Early intervention – a family perspective

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Reference: Dyregrov, A. (2001). Early intervention–a family perspective. *Advances in Mind–Body Medicine, 17,* 9–17.

Early intervention – an introduction

Early intervention encompasses various efforts instigated to help people following a critical or traumatic event. It ranges from the comfort and care shown those who are admitted to hospital following an injury, to more structured forms of psychological support provided in group settings, such as "Critical Incident Stress Debriefings" (CISD) also called "Psychological debriefings". These interventions belong to the domain of "crisis intervention", aiming at reducing distress, stabilizing the situation, minimizing recovery time and restoring function in persons, families and communities. The interventions used vary from setting to setting, from more formalized programs to secure follow-up for emergency personnel that deal with critical situations on an almost daily basis (Critical Incident Stress Management – CISM – see Everly & Mitchell, 1997) to less structured interventions for people who suddenly and without any training are exposed to a traumatic event. Unfortunately "debriefing" has come to be a common denominator both for very brief early interventions and for more elaborate practices.

Within the last decade there has been mounting debate about "immediacy", or early intervention, one of the principles of crisis intervention. Most of the debate has focused on "psychological debriefing", culminating in a recent book (Raphael & Wilson, 2000) that encompasses different perspectives and arguments from those supporting and criticizing such interventions. Unfortunately some of the empirical "testing" of these early interventions have evaluated intervention practices (short interventions lasting an hour or less) provided by people with a minimum of training, that from a clinical viewpoint must be seen as not only inadequate, but potentially harmful (Dyregrov, 1998). It is unlikely that people who experience highly stressful events will benefit from very short interventions (lasting less than an hour), and it does not seem very humane to enter a family or person's life at a very sensitive stage in their life, and then withdraw without proper follow-up. With such practice one may expect harm to be done.

Instead of trying to add to the heat of this discussion this article will present experience and reflections based on more than 20 years of experience in working with individuals, families, organizations and communities, both in the immediate time period following traumatic events and also in long-term follow-up. The experience spans five years of working as a psychologist with families that lost small children or experienced other crisis situations in relation to serious illness in children, followed by almost two decades of working with families following other sudden death and acute crisis situations. Families are referred to our center from police, general practitioners, hospitals, and others. Many family members, or members of their social or family network, contact us directly as the center is well known

locally. Thus we often meet persons and families in the immediate phase following a critical or traumatic event, be that in our office, a home or in the community. In addition the reflections are based on working with a variety of man-made and natural disasters in Scandinavia and elsewhere, including transportation disasters, fires, maritime disasters, earthquakes and war.

What kind of help do people want following such situations?

Through a series of studies of bereaved populations throughout Norway (Dyregrov, Nordanger & Dyregrov, 2000a,b; Nordanger, Dyregrov & Dyregrov, 2000) we have documented that bereaved family members want the following: a) early help, b) outreach help, c) information about the event and potential reactions, d) possibility to meet with others who experienced the same or a similar situation, and e) help over time. These are the interventions emphasized within crisis intervention, apart from the accent on help over time. The families' highlighting of help over time is important though, as it reflects the fact that many family members experience considerable problems over time, both individually and also in family functioning. Although the need for follow up over time is most evident following sudden death, several trauma situations (i.e., hostage situations, rape, violent robbery) lead to reactions with a prolonged time course where the follow-up needs exceed the time frame originally believed necessary within crisis intervention.

In order to secure that immediate and proper follow-up is provided in a coordinated manner, both following day-to-day trauma and crisis situations, and following major disasters, structures have to be in place to coordinate the follow-up and to secure sound intervention. In our studies (Dyregrov, Nordanger & Dyregrov, 1998; Nordanger, Dyregrov & Dyregrov, 1998), we have found that when the following structures exist in a community, people are best cared for: a) a formalized plan of action for both immediate and long-term support, b) a coordinator for intervention activities, c) a local crisis team, d) written procedures for what needs to be done.

