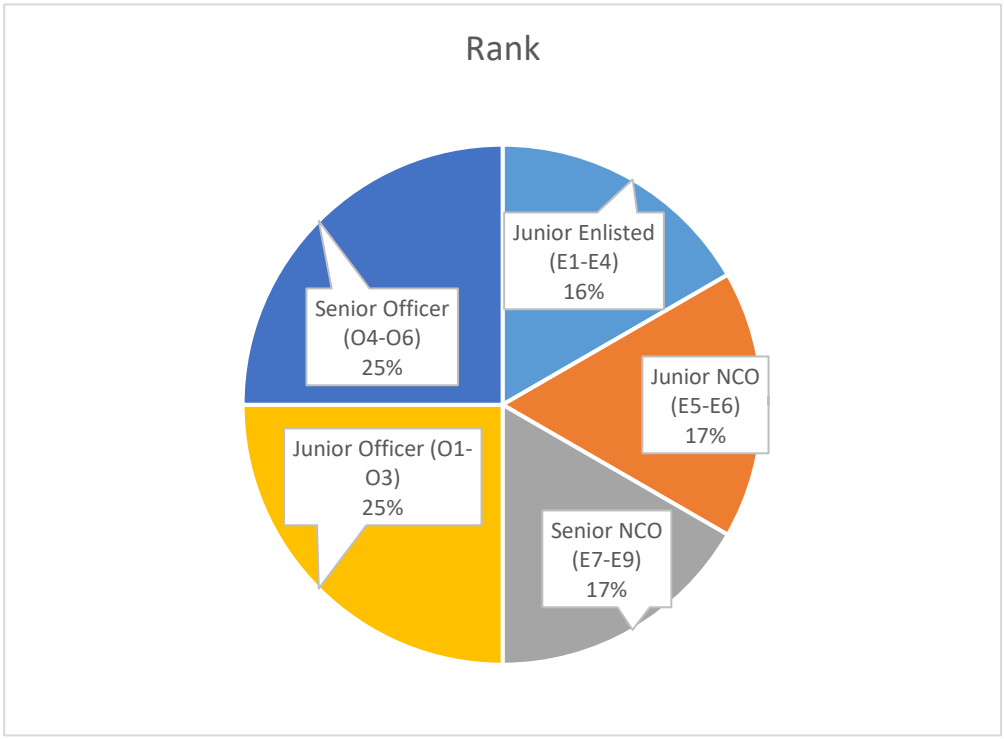

Figure 4.2. Rank of Participants.

Following the demographic data, thirteen statements were presented that required the participant to state their level of agreement with the statement. Each statement used a seven–point Likert scale from one (representing “I do not agree at all”) to seven (representing “I agree completely”). Each statement required a response. The post-training survey asked the same

Likert scale questions. The statements focused on confidence in ability, knowledge, technique, and willingness. Agreement with the statements would represent knowledge, confidence, and motivation related to the topics of the training and crisis management as a peer. The higher the agreement, the more confident and knowledgeable the participant would reportedly be.

Of the Likert scale statements, "I know how to improve my own resiliency" scored the lowest with an average of 2.92. The two statements that scored the highest were related to leaders and family members willingness to assist during a crisis with an average of 4.58 each. All remaining statements averaged between 3.00 and 3.67 agreement, which is below the middle value of 4.0.

Table 4.3. Pre-Training Agreement Statements

Pre-Training Agreement Statements	
Statement	Average
I know about the phases of a crisis.	3.42
I can recognize the warning signs of a crisis.	3.42
I am willing to intervene in a crisis if safe to do so.	3.67
I know the skills and best practices to intervene in a crisis safely.	3.33
I know the importance of stabilization and normalization.	3.08
I know the importance of reintegration.	3.00
My leaders and managers will help me if I experience a crisis.	4.58
My family will help me if I experience a crisis.	4.58
I can help my family members if they experience a crisis.	3.67
I know how to find assistance during a crisis intervention.	3.08
I know about the emotional impacts a crisis can have on the intervener.	3.00
I know how to improve my own resiliency.	2.92
I know it is important to prepare myself prior to intervening in a crisis.	3.17

Next, the pre-training survey asked the participants to identify specific topics that the participant "understood well." This use of the adjective "well" allows for a subjective reflection of topics and could be understood differently by each participant. One of the goals of the project

was to increase knowledge and confidence relating to crisis management as a peer. Therefore, it is more important that the participant reflects on their learning, knowledge, and experiences.

The same list of topics was then presented, but with instructions to select topics that the participant did "not understand well." This likewise allowed the participants to reflect on what topics they may not know, may not know in depth, or otherwise feel that their understanding is lacking.

Table 4.4. Pre-Training Topic Understanding Responses

Pre-Training Topic Understanding Responses		
Topic	Understood Well	Did Not Understand Well
What is a Crisis	4	2
Types of Crises	1	5
Causes of a Crisis	8	6
Crisis Prevention	4	7
Identifying a Crisis	1	9
Intervention Techniques	2	10
Peer Support during Crisis	0	11
Interventionist Impact	3	11
Professional Resources	0	11
Post-intervention	0	11
Reintegration	0	11
Normalization Techniques	0	10
Building Resiliency	9	2
Ethical Considerations	3	5

At the training program's conclusion, the participant's final step was to submit a post-training survey. The software platform connected the participants' responses, so the post-training survey did not ask for any demographic information. The post-training survey presented the same list of Likert scale statements as the pre-training survey. For all statements, there was an improvement in the level of agreement of the statement. The statement "I know the importance of stabilization and normalization" increased the most by an average of +2.67. The questions

related to leader and family assistance increased the least, which could be attributed to their high level of agreement from the beginning of the training.

Table 4.5. Post-Training Agreement Questions

Post-Training Agreement Questions		
Question	Average	Change
I know about the phases of a crisis.	5.42	+2.00
I can recognize the warning signs of a crisis.	5.42	+2.00
I am willing to intervene in a crisis if safe to do so.	5.33	+1.66
I know the skills and best practices to intervene in a crisis safely.	5.42	+2.09
I know the importance of stabilization and normalization.	5.75	+2.67
I know the importance of reintegration.	5.58	+2.58
My leaders and managers will help me if I experience a crisis.	5.58	+1.00
My family will help me if I experience a crisis.	5.58	+1.00
I can help my family members if they experience a crisis.	5.67	+2.00
I know how to find assistance during a crisis intervention.	5.33	+2.25
I know about the emotional impacts a crisis can have on the intervener.	5.33	+2.33
I know how to improve my own resiliency.	5.50	+2.58
I know it is important to prepare myself prior to intervening in a crisis.	5.75	+2.58

When analyzing by rank, all groups demonstrated increased agreement (table 4.6). The senior NCOs and junior officers reported the largest average agreement increase at +2.39 and +2.46 respectively. junior enlisted and junior NCOs reported a +1.77 change and senior officers reported a +1.89 change.

Table 4.6. Agreement by Rank Group

Agreement by Rank Group			
Rank	Pre	Post	Change
Junior Enlisted (E1–E4)	3.12	4.88	+1.77
Junior NCO (E5–E6)	3.73	5.50	+1.77
Senior NCO (E7–E9)	3.58	5.96	+2.39
Junior Officer (O1–O3)	3.23	5.69	+2.46
Senior Officer (O4–O6)	3.85	5.74	+1.89

The post-training survey instrument slightly modified the wording of the topic understanding questions. Specifically, participants were asked to identify which topics they "now understand better, even if you understood them well before the training." The instructions specifically did not instruct the participant that if a participant understood the topic before the training, they should not select it at the end. In other words, even if the participant understood the topic well before the training, they should still select the topic if they understood it well after the training. The term "better" is also a subjective opinion for the participant based upon reflection, intentionally selected for similar reasons as "well."

Two topics demonstrated a decrease in understanding from before the training. During informal feedback sessions, it was communicated that the training revealed more depth to "Causes of a Crisis" and "Building Resiliency," and that several participants felt they knew the material thoroughly before the training sessions. Therefore, they did not understand those topics "better" in their views. All other topics were reported as being better understood.

