Critical Incident Stress Management

4 Lessons for PHO Professionals

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4 Lessons from "Textbook" Crisis Intervention Training

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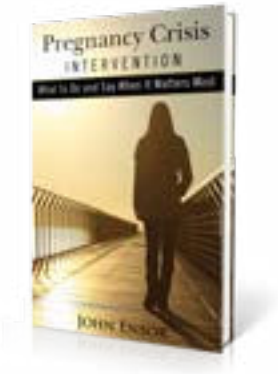


What do we learn from the professional field of Crisis Intervention, or Critical Incident Stress Management (CISM) that especially informs the work of pregnancy crisis intervention (PCI)? Let me provide you with some introductory answers. For more, see Pregnancy Crisis Intervention: What to Do and Say When It Matters Most (Hendrickson, 2019).

Society's attempt to understand human crises and construct models of intervention is a recent development within the broader field of psychology and counseling. In 1944, Gerald Caplan and Erich Lindemann were the first to *analyze the dynamics of human crisis and publish a model of intervention.* Ever since, the field of crisis intervention has grown apace.

In my research, I examined many books on crisis intervention. They begin with theory—understanding the human experience of crisis and introducing current approaches to crisis intervention. The rest is application. Each chapter focuses on a sub-specialty within crisis intervention. These typically include substance abuse, intimate partner violence, sexual assault, child sexual assault, suicide ideation, emergency response in the workplace/schools, military re-entry, disaster response and more.

I have yet to find a book on CISM that deals with crisis intervention related to pregnancy. I wrote *Pregnancy Crisis Intervention,* in part, to put us on the map professionally as well as to help us grow professionally.

I also reviewed textbooks endorsed by the *National Abortion Federation* which are used to train people in abortion. After all, the abortion business exists as a crisis intervention service. It's important for us to understand how they train in terms of counseling women in a pregnancy-related crisis prior to abortion.

What follows, are 4 critical lessons that especially inform the work of pregnancy crisis intervention (PCI).

LESSON 1: All crisis intervention organizations start as grassroots movements using volunteers; and as they mature, they do not outgrow the use of volunteers, or rely solely on licensed professionals as counselors.

The first big takeaway from this research is affirmative in nature. **All crisis intervention organizations started as a grassroots movement using *volunteers*.** You may be confident that, in the main, *our PHO movement is maturing along the same trend lines as all other crisis intervention movements.* We are as professional if not more so, than any other crisis intervention efforts. And that includes the use of volunteers.

The longstanding (8th edition) textbook, *Crisis Intervention Strategies*, reports,

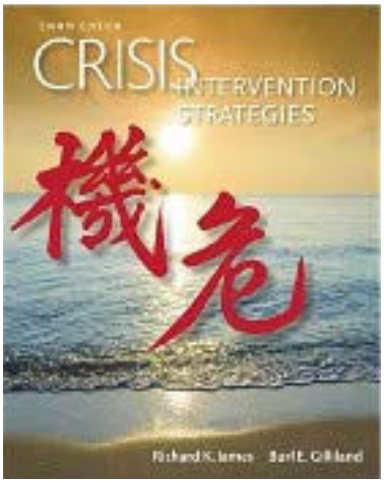
> To really understand the evolution of crisis intervention, though, is to understand that several social movements have been critical to its development, and these did not start fully formed as "crisis intervention" groups by any means. Three of the major movements that helped shaped crisis intervention into an emerging specialty were Alcoholics Anonymous (AA), Vietnam veterans, and the women's movement of the 1970s. Although their commissioned intentions and objectives had little to do with the advancement of crisis intervention as a clinical specialty.

Grassroots efforts always start with volunteers, then with experience, move to "trained volunteers." From the same textbook:

> Contrary to the popular misconception that paid veteran crisis workers descend on a large-scale disaster like smokejumpers into a forest fire, most crisis intervention in the United States is done by volunteers... Volunteerism is often the key to getting the fledgling crisis agency rolling. The use of trained volunteers as crisis workers has been a recognized component of many crisis centers and agencies for years.

In other words, it is *accepted* practice within the field of crisis counseling for much of the work, including the main work of counseling, to be done by volunteers.