The role of mental health professionals

Mental health professionals play an important part in the organization and provision of such structured interventions, and although they do not necessarily have to be part of the practical delivery of "psychological first aid", they should have the responsibility for conducting psychological debriefing and other more specialized services, including specific help to those who need more than immediate support. To achieve this mental health

professionals need knowledge of crisis theory, experience from providing crisis intervention, a non-psychiatric attitude (skills in meeting ordinary people who have experienced an unusual situation) and understanding of family dynamics. Through psychoeducational activities, reframing, helping people reestablish social contact and occupational activities, the mental health professional can help people regain control and reduce untoward effects of the situation they have experienced.

Family consequences of trauma

While much is known about the factors that influence individual recovery, less is known about the aspects that influence family adaptation to trauma and grief over time. Family recovery will be determined by the interplay of factors such as: nature of the stressor, the family's prior history of trauma, loss and, prior and current functioning of the family, family coping resources, and availability of help and support. Unfortunately early interventions are often described without an adequate sensitivity to family dynamics. Early intervention for families is more than comforting and providing information, it must ensure a platform that can facilitate long-term coping, as such events can have a profound influence on the family over time.

Traumatic events have the capacity to disturb vital functions within the family such as parenting functions including emotional nurturing, education, and protection. Children may be particularly at risk when trauma occurs in the family, as traumatized parents often reduce physical contact (Field, Seligman, & Scafidi, 1996) and try to shield their offspring from facts. Communication, intimacy, expressiveness and role-distribution may be affected, resulting in a reduced capacity to cope with internal and external demands. Already we see immediate implications for early intervention: parents must be guided towards providing physical comfort to their children, and be advised on the importance of communicating facts to children.

An example illustrate how such phenomena even can affect communication over several generations:

> *Years ago a family lost a little girl in an accident. A four-year-old girl witnessed her sister's death. Although grief crisis intervention was provided, the intervention focused on the parents. Ten years later the mother sought help because intrusive images from the accident still bothered her. In the course of treatment it became apparent that this woman's mother had lost two children, and never wanted to talk with her daughter about this. She stated: "There was no room for me, because there*

was already two dead children on my mother's lap". In turn, when my client lost her child, she found it difficult to confide in her mother. From her mother she had learned to put on a happy facade and deny her own reactions. Not only did this lead to her mother denying her own feelings, but it eventually set the stage for how her own daughter handled the loss of her sister. She never spoke to the mother about this.

Then a few years ago I met my client's now nearly adult daughter who witnessed her sister's death. An elderly man had tried to seduce her, and although this event in itself had caused her only minor harm, she felt strong pressure to fulfill her parent's often unspoken expectations. These problems were addressed in family sessions. However, in the course of our contact she also described how she had experienced the loss of her sister more than ten years previously. I learned two important things; First, she had for years held a misperception about what happened that easily could have been corrected with a more open family climate towards communication of facts and by involving the child in the immediate follow-up. Second, she told an important fact from the accident that never had been communicated to her parents; a fact that would have changed our perception of what took place. She did not remember why she had not told this to her parents. I believe this echoed the family's history of restricted communication, and a more family based intervention at the time of the accident could have helped both the child and the parents in dealing with the loss.

When working with families it is obvious that while the immediate reactions often are similar, involving shock reactions characterized by unreality etc., reactions over time differ greatly due to differences in personality, previous experience, age and interactions with the wider social network. If there is asynchrony in reactions this can cause problems and conflicts in the family, i.e., lack of understanding from parents regarding absence of strong emotional reactions in children, or inability of members to support each other, or problems caused by different gender reactions in grief and trauma. Women tend to experience more intense emotional reactions that last over a longer time. They also tend to use confrontational coping styles where they want to talk about and share feelings around what happens, while men use more avoidance strategies where they work through the event alone, in a more private manner, often through activities and rituals. This lack of synchronism can lead to blaming for not reacting enough, for dwelling on the thoughts about the lost one, or for lack of understanding of one's partner's reactions. Early interventions that include provision of

information about such problems within the first week of the crisis event can stimulate family resiliency.