The same list of topics was presented, and participants were asked to identify which topics they did not understand well. There were no increases in selected topics from the pre-training survey. The "Types of Crises" topic was reported most frequently, but matched the pre-training reported number. Similarly, "Ethical Considerations" received four responses indicating a lack of understanding "well."

Table 4.7. Post-Training Topic Understanding Responses

Post-Training Topic Understanding Responses						
Topic	Understood Well			Did Not Understand Well		
	Before	After		Before	After	
What is a Crisis	4	7	+3	2	2	+0
Types of Crises	1	7	+6	5	5	+0
Causes of a Crisis	8	7	-1	6	2	-4

Crisis Prevention	4	10	+6	7	0	-7
Identifying a Crisis	1	9	+8	9	0	-9
Intervention Techniques	2	12	+10	10	0	-10
Peer Support during Crisis	0	12	+12	11	0	-11
Interventionist Impact	3	11	+8	11	1	-10
Professional Resources	0	9	+9	11	2	-9
Post-intervention	0	12	+12	11	0	-11
Reintegration	0	12	+12	11	0	-11
Normalization Techniques	0	12	+12	10	0	-10
Building Resiliency	9	7	-2	2	1	-1
Ethical Considerations	3	6	+3	5	4	-1

Data Analysis

Based upon the gathered data, the project achieved its goal of preparing military-connected leaders to intervene in the development and stabilization of a psychological, or mental, crisis. The primary data to support this assertion is the increase of agreement with key assertions related to crisis management, the overall increase in understanding of the topics presented, and the overall decrease in topics not understood well. In each dataset, the overall result indicates the training was effective at improving preparedness and knowledge to assist peers experiencing a crisis.

Agreement Statement Analysis

Prior to participating in the training, the overall average level of agreement across all statements by all participants was 3.45. Individually, the participant with the lowest reported agreement with the statements provided a 2.92 average agreement score. The highest average reported agreement score by a single participant was 3.92. A score of 4.0 would be the middle of the Likert scale, so each participant expressed a level of agreement less than the middle of the scale on average across the topics.

There could be several explanations for this. Participants who volunteered to participate may have believed that they needed the training, so they rated their level of agreement lower based on confidence. The questions fell into categories related to the learning material, so a recognized lack of knowledge and training could indicate that they disagree that they had the knowledge and skills prior to participation.

Notably, the two statements that received the highest average agreement score were “My leaders and managers will help me if I experience a crisis” and “My family will help me if I experience a crisis.” Both of those statements represent intent beyond the individual participant. All other statements were presented in the first-person, directly addressing the individual participant.

The aggregate of the post-training survey responses demonstrates an increase in agreement for all topics, demonstrating an increase in confidence, motivation, and knowledge. Since the statements related to external intent each began with the highest level of agreement, they experienced the lowest average increase at +1.0. The statement that increased the most in aggregate was “I know the importance of stabilization and normalization,” which began with a 3.08 average agreement score and ended with a 5.75 average agreement score, which was one of two statements to receive a 5.75 average agreement score. The other statement that received a 5.75 post-training agreement score was, “I know it is important to prepare myself prior to intervening in a crisis.”

Overall, the agreement scores increased by +2.06, starting at an average agreement score of 3.46 and ending with an average agreement score of 5.51. As a cohort, the participants reported higher agreement scores across all statements. This indicates that, at least according to the participants’ self-reflection on their level of agreement, the training improved their

knowledge and preparedness. Figure 4.3 shows the analysis results, including pre-training average scores, post-training average scores, and the change in the average scores.

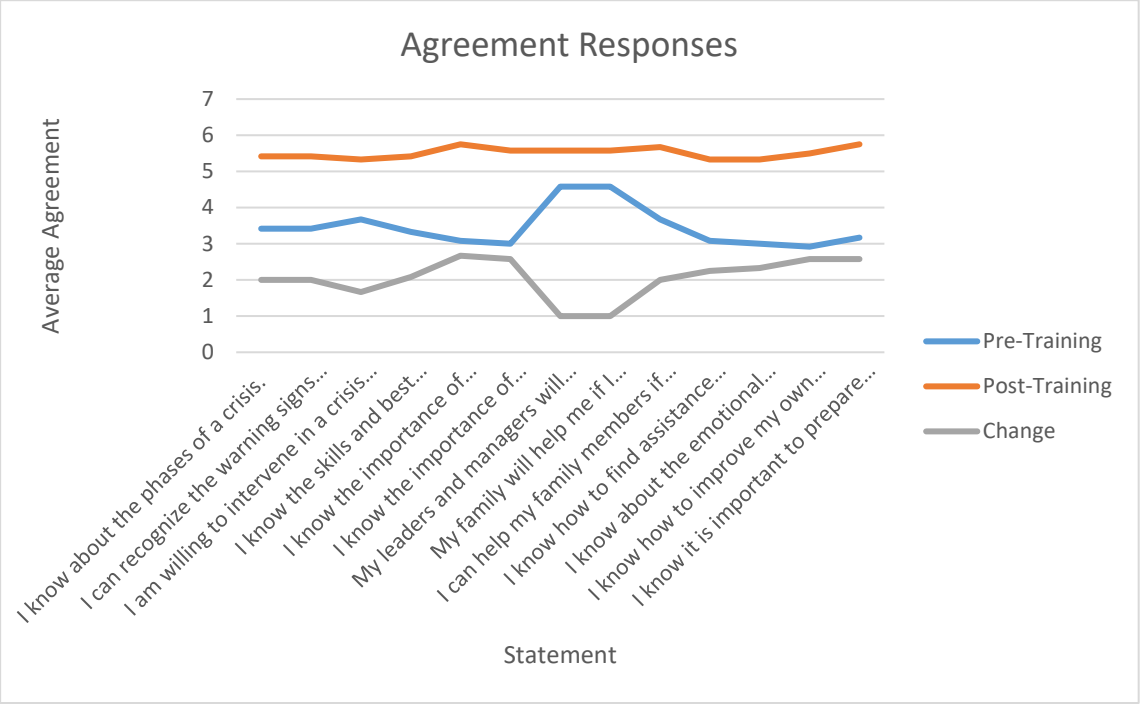

Figure 4.3. Agreement Responses Before and After the Training.

Analysis also reveals that agreement with the topics increased holistically. Specifically, participants reported high agreement across all statements, as seen in figure 4.4. This represents a generalized growth in knowledge across topics that could better prepare participants for future prevention, intervention, and post-intervention support.

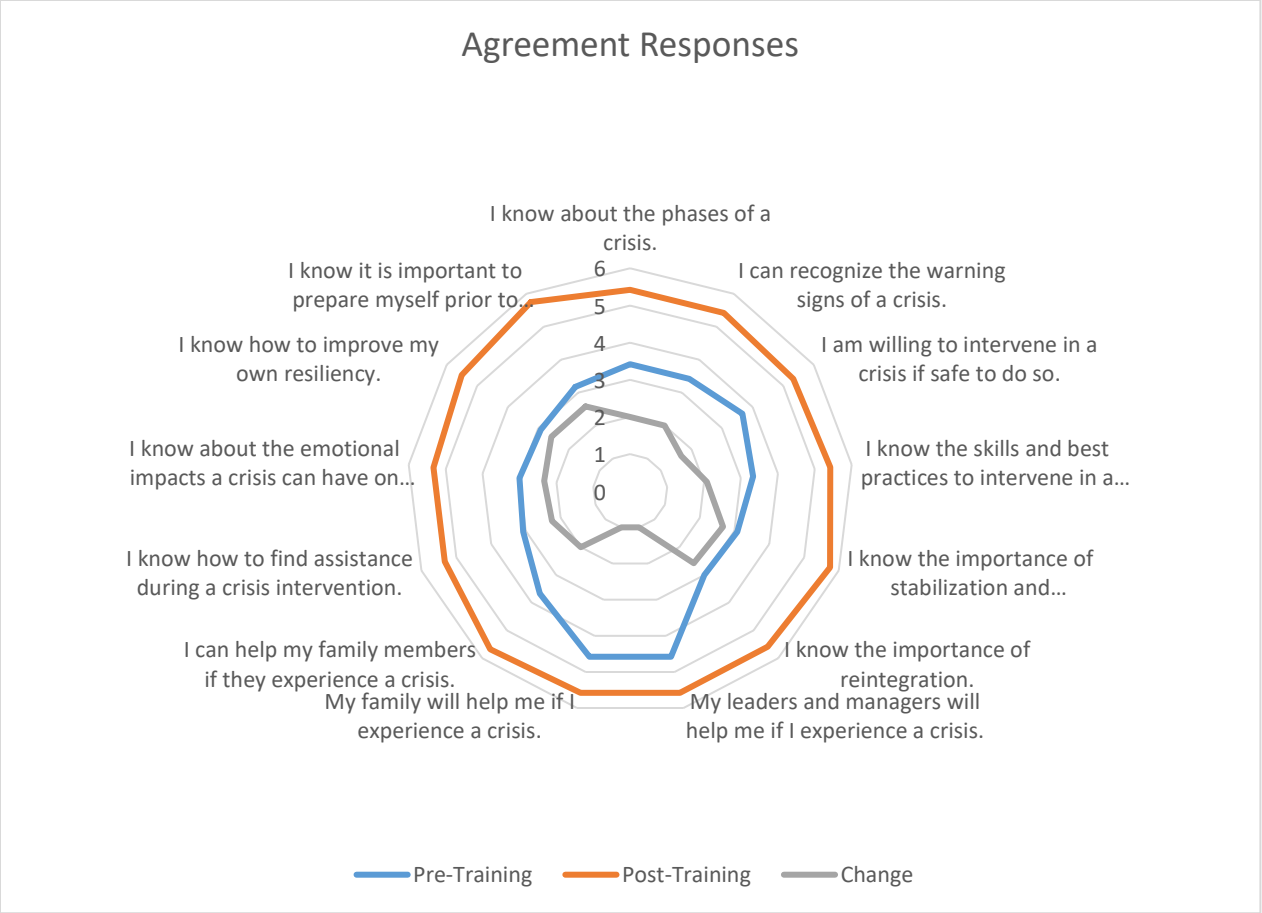

Figure 4.4. Overall Agreement with Presented Statements.

When analyzing by rank cohort, the senior NCOs and junior Officers reported the largest increase in agreement as shown in figure 4.5. The senior NCOs also reported the highest average agreement across all statements amongst the ranks, even though their starting average score was the median average in the pre-training responses. The junior enlisted and junior NCO cohorts reported the lowest change and the lowest post-training averages. This discrepancy should be further explored for future training implementations to determine if there are specific changes that could further improve the reported agreement of those two groups. For example, there could be an improvement in presentation, methodology, or content that would help the more junior

ranks increase their level of agreement to be more in line with the improvements in the more senior rank groups.

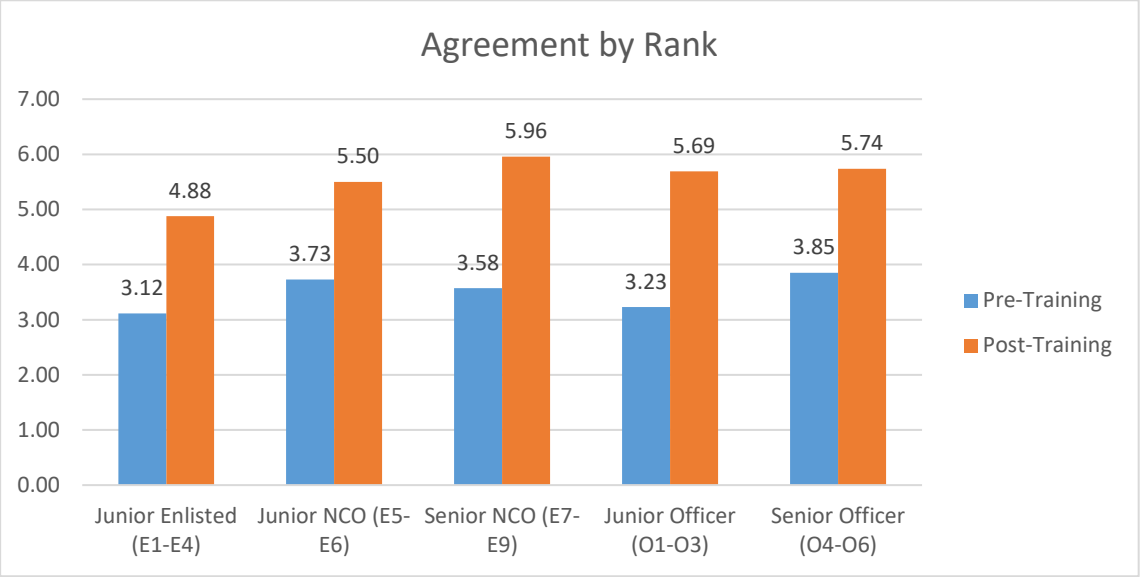

Figure 4.5. Agreement by Rank.

Topic Analysis

The second primary portion of the pre-training and post-training survey instruments presented the participants with a list of topics and asked them to identify which topics they understood well and which they did not. Prior to the training, no participants stated that they understood "Peer Support During Crisis," "Professional Resources," "Post-intervention," "Reintegration," or "Normalization Techniques" well. Only one participant stated they understood the "Types of Crises" and "Identifying a Crisis" topic well. However, nine participants stated they understood "Building Resiliency" well, and eight participants stated they understood "Causes of a Crisis" well.

Recent initiatives within the ministry context have emphasized resiliency and readiness. Similarly, there is required training on suicide prevention and intervention, which briefly trains warning sign identification. Therefore, the two topics that were most widely understood are

expected. Similarly, the identified problem correlates with a lack of training and knowledge related to crisis management for peers, so it was also expected that the least understood topics would be related to topics not traditionally trained through other methods or programs.

After the training, the post-training survey instrument asked the participants to identify which topics they now understood well, even if they understood that topic well prior to the training. As shown in figure 4.6, the topics with the most significant increase in reported understanding were specifically designed for the problem within the ministry context. Specifically, “Peer Support during Crisis,” “Post-intervention,” “Reintegration,” and “Normalization Techniques” all were reported as “understood well” post-training by all participants where none had reported “understanding well” prior to the training.