Early intervention in families

The primary focus of the interventions immediately after the event, whether for individuals, families or groups, are to a) provide comfort and care to reduce arousal (creating a caring climate) and b) secure information for those affected. Immediately after a trauma, family members are in a situation where their senses are sharpened to allow rapid intake of information. Although much debated, new memory research suggests that in situations of intense arousal, memory enhancement mechanisms are activated (van der Kolk & Fisler, 1995), a phenomenon I tentatively called "supermemory" (Dyregrov, 1992) to emphasize the intense, vivid memory that can be experienced following such situations. At the same time many experience reduced emotional reactivity (or dissociation), as well as memory loss (Joseph, 1999). We believe this sharpening of the senses and dissociation is part of a mobilization of mental resources that help us cope with a critical event. It secures intake of information and together with focused attention on important aspects of the situation, and rapid utilization of previous experience and learning stored in memory, people can respond appropriately (see Dyregrov, Solomon & Bassøe, 2000). However, the sharpening of the senses also means that the caring climate they experience has the potential to be felt as very caring and helpful or, distant, cold and unhelpful. This makes it extremely important that the family is met by a good system for immediate help.

Because of the heightened sensitivity to all aspects of their environment, a high emphasis must be placed on establishing a caring climate that can reduce arousal. In this period memories of events become consolidated (Pitman, 1989) and the lowering of psychic distress and physiological arousal takes precedence. Parents and siblings can years after an event return to this situation, either with a positive focus: "The doctor had tears in his eyes. Can you imagine that he cared so much for us that he cried", or with strong, negative intrusive memories: "I will never forget how we were left waiting and waiting with no information at all». The experience of a "cold", inhumane climate in the aftermath of a critical or traumatic event, or the "brutal" transmission of facts, can have a very negative impact:

> A child died in the intensive care unit while the parents were kept waiting outside her hospital room. While the department usually allows the parents to be present in such situations, the frantic efforts to save her life made the staff overlook the parents. A secondary trauma was afflicted on the parents by an anesthesiologist who met the

mother's understandable criticism of being left out from her daughter's final moments with the following words: "She would not have felt any difference anyway"

The first day of the traumatic event(s) is often extremely important in how individuals and families interpret a critical event, how they make their initial evaluation of their role in the event, and how they cope and recover over time. Not only is this related to the traumatic impact of this day, but also to the resulting cognitions regarding one's own and other's reactions. During the first days following the event we aim at helping survivors of traumatic events regain a sense of control by allowing them to step-by-step look at the decisions they made to survive or deal with the situation. Often the focus is redirected from their helplessness and the tragic outcome for others, to seeing how they made the right choices to survive or being able to handle the situation. Regaining a sense of control and belief in personal efficacy is at the core of these interventions.

In this time period we need to respect the emotional suppression or dissociation that allow people to focus on what has happened, and should not try to stimulate emotional processing of the event before individuals are ready for this. Shalev (2000) has raised this point recently when he asks if debriefing inappropriately can disturb the protective shield of those who are still numb or dissociated.

Handling sensory impressions

Family members who have been exposed to and continue to be bothered by strong sensory impressions should be given advice on what they can do to take control of the intrusive memories. Both children and adults can be taught self-help techniques, i.e., told to imagine that they see the traumatic image (or film) on a television-screen, instructed to imagine that they have a remote control in their hand, and then to turn the image off. Alternatively, they are to see the haunting image in front of them, and then in some way manipulate it to take control over the intrusive images (Dyregrov, 1997a). These methods have also become part of the information provided participants in group debriefings (Dyregrov, 1997b).