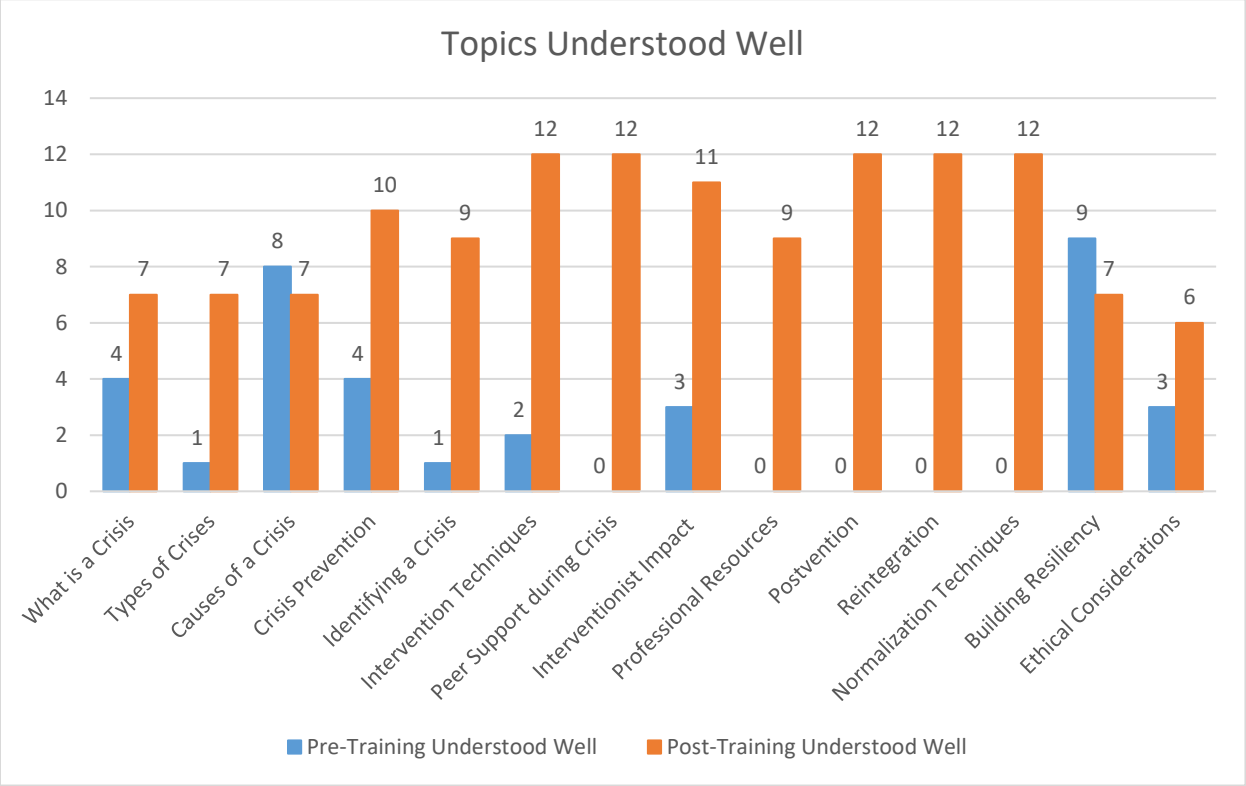

Figure 4.6. Topics Understood Well Before and After Training.

Other topics also noticeably improved. The “Identifying a Crisis,” “Crisis Prevention,” “Interventionist Impact,” and “Professional Resources” topics each increased to nine, ten, eleven, and nine participants reporting understanding well, respectively. The “Ethical Considerations” topic had the least participants reporting understanding it well with six.

As noted, two topics decreased in their reported understanding. The “Causes of a Crisis” topic and “Building Resiliency” topic both reported a decrease. However, more than half of the participants reported they understood each topic well. Further analysis into the reason for the reported drop may be warranted. For example, the topics may not have been covered in the appropriate depth or approachability.

Based upon this result, the goal of training and preparing on the importance of peers in crisis management was met. Additional changes or additions to related topics, especially “Ethical Considerations,” “What is a Crisis,” “Types of Crises,” “Causes of a Crisis,” and “Building Resiliency,” could further improve the results in future iterations. However, a balance must be maintained between time, content breadth, and depth. Additional continuing education could supplement the newly acquired skills. The final training module provided additional resources external to the training that could supplement those categories as well.

The final prompt on the post-training survey asked participants to identify which topics they did not understand well. The responses are not an exact inverse of the topics that participants understood well but do follow the observed trend. Specifically, the “Types of Crisis” and “Ethical Considerations” topics were reported as the least understood, with five and four participants, respectively, reporting those topics as not understood well. Additional analysis and follow-up surveys could seek to better understand how to improve these topics. However, the “Ethical Considerations” topic was intentionally vague as the legal and ethical frameworks vary

by state and are hard to contextualize specifically.[2] Therefore, the module likely left a lot of ambiguity about specifics.

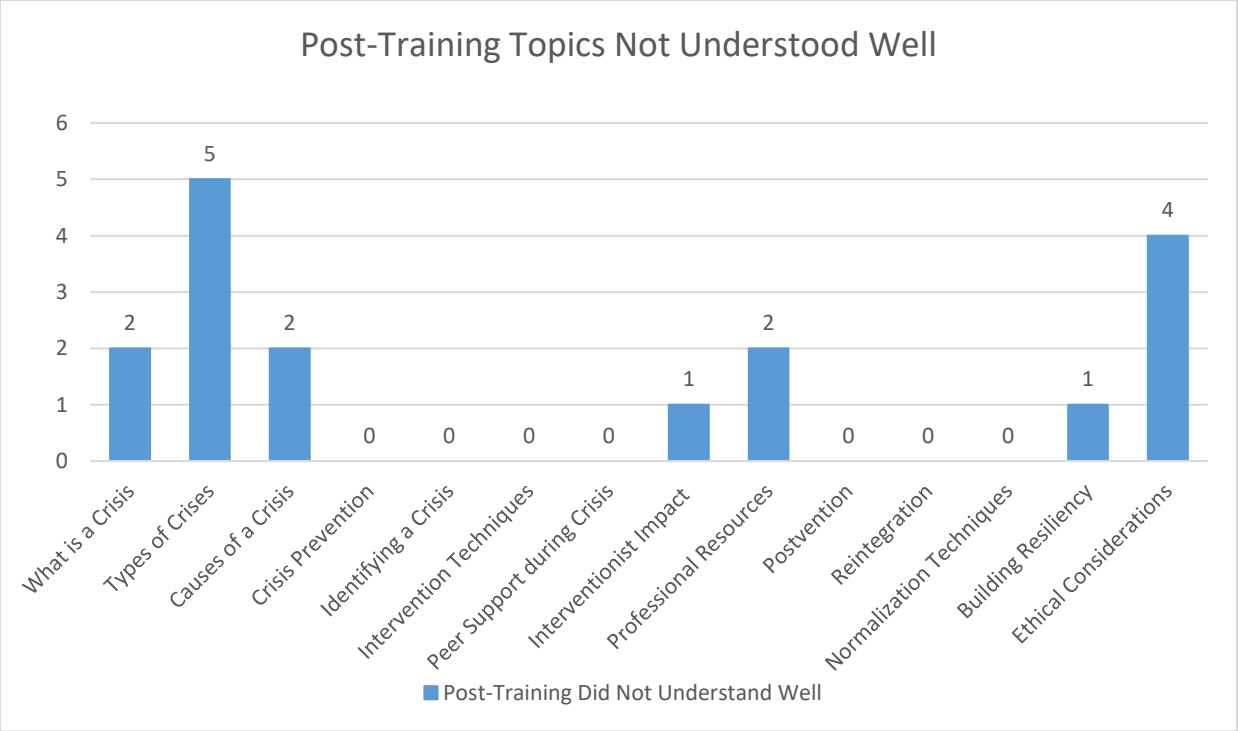

Figure 4.7. Topics Not Understood Well Following Training.

Potential Improvements for Future Training Sessions

One change that would be beneficial in future interventions would be to change the wording of the topic understanding prompts. Although they were intended to be reflective, each participant may have had a different understanding of what "understand well" means in this context. For example, it may be more advantageous to ask participants about topics they understood and which topics they want to understand better in the pre-training survey, then ask which topics they felt they understood better in the post-training survey. That would still allow subjective reflection while reducing ambiguity.

[2] Cheng, "COVID-19 Epidemic Peer Support," 788.

Similarly, or alternatively, it could be beneficial to remove the prompt on the pre-training survey that asks the participant to identify which topics they "do not understand well." Although there is a subtle difference between "don't understand well," "don't understand at all," and "understand but not at the depth I want," in the context of the survey instrument, it appears to be the inverse of topics that are "understood well." Instead, the pre-training survey instrument could remove that prompt, leaving the post-training survey prompt in place to ascertain topics that need refinement in the training.

Alternatively, the topics could be converted to Likert scale responses. This would provide a gradient of reported understanding instead of a binary choice. This would also align with the previous questions regarding agreement, so could aid in consistency.

The survey instruments also relied on a subjective interpretation for understanding and agreement. No tools developed or implemented objectively measured a participant's understanding of the topic. It could be useful to expand the training with checks on learning to determine if there are objective increases in learning or if the increases were purely subjective.

Summary of Results

Ultimately, the data supports the assertion that the intervention improved the problem found within the ministry context. Although no crises have occurred that would demonstrate a practical application of the improvements since the training, the reported data supports that peers were more able, more willing, and more proficient in the areas of peer support during crisis situations. Both agreement with statements of confidence and selected topics increased from pre-training reports.

It is not intended that this is a one-time intervention. The goal is to continually improve the training material and make it available to others. That process will require time, effort, and

further research. Additionally, feedback from the participants and the analysis of the data demonstrates areas of improvement. Areas to improve include the survey format, the survey questions, and training material improvements.

Crisis management, like suicide, is a serious problem.[3] A single training program will not prevent all future crises. It also will not ensure that peers are always able and willing to provide support before, during, and after a crisis. However, the data supports continuing use of this training to increase confidence, knowledge, and willingness to help others in crisis.

[3] Bryan, *Rethinking Suicide.*

CHAPTER 5: CONCLUSION

The problem was that military-connected leaders in the 302D Maneuver Enhancement Brigade geographical areas lacked the training to recognize and intervene when others experience a crisis. The purpose of this DMIN action research project was to develop and implement a voluntary training program for crisis recognition and intervention for leaders and peers. In doing so, the training sought to increase the knowledge, skills, confidence, and willingness of peers to intervene when another peer experiences a psychological or mental health crisis.

A psychological crisis occurs when a single stressor or several combined stressors combine to overwhelm an individual's typical coping mechanisms, causing dysfunctional behaviors to arise.[1] A crisis is time-limited, acute, and typically requires an intervention for successful recovery and stabilization. The most effective crisis intervention support is proximal and visible.[2] Often, peers are the closest in both proximity and visibility when an individual experiences a crisis. Their intervention, therefore, is critical for immediate stabilization and long-term normalization.

Unfortunately, intervening in a crisis results in a variety of emotions that, if not prepared for, could result in a second crisis. Those emotions include frustration, inadequacy, lack of

[1] Ghelani, "Knowledge and Skills," 2.

[2] Magill, "'Really There Because They Care," 7.

control, lack of understanding, and heightened fear.[3] If a peer is untrained and unprepared, those emotions could overwhelm them and reduce their confidence or capability to effectively assist others.

Therefore, this training sought to prepare military-connected peers with the knowledge, skills, and confidence to prevent, intervene, stabilize, and normalize a peer in crisis. The training consisted of several sessions and modules including videos, downloads, and discussions. These modules were distributed online and accessible from any web browser. The tool presented each module in order, although participants could revisit any previous module for review or clarification. The data collected consisted of structured interviews, pre-training survey responses, and post-training survey responses. These were anonymous to ensure that honest feedback and assessment could be provided.

The results of the data analysis indicate that the participants felt more knowledgeable and confident about managing a crisis. Across all statements of confidence, participants reported increased confidence, indicating that they would be more likely willing to prevent, intervene, and support a peer in confidence. Not all statements or topics improved equally. There are likely additional modifications to the training that could improve the results. Likewise, there are additional changes to the training methodology that may enable even better improvements, including the addition of "check on learning" style activities. The research is timely, relevant, and important with several key implications, applications, and limitations.

[3] Mishara, "Systematic Review," 5.

Research Implications

The literature is clear that anyone can experience a psychological crisis.[4] The literature is also clear that those experiencing a crisis are best served by resources that are proximal in distance, visibility, relationship, accessibility, and availability.[5] Peers often meet those requirements in their roles as family members, friends, colleagues, and supervisors.

Since the 1970s and 1980s, law enforcement has largely been used to solve acute mental health crises.[6] However, those departments are often overstretched and report spending more time managing mental health related incidents than they spend time on traffic accidents, assaults, non-crisis interventions, and burglaries.[7] To aid in reducing this burden on law enforcement officers and to better serve those in crisis, the use of peers is increasingly important, as this research demonstrated.

Peers provide personal and contextualized support due to their proximal relationship. When an individual experiences a crisis, peers are likely the first to notice. The sooner a crisis can be mitigated or intervened, the more likely the recovery will be successful and with minimal long-lasting distress. However, applying appropriate crisis prevention, intervention, and post-intervention techniques may not occur due to a lack of training, skills, negative attitudes, and confidence.[8]

This research demonstrates that, since peers are critical in crisis management, peer skills can and should be improved. The method of improvement used video and text to deliver the

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[4] Lawrence, "Trauma-focused Counselling," 617.

[5] Magill, "Really There Because They Care," 7.

[6] Ghelani, "Knowledge and Skills," 2.

[7] Crisanti, "Beyond Crisis Intervention Team (CIT) Training," 104.

[8] Sansen, "Daring to Process the Trauma," 1.

training content. As a result of participating, the research demonstrated that confidence, knowledge, techniques, and skills can be improved, therefore potentially improving the lives of other peers in crisis.

The need for initial and continued education on peer crisis management is obvious. In-person synchronous training provides unique opportunities to discuss, roleplay, and explore as a group. However, in-person training requires dedicated scheduling, timing, and a centralized location. This could be prohibitive, especially for leaders engaged in multiple roles or careers. Therefore, approachable, flexible training that allows for interruption may be more accessible to non-professionals who may be able to dedicate working hours to the training.

The training developed as part of this research was web-based and distributed asynchronously. It provided the ability to receive feedback or answers to questions as they arose. Consistent with Sansen, web-based training has demonstrated the ability to provide beneficial training in crisis management.[9] This research project demonstrated that the developed training improved negative attitudes, skills, and confidence for the participants even when distributed asynchronously.

Research Applications

Generally, the developed training and data analyzed as part of the research demonstrate a critical need for peers in crisis prevention, intervention, and post-intervention support. As anyone may experience a crisis, it cannot be assumed any specific context, location, or level of professional support will be present. Therefore, the application of this research is both immediate and general.

[9] Sansen, "Daring to Process the Trauma," 6.

The research results are directly applicable to the immediate ministry context. The Soldiers who participated demonstrated generalized improvement in knowledge and willingness to assist peers experiencing a crisis. Therefore, the developed training applies to the participants and likely applicable to others within the immediate ministry context. No crisis has occurred since receiving the training that warrants an intervention. Therefore, the skills and confidence are theoretical until a practical opportunity arises. However, self-reported knowledge and confidence improved, which was a primary goal of the research and is useful in this context.

Expanding beyond the immediate ministry context, it is likely that the training would produce similar results for other members of the unit and similar units. Army Reserve TPU Soldiers often meet for two days each month. A dedicated four-hour training block would likely be a challenge, especially when combined with other training requirements. Therefore, asynchronous training would likely be the best approach if applying the project to other teams.

One limitation of the research is that the participants were all TPU Soldiers. Although this limitation will be discussed further, the research implications would likely apply to other military contexts. For example, active component servicemembers who see peers regularly may be able to apply the training within their context more acutely. The training was designed for military-connected peers, assuming a mix of servicemembers, veterans, and civilians. However, the project should still be beneficial in a purely military context absent other backgrounds.

Although the ministry context focused on members within a specific US Army Reserve TPU unit, the actual content that was developed did not rely on military experience, training, or knowledge. What military-connected content there is within the material was largely anecdotal or illustrative. Removal or modification of that content would not materially change the concepts trained.

Therefore, the developed training could be applied in other non-military community contexts. Veteran groups, social clubs, churches, and similar contexts could find the content useful and applicable. Like medical first aid courses, a modified version of the training that maintains the focus and conceptual framework could provide a similar "crisis first aid" training to the larger community centers and leaders.

Similarly, the research could be applicable to business settings. In a corporate environment, such as an office space or asynchronous communication platform, employees and managers engage with one another, communicate, and interact for significant portions of the day. Individuals presenting precursors may first be recognized by peers within the context of a job or corporate environment. Recognition of the precursors could be critical to mitigating a crisis. Although an intervention may not be as likely, especially in remote asynchronous working environments, post-intervention and normalization skills would be applicable.

Overall, the research is applicable in several different contexts. Everyone is responsible for building lives worth living, which is a fundamental concept of crisis prevention.[10] Even so, anyone may experience a psychological crisis. The research implications are applicable to peers across domains, industries, and contexts. However, it is not universally applicable, and the research does have limitations.

Research Limitations

There are several limitations of the research and action project. The project was designed for a unique problem within a ministry context. The limitations include the cohort demographics, the size of the cohort, and the modality of the training provided.

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[10] Bryan, *Rethinking Suicide*, 198.

The first significant limitation of the research is that the training program participants were all current military service members. The cohort did not consist of any non-active veterans, any government civilians, any non-government civilians, or any friends or family of service members. Military service members typically receive suicide prevention training at least once each year, and often receive reminders about taking care of their fellow servicemembers. That foundational knowledge and exposure may not exist amongst non-serving civilians or may exist in a different frame of reference than those actively serving in the military.