If sensory intrusions continue over the first few days, exposed persons are also motivated to describe their sensory images, and the thoughts associated with these, in detail. This is to secure that sensory fragments are put into words in a sequential manner, and linked to other parts of the experience. This is done in order to make the implicit memories explicit. However, both in family- and group work, this is a complicated issue that should be treated with care. If recollections are to be focused on in detail in a group, one runs the risk of having

people traumatized by listening to other people's horrific stories (Dyregrov, 1999). Care should therefore be taken before undertaking this task. Only when all people present have experienced similar sensory exposure, should this be conducted in a family or group.

Promoting family recovery

With early intervention one can prevent the development of secrets, another "minefield" within families (Brown-Smith, 1998). I recently met a group of survivors from a transport disaster about one-year after the event. This group included a mother who survived the disaster together with her four-year-old daughter. By a mental health professional in training she had been told to hide from the girl the fact that there had been many deaths in the disaster, even though the girl had asked if everyone was brought out and had many other questions about the other passengers. Proper early intervention with a focus on the child's needs would have secured open communication and maybe prevented some of the nightmares the child had suffered. This example also illustrates the need for proper training and background for those involved in such interventions.

When facts about a trauma are hidden from parts of the family system, this can greatly affect the trust and stability in the system over time. No more tragic is this than in cases of suicide where children are told that a sibling or a parent died of a heart failure or another less stigmatizing cause. Then later they may learn the reality through their friends, or worse, first get to know about this later in life. Sometimes it is a partner that keeps back information in relation to a trauma or loss from the other partner with reduced trust and continued suspicion that other facts as well are held back. Early intervention aim to reduce the building of these invisible walls, and to secure open, direct communication between various members and subsystems in the family.

Psychoeducational interventions

In a long-term follow-up study of SIDS families 12 to 15 years following a child's death (Dyregrov & Dyregrov, 1999), parents were interviewed about what they found helpful for their long-term coping with the loss. They emphasized the early provision of information about individual and family reactions that provided them with a map of the terrain they were entering, a finding echoed by other traumatized families as well. Almost every family return to the value of the information they receive about various reactions (thoughts, feelings, behaviors), and changes in family and social interaction commonly experienced after a trauma. Being mentally prepared for what is to be expected help them identify, sort out and

accept their reactions as part of a normal reaction, and helps in dealing with their partner- and social relationships. Early intervention includes the therapeutic tasks of preparation, explanation, interpretation and "teaching" about what people can experience. However, it is essential that this be done in such a way that those who experience little or no reactions or problems can experience that this also is normal and not a sign of pathology.

Preferably within the first two weeks of the event, but not in the first shock phase, partners must receive information concerning usual gender differences (i.e., speed of recovery, intensity of reactions, interpretation of partner behavior, self blame and blame of partner). By giving such information one may prevent undue blaming between the partners, lessen potential conflicts, and increase their sense of control. By helping the family members exchange information, express emotions and listen to each other, intra-family cohesion is advanced. Low-conflict couples have been found to use non-verbal communication and code words and signals to let each other know how they feel (Gilbert, 1989).

Improving family communication and cohesion is not an easy task. By making the discussion of communication, role distribution, emotional gratification, conflict, etc., part of the follow-up sessions, it is possible to work directly to establish a favorable climate for recovery from trauma. In a similar manner we can help the family understand social network reactions and give them practical suggestions for how they can activate their social resources.

Conclusion

Early intervention has the potential to reduce unnecessary pain and distress in individuals, families and communities. In this article the focus has been on the challenges in family intervention. With traumatic events having the capacity to adversely affect family functioning over extended periods of time, even over generations, it is important to work to foster an open and direct climate for communicating about what has happened. However, when early intervention is broadened to encompass the family perspective it also adds responsibility. To be able to provide adequate services in this area, the helpers not only need solid skills within crisis intervention, but knowledge about family dynamics and the effects of trauma on the family. Here, as within all human helping relationship, we may cause more pain if we lack the knowledge and skill necessary to tailor-make our interventions to the people we meet.