Further, military service members serve within a defined unit, organized into sections by role or unit organization. For example, a servicemember will serve in a clearly defined section such as “Personnel” or within a clearly defined unit structure such as “First Platoon.” That structure provides collective training, trust building, connection, and identity. These traits, while existing in civilian contexts, are inherently different due to the role and mission of the military. This may influence several aspects of the training for non-service members, including willingness, recognition, and ongoing post-intervention support.

The participants were all members of a US Army Reserve TPU unit that meets approximately once each month for two days. Therefore, the participants do not see each other regularly throughout the month. While the training demonstrated improved knowledge and confidence, its practical implication may not be demonstrated with members in the unit itself. In other words, if a member of the ministry context experiences a crisis between training events, it is not clear that the training would be useful for intervention, given the low likelihood of one of the participants being proximal at the time. This limitation could be reduced through multiple iterations of the training, however.

This specific limitation is also unique to the ministry context and is intentional. If the training was applied outside of the ministry context, this limitation may be reduced or eliminated. For example, if provided to members of an active component military unit or a business context, where participants routinely interact with each other, this limitation would not be applicable.

The research was also limited by its size and the limited demographics or the participants. All twelve participants were members of the same brigade within the ministry context. While there was a range of ranks, most of the participants were either officers or non-commissioned officers. Although anyone can experience a crisis, these rank cohorts tend to have more experience and training, including mandated training from the military related to suicide prevention. Therefore, they may have participated with a foundational level of knowledge that may not be present in other contexts or groupings.

The limited size of the participants is also a limitation that must be considered. Although intentional for this specific action project, a larger number of participants may yield different results post-training. This could be due to shared experiences, the relationship with the content deliverer, or localized influences such as recent trauma or tragedy. More research will be needed to examine whether the project results can be repeated in larger and more diverse groups of participants.

The research is also limited by its singular modality. Specifically, the training delivery was conducted through a web-based research platform that used video and text to train the content. The content was accessed asynchronously with support as needed initiated by the participant. Therefore, the results of the research are applicable within that context. It is

unknown whether the results would improve, worsen, or remain the same if the modality was changed.

For example, if the training was conducted during an in-person session, the participants may be able to collaborate or share their own experiences. The impact of this collaboration is unknown. However, that may also limit the accessibility of the training as scheduling and travel could be a challenge.

Alternatively, a more course-like approach could be helpful. Discussion groups and similar communication tools could be integrated to simulate those interactions. However, it is not clear if that would aid or detract from the training.

There also was not an established level of pre-knowledge prior to the training. However, since all participants had military experience and training, there was a base-level assumption of understanding regarding crisis prevention and intervention. In other contexts, this may not be the case. Therefore, pre-assessment prior to participation, with read-ahead or watch-ahead material made available to ensure a shared foundational understanding prior to conducting the training, could be useful to explore.

Further Research

While the project was successful, there is further research that can build upon this outcome. Further research includes directly expanding the reach of the training and exploring changes to the research content itself. While both can be explored independently, there is additional research to track the combination of both explorations potentially. In other words, while it may be useful to conduct research simply by expanding the number of participants, and it may also be useful to conduct research simply by modifying the modality or content, the

author believes that the more interesting potential further research would examine the effects of both approaches.

As discussed, the primary limitations of the research involve the scope and the modality. Additional research could be conducted to increase the number of participants to address scope. For example, several research questions could be explored. One research question would be whether the outcomes change as more cohorts receive the training. Similarly, another question would be whether the outcomes change if the size of the cohorts changes significantly, such as training fifty participants, instead of the small group approach in this project. Another potential research question is if the outcomes remain the same if the cohort model is removed and participants can proceed completely independently.

Aside from the scope of the number of participants, another area of future research could involve examining the scope of the participants' demographic information. For example, it may be interesting to research if the outcomes remain consistent if more rank groups are trained, either independently or integrated within a cohort. As the current project consisted of significantly more leaders with authority than Soldiers not in leadership positions, it may be interesting to research the impact of the training on more junior enlisted Soldiers specifically.

Further, the participants were all US Army Reserve TPU Soldiers. It is unclear if the training would be as beneficial in non-TPU contexts. Additional research could examine the outcomes of the training program in non-reserve military units. The training could also be expanded to non-military contexts, such as business, community, and education contexts. Within those contexts, research may also be conducted to determine what the pre-training level of objective knowledge is, since the assumption of pre-existing military-delivered training on

suicide intervention cannot be assumed. A multi-phase approach would likely be warranted, especially if the participant demographics were diverse.

The current research was delivered asynchronously through a web-based video and text platform. While that medium was appropriate for the ministry context, not all participants may benefit from that delivery mechanism. Additional research could examine the medium of delivery, such as through more video role-plays, audio delivery, or more text-based content such as written articles or books. Adapting the material may or may not change the outcomes, especially if a multi-delivery approach was developed.

The current training was delivered asynchronously. This was intentional to minimize interference with careers and to minimize the expense of travel. However, that limitation does open the possibility of exploring additional approaches. A multi-modal approach could be researched. An example approach could be based on the Franklin Covey Institute leadership and business training program, which is widely regarded as an effective and successful organization and training institute.[11]

For example, in their "Speed of Trust for Military" certification training, they used asynchronous pre-training for one week. This consisted of reading, short-answer personal responses to prompts, and checks on learning that were for informational purposes only. Once completed, the next was a combination of synchronous virtual meetings and asynchronous study. A similar model may be developed with this training that could leverage benefits of each modality.

[11] Examples of their training methodologies can be found at https://www.franklincovey.com/.

Summary

Ultimately, a psychological crisis can bring significant distress to the individual experiencing a crisis and their loved ones. Steps to prevent, intervene, and stabilize crises will reduce the level and scope of the distress. Providing ongoing stabilization, reintegration, and normalization will help mitigate future crises. These tasks currently often fall on law enforcement and clinical providers, but those resources may not always be available, proximal, or ideal, especially as those systems are stretched.

Instead, it is often a peer who first notices the precursors of a crisis or who is present when a crisis ensues. This group is often the least trained and prepared. By improving the preparedness, readiness, and confidence of peers with crisis management, crises can be mitigated, if not prevented. This research project sought to develop an approach to improving that knowledge and confidence.

The project was successful within the context of the problem. It had some notable limitations, including the size of the participants and the modality of delivery. However, it was successful and can likely be applied in other contexts. It also provides several opportunities for future study and research. The more that can be done to prevent, intervene, and support those who experience a crisis, the more the quality of life of those experiencing distress can be improved.

APPENDIX A

CONSENT FORM FOR STRUCTURED INTERVIEWS IN PHASE 1

Consent

Title of the Project: Crisis Management and Peer Support
Principal Investigator: Kevin H. Eaton, PhD, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be above the age of 18 and have a connection to the military community. This connection could be as a current serving member, a veteran of military service, a family member of a service member or veteran, or a colleague of a veteran or service member. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to develop a new training approach to better train non-professional peers to assist those experiencing a crisis. Often, a crisis develops when exposed to significant stress. Peers, colleagues, and supervisors are often the first to recognize the crisis and may need to provide crisis intervention and follow-on support.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Participate in a confidential structured interview that will ask you for more details about a specific crisis situation you witnessed or participated in. This interview will take approximately 20 minutes. You will have the option to allow the interview to be recorded or for the interviewer to take detailed notes during the interview.
2. At the conclusion of the interview, you will be offered the opportunity to participate in a training program in crisis management as the next part of this research project.

How could you or others benefit from this study?

The direct benefit participants should expect to receive from taking part in this study is free training on how to assist others experiencing a crisis. This could include new skills, new knowledge, and improved preparation in case a friend, family member, or colleague experiences a crisis.

Benefits to society include a reduction in demand for professional and law enforcement crisis management teams if the crisis is not medical or dangerous. Like gatekeepers in suicide prevention programs, the more aware members of society are about the causes, prevention, intervention, and recovery techniques of a crisis, the more able the crisis can be safely managed.

What risks might you experience from being in this study?

The risks involved in this study include triggering of previous crises you may have experienced in the past. Topics discussed include suicide, crisis, and trauma. No specific cases, descriptions of specific cases, or audio-visual references relating to specific crises will be used. The likelihood of this risk is minimal if you are able to freely think about and talk about crises in general.

Injury or Illness: Liberty University will not provide medical treatment or financial compensation if you are injured or become ill as a result of participating in this research project. This does not waive any of your legal rights nor release any claim you might have based on negligence.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential, and no demographic data will be recorded with the interview. The interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored in an encrypted, password protected software system. Any paper forms will be securely stored until entered into the software system. Once transferred, the paper form will be destroyed. Only the aggregate results of the study will be presented. No individual responses will be presented or shared. After three years, all electronic records and associated forms will be deleted.
- Interviews may be recorded and transcribed. Recordings will be summarized into a notes system that is encrypted and password protected. Any recordings of the interview will be deleted after this process. The notes and summaries will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these notes.]
- Confidentiality cannot be guaranteed in group training sessions or meetings. While discouraged, other members of the training event may share what was discussed with persons outside of the group. No personal or sensitive information should be shared in the group session.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Kevin Eaton.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio record me as part of my participation in this study if I participate in the optional interview.

_____

Printed Subject Name

_____

Signature & Date

APPENDIX B

CONSENT FORM FOR TRAINING IN PHASE 2

Consent

Title of the Project: Crisis Management and Peer Support
Principal Investigator: Kevin H. Eaton, PhD, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be above the age of 18 and have a connection to the military community. This connection could be as a current serving member, a veteran of military service, a family member of a service member or veteran, or a colleague of a veteran or service member. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about, and why is it being done?

The purpose of the study is to develop a new training approach to train non-professional peers better to assist those experiencing a crisis. Often, a crisis develops when exposed to significant stress. Peers, colleagues, and supervisors are often the first to recognize the crisis and may need to provide crisis intervention and follow-on support.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

3. Fill out a pre-training survey that will provide general information about your knowledge and experience with crisis management. This survey should take less than 15 minutes to complete.
4. Participate in a training program that will be available online. You will be able to complete this training on your own time and schedule. The length of time this will take will depend on how familiar you are with crisis management but should take less than 3 hours in total. You will have two weeks from the start of the project to complete this training. The training must be completed by _____.
5. Participate in a virtual training session to review the training, ask any questions, and practice any new skills. This session will last approximately 1 hour.
6. Fill out a post-training survey that compares your prior experiences with your new knowledge. This survey should take less than 10 minutes to complete.

How could you or others benefit from this study?

The direct benefit participants should expect to receive from taking part in this study is free training on how to assist others who are experiencing a crisis. This could include new skills, new knowledge, and improved preparation in case a friend, family member, or colleague experiences a crisis.

Benefits to society include a reduction in demand for professional and law enforcement crisis management teams if the crisis is not medical or dangerous. Like gatekeepers in suicide prevention programs, the more aware members of society are about the causes, prevention, intervention, and recovery techniques of a crisis, the more able the crisis can be safely managed.

What risks might you experience from being in this study?

The risks involved in this study include triggering of previous crises you may have experienced in the past. Topics discussed include suicide, crisis, and trauma. No specific cases, descriptions of specific cases, or audio-visual references relating to specific crises will be used. The likelihood of this risk is minimal if you can think about and talk about crises in general freely.

Injury or Illness: Liberty University will not provide medical treatment or financial compensation if you are injured or become ill as a result of participating in this research project. This does not waive any of your legal rights nor release any claim you might have based on negligence.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential through the use of codes. A numeric code will track you through the surveys, training, and final session. During the final session, you should not reveal your code to other participants or the researcher.
- Data will be stored in an encrypted, password protected software system. Any paper forms will be securely stored until entered into the software system. Once transferred, the paper form will be destroyed. Only the aggregate results of the study will be presented. No individual responses will be presented or shared. After three years, all electronic records and associated forms will be deleted.
- Confidentiality cannot be guaranteed in group training sessions or meetings. While discouraged, other members of the training event may share what was discussed with persons outside of the group. No personal or sensitive information should be shared in the group session.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Kevin Eaton.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

_____

Printed Subject Name

_____

Signature & Date

APPENDIX C

Recruitment Email for Structured Interviews

Dear [Recipient]:

As a doctoral student in the School of Divinity at Liberty University, I am conducting research as part of the requirements for a Doctor of Ministry in Pastoral Counseling degree. The purpose of the study is to develop a new training approach to better train non-professional peers to assist those experiencing a crisis. Often, a crisis develops when exposed to significant stress. Peers, colleagues, and supervisors are often the first to recognize the crisis and may need to provide crisis intervention and follow-on support.

As previously discussed, you expressed an interest in providing information or insights based on your previous experiences. I would like to schedule an interview if you are still interested in participating. For this portion of the research, participants must be 18 years or older and have experienced or assisted others experiencing a psychological crisis.

The interview will be conducted telephonically, utilizing a messaging app we both agree upon or in person. It will take approximately 20 to 40 minutes, depending on the depth of your responses. You will have the option of allowing the interview to be recorded. If recorded, it will be audio only. A summary will be written after the interview and the recording will be destroyed. If not recorded, a summary will be developed based on notes taken by the interviewer during the session. The notes will be converted into a summary and then destroyed. Your name and other personally identifiable information will not be linked or stored alongside the summaries. The summaries will be used to enhance the training program development that will be administered in the next phase of the research.

To participate, please read over the attached Consent form. If you have any questions about the research project, the interview, or how your responses will be used, please be sure to ask them prior to agreeing to participate. I am currently scheduling interviews during the week of _____ to _____. I will try my best to be flexible to your schedule. If you agree to participate, please return the signed consent form and provide me with some dates and times that work best for the interview. I will respond with a confirmation of the date, time, and method of the interview.

Sincerely,

Kevin H. Eaton, PhD

APPENDIX D

STRUCTURED INTERVIEW QUESTIONS

1) Do you agree to waive any pre-existing confidentiality requirements, such as confidentiality created due to your relationship with the researcher, during the course of this interview so that your responses may be used for the purposes of the research action project? Your identity will be protected, and the names and non-critical demographic details of your responses will be removed or changed for privacy purposes.

2) What was the nature of the crisis in which you intervened?

3) Can you explain your role and relationship with the individual in crisis?

4) How were you made aware of the crisis?

5) How prepared did you feel prior to intervening?

6) What happened during the intervention?

7) How did the intervention end?

8) Did you assist in any post-intervention or reintegration care?

9) What was the most difficult challenge when conducting the intervention?

10) Were there things you weren't prepared for during the intervention?

11) If you were called on to intervene again in the future, what do you think you would need in order to be more able, willing, or knowledgeable?

12) Is there anything else you would like to share regarding this crisis intervention?

APPENDIX E

RECRUITMENT EMAIL FOR TRAINING

Dear [Recipient]:

Thank you for expressing interest in the research project. As a doctoral student in the School of Divinity at Liberty University, I am conducting research as part of the requirements for a Doctor of Ministry in Pastoral Counseling degree. The purpose of the study is to develop a new training approach to better train non-professional peers to assist those experiencing a crisis. Often, a crisis develops when a person is exposed to significant stress. Peers, colleagues, and supervisors are often the first to recognize the crisis and may need to provide crisis intervention and follow-on support.

Participants in this portion of the project will be asked to answer a pre-training survey. This survey should take less than 15 minutes. Based upon the results of the survey, your eligibility will be determined. If eligible, you will be asked to complete approximately 3 hours of training using a web-based training platform. The platform will not store any personally identifiable information. You will create a password and be given a unique numeric participant code. This code will be the only link between you and your progress. Do not share this code with others, including the researcher.

The training does not need to be completed all at once. Your progress will be saved, and you may return to it at any time during the research project. The training will consist of reading materials, video recordings, and other multimedia. The topics covered are focused on peer-support during crisis management, including prevention, intervention, post-intervention, and recovery. You will have two weeks to complete this training.

After completing the training, you will be asked to attend a synchronous training session that will last up to one hour. This session is scheduled for _____ at _____. The purpose of this session is to collaborate with other participants, discuss what was covered, summarize the concepts, and share feedback with the researcher.

Following that session, you will fill out another survey that will be very similar to the first survey you submitted. It should take less than ten minutes to complete.

The surveys and the asynchronous training will be tied to your code and will be anonymous. During the final training session, your responses and interactions will not be anonymous. Although highly discouraged, other participants may tell others about what occurs in the training session. Therefore, please ensure you do not share your code or other sensitive information during that session.