References:

Brown-Smith, N. (1998). Family Secrets. Journal of Family Issues, 19, 20-42

Dyregrov, A. (1992). Katastrofpsykologi. Lund: Studentlitteratur.

Dyregrov, A. (1997a). Barn og traumer. (Children and Trauma) Bergen: Sigma forlag.

Dyregrov, A. (1997b). The process in critical incident stress debriefings. Journal of Traumatic Stress, 10, 589-605.

Dyregrov, A. (1998). Psychological debriefing – An effective method? Traumatology, 4:2, Article 1. http://www.fsu.edu/^trauma/

Dyregrov, A. (1999). Helpful and hurtful aspects of psychological debriefing groups. International Journal of Emergency Mental Health, 3, 175 – 181.

Dyregrov, A. & Dyregrov, K. (1999). Long-Term Impact of Sudden Infant Death: A Twelve to Fifteen Year Follow-Up. Death Studies, 23, 635-661.

Dyregrov, A., Solomon, R. M. & Bassøe, C. F. (2000). Mental mobilization on critical incident stress situationsInternational. Journal of Emergency Mental Health, 2, 73-81.

Dyregrov, K, Nordanger, D., & Dyregrov, A. (1998). Omsorg for etterlatte etter selvmord. Kommunestudien. Rapport. Senter for Krisepsykologi. Bergen. (113 s.)

Dyregrov, K, Nordanger, D., & Dyregrov, A. (2000a). Omsorg for etterlatte ved selvmord. Etterlattestudien. Rapport. Senter for Krisepsykologi. Bergen. (171 s.)

Dyregrov, K, Nordanger, D., & Dyregrov, A. (2000b). Omsorg for etterlatte ved brå, uventet død. Evaluering av behov, tilbud og tiltak. Rapport. Senter for Krisepsykologi. Bergen. (80 s.)

Everly Jr., G. S. & Mitchell, J. T. (1997). Critical incident stress management. A new era and standard of care in crisis intervention 2nd edition. Chevron Publishing Corporation.

Field, T., Seligman, S., & Scafidi, F. (1996). Alleviating posttraumatic stress in children following hurricane Andrew. Journal of Applied Developmental Psychology, 17, 37-50.

Gilbert, K. R. (1989). Interactive grief and coping in the marital dyad. Death Studies, 13, 605-626.

Joseph, R. (1999). The neurology of traumatic "dissociative" amnesia: commentary and literature review. Child Abuse & Neglect, 23, 715 – 727.

Nordanger, D, Dyregrov, K., & Dyregrov, A. (1998). Omsorg for etterlatte etter

krybbedød og barneulykker. Tilbudet i norske kommuner. Rapport. Senter for Krisepsykologi. Bergen. (72 s.)

Nordanger, D, Dyregrov, K., & Dyregrov, A. (2000). Omsorg for etterlatte etter krybbedød og barneulykker. Etterlattestudien. Rapport. Senter for Krisepsykologi. (130 s.)

Raphael, B. & Wilson, J. P. (2000) (Eds.). Psychological debriefing. Theory, practice and evidence. Cambridge: Cambridge University Press.

Pitman, R. K. (1989). Post-traumatic stress disorder, hormones and memory. Biological Psychiatry, 26, 221-223.

Shalev, A. Y. (2000). Stress management and debriefing: historical concepts and present patterns. In B. Raphael. & J. P. Wilson (Eds.). Psychological debriefing. Theory, practice and evidence. Cambridge: Cambridge University Press.

Shalev, A. Y., Bonne, O., & Spencer, E. (1996). Treatment of posttraumatic stress disorder: a review. Psychosomatic Medicine, 58, 165-187.

Van der Kolk, B.A. & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: overview and exploratory study. Journal of Traumatic Stress, 8, (4), 505-525.