To participate, please visit _____ to get started. If you have any questions about the research project, the interview, or how your responses will be used, please be sure to ask them prior to agreeing to participate.

Thank you for your consideration,

Kevin H. Eaton, PhD

APPENDIX F

PRE-TRAINING SURVEY

Demographic Information

Participant Code:

What is your age range:

18–24 25–30 31–36 37 or older

Are you in the military or a military service veteran?

Yes No

If so, what best describes your most recent rank:

Junior Enlisted (E1–E4) Junior NCO (E5–E6) Senior NCO (E7–E9)
Warrant Officer (W1–W5) Junior Officer (O1–O3) Senior Officer (O4–O6)
Other

Do you supervise other Soldiers or veterans in your current occupation?

Yes No

Do you have immediate family members who are currently serving or have served in military service?

Yes No

Please indicate which US state you either live in, work in, or perform military-related training in:

Maine New Hampshire Vermont Massachusetts
Connecticut New York Pennsylvania Rhode Island

Crisis Management

On a scale of 1–7, please select your agreement with the following statements, where 1 means "I do not agree at all" and 7 means "I agree completely." Please be honest, as you will have the opportunity to answer these questions again after the training.

I know about the phases of a crisis.

1 2 3 4 5 6 7

I can recognize the warning signs of a crisis.

1 2 3 4 5 6 7

I am willing to intervene in a crisis if safe to do so.

1 2 3 4 5 6 7

I know the skills and best practices to intervene in a crisis safely.

1 2 3 4 5 6 7

I know the importance of stabilization and normalization.

1 2 3 4 5 6 7

I know the importance of reintegration.

1 2 3 4 5 6 7

My leaders and managers will help me if I experience a crisis.

1 2 3 4 5 6 7

My family will help me if I experience a crisis.

1 2 3 4 5 6 7

I can help my family members if they experience a crisis.

1 2 3 4 5 6 7

I know how to find assistance during a crisis intervention.

1 2 3 4 5 6 7

I know about the emotional impacts a crisis can have on the intervener.

1 2 3 4 5 6 7

I know how to improve my own resiliency.

1 2 3 4 5 6 7

I know it is important to prepare myself prior to intervening in a crisis.

1 2 3 4 5 6 7

Please select the topics you believe you understand well.

What is a Crisis	Types of Crises	Causes of a Crisis
Crisis Prevention	Identifying a Crisis	Intervention Techniques
Peer Support during Crisis	Interventionist Impact	Professional Resources
Post-intervention Techniques	Reintegration	Normalization
Building Resiliency	Ethical Considerations	

Please select the topics you believe you do not understand well.

What is a Crisis	Types of Crises	Causes of a Crisis
Crisis Prevention	Identifying a Crisis	Intervention Techniques
Peer Support during Crisis	Interventionist Impact	Professional Resources
Post-intervention	Reintegration	Normalization Techniques
Building Resiliency	Ethical Considerations	

APPENDIX G

POST-TRAINING SURVEY

Participant Code:

Crisis Management

After participating in the training, please think about how your understanding of crisis management may have changed. On a scale of 1–7, please select your agreement with the following statements, where 1 means "I do not agree at all" and 7 means "I agree completely."

I know about the phases of a crisis.

1 2 3 4 5 6 7

I can recognize the warning signs of a crisis.

1 2 3 4 5 6 7

I am willing to intervene in a crisis if safe to do so.

1 2 3 4 5 6 7

I know the skills and best practices to intervene in a crisis safely.

1 2 3 4 5 6 7

I know the importance of stabilization and normalization.

1 2 3 4 5 6 7

I know the importance of reintegration.

1 2 3 4 5 6 7

My leaders and managers will help me if I experience a crisis.

1 2 3 4 5 6 7

My family will help me if I experience a crisis.

1 2 3 4 5 6 7

I can help my family members if they experience a crisis.

1 2 3 4 5 6 7

I know how to find assistance during a crisis intervention.

1 2 3 4 5 6 7

I know about the emotional impacts a crisis can have on the intervener.

1 2 3 4 5 6 7

I know how to improve my own resiliency.

1 2 3 4 5 6 7

I know it is important to prepare myself prior to intervening in a crisis.

1 2 3 4 5 6 7

Please select the topics you believe you now understand better, even if you understood them well before the training.

What is a Crisis	Types of Crises	Causes of a Crisis
Crisis Prevention	Identifying a Crisis	Intervention Techniques
Peer Support during Crisis	Interventionist Impact	Professional Resources
Post-intervention	Reintegration	Normalization Techniques
Building Resiliency	Ethical Considerations	

Please select the topics you believe you do not understand well.

What is a Crisis	Types of Crises	Causes of a Crisis
Crisis Prevention	Identifying a Crisis	Intervention Techniques
Peer Support during Crisis	Interventionist Impact	Professional Resources
Post-intervention	Reintegration	Normalization Techniques
Building Resiliency	Ethical Considerations	

APPENDIX H

TRAINING OUTLINE AND INITIAL TOPICS

- Introduction and Overview
- The Nature of a Psychological Crisis
    - Definitions from literature
    - What they look like in various situations
    - What is happening mentally, emotionally, and physically
    - Statistics and likelihood of experiencing a crisis or intervening
- Precursors of Crises
    - Reactions to stress and coping mechanisms
    - Types of precursors
        - Financial
        - Relational
        - Identity-based
        - Overwhelming stress
    - Flailing and braking systems
- The Importance of Peers in Crisis Management
    - Who is likely to see someone in crisis
    - Importance of quick intervention and stabilization
    - Building on established relationships
- Crisis Prevention
    - Building lives worth living
    - Levels of prevention
        - Societal
        - Community
        - Peer groups
        - Close family
        - Individual
    - Occupational risk reduction analogies
- The Ethics of Crisis Intervention
    - Understanding the limits of competency
    - Preventing developing a second crisis
    - Ethical considerations
    - Legal considerations
- Crisis Intervention Skills and Techniques
    - Preparing and resource awareness
    - Analysis and initial decision making
    - Communication techniques
    - Safety concerns

- Emotional Trauma and Resiliency for the Intervener
    - Building on preparation
    - Knowing yourself and how you respond
    - Importance of practice and role play
    - Mindfulness
    - Debriefing
    - Talking it out
- Stabilization Resources
    - Recognizing what to do next in the context
    - Deciding if more intervention is needed
    - Remaining present
    - Transitioning
- Post-intervention Support
    - What is post-intervention
    - Importance of post-intervention
    - Importance of normalization
    - Remaining available
    - Assisting with coping skills and “riding the waves”
- Reintegration and Follow Up Techniques
    - Importance of follow up
    - Defining a new normal
    - Normalizing the crisis
    - Reestablishing connections
    - Remaining connected
- Building Healthy Coping and Resiliency Skills
    - Turning post-intervention into prevention
    - Identifying what worked and what didn’t
    - Building on successes
    - Building resiliency
- Conclusion and Next Steps
    - Summary of crisis phases
    - Additional training opportunities

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IRB APPROVAL LETTER

January 13, 2023

Kevin Eaton
Jonathan Sullivan

Re: IRB Application - IRB-FY22–23–587 Crisis Management and Peer Support

Dear Kevin Eaton and Jonathan Sullivan,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds that your study does not meet the definition of human subjects research. This means you may begin your project with the data safeguarding methods mentioned in your IRB application.

Decision: No Human Subjects Research

Explanation: Your project is not considered human subjects research because it will consist of quality improvement activities, which are not "designed to develop or contribute to generalizable knowledge" according to 45 CFR 46. 102(l).

Please note that this decision only applies to your current application. Any modifications to your protocol must be reported to the Liberty University IRB for verification of continued non-human subjects research status. You may report these changes by completing a modification submission through your Cayuse IRB account.

Also, although you are welcome to use our recruitment and consent templates, you are not required to do so. **If you choose to use our documents, please replace the word *research* with the word *project* throughout both documents**.

If you have any questions about this determination or need assistance in determining whether possible modifications to your protocol would change your application's status, please email us at irb@liberty.edu

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office