Further, it is *accepted* practice within the field of CISM to receive specialized, in-house training, and thereafter be referred to as "counselors." This is common in drug/alcohol addiction, divorce recovery, military reentry, suicide prevention, and so on. Conversely, it is not true that crisis interventions services are worried that the word "counselor" opens them up to attack. "Counselor" is not a professional term within the field of crisis intervention the way "doctor" is within medicine. It means only that you have been trained and authorized by the agency to provide counseling in the field of crisis intervention that the agency exists to provide.



Further, as a crisis intervention movement matures, it does not outgrow the use of volunteers, or rely solely on licensed professionals as counselors. As George Everly writes in *Assisting Individuals in Crisis*, "Both mental health clinicians and peer support personnel may perform crisis intervention and CISM services . . . but specialized training is essential for both groups."

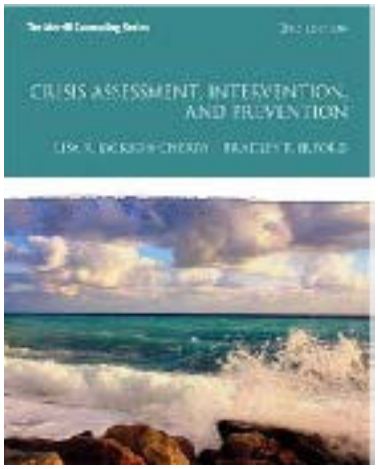
This is the path we are on. As the Charlotte Lozier Institute reports,

> Pregnancy centers rely upon a high percentage of community-based volunteers to operate and provide client care on many levels. Nine in 10 people involved at pregnancy centers are volunteers engaged in client consultation and education, reception, fund raising, center upkeep, and accounting. In addition, licensed medical professionals from a variety of disciplines volunteer to fill needed roles with their expertise to improve the health of individuals and families in their community.
>
> Volunteers who interact with clients are required to complete specialized training at centers and/or at the national level. e training focuses on integrity and quality of care, where honesty, compassion, and empathy towards clients are paramount." (*A Half Century of Hope: 1968-2018,* Pregnancy Center Service Report, 3rd Edition)

You can be confident that you are a professional organization within the field of CISM if you use volunteers (and staff emerging from volunteers). Call them whatever you want, but train them well in pregnancy crisis intervention. As research, experience and resources develop, help your team identify themselves as specialists within the field of crisis intervention.

LESSON 2: By both definition and by presenting characteristics, PHO's are in the business of crisis intervention or critical incident stress management (CISM). See yourself as a part of this professional field of service.

The main questions we are seeking to answer is: *What do we learn from the professional field of Crisis Intervention, or Critical Incident Stress Management (CISM) that especially informs the work of pregnancy crisis intervention (PCI)?*



More specifically, what is the textbook understanding of crisis? What are the presenting characteristics? And how does the answer stack up to what we see every day in a PHO?

The textbook, *Crisis Assessment, Intervention and Prevention*, describe the human experience of crisis:

> "People are in a state of crisis when they face an obstacle to important life goals—an obstacle that is, for a time, insurmountable by the use of customary methods of problem-solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at solution [sic] are made."

All of us working in a PHO not only recognize this definition of crisis, but we also recognize the presenting characteristics as well. In Helping People in Crisis, Douglas A. Puryear writes,

> A state of crisis is characterized by:
>
> 1. ***Symptoms of stress*** The person in crisis is experiencing both psychological and physiological stress in ways that can include headaches, depression, anxiety, bleeding ulcers, etc.
> 2. ***An attitude of panic or defeat*** A person who has tried every way he can to solve a problem and has failed feels overwhelmed, inadequate, and helpless. He will tend to be either agitated, with unproductive behavior. . . or he will tend to be apathetic (retreating into bed or into a drunken stupor).
> 3. ***A focus on relief*** In this state, a person is primarily interested in relief of the pain of stress—the headache, the depression... There is little gathering or noticing of new facts or new ideas, and little organized effort at problem-solving. Relief will generally be sought by discharge behavior, withdrawal behavior, or turning to others for rescue.
> 4. ***A time of lowered efficiency*** In this state, a person may continue to function normally, but his efficiency is markedly lower, and those problem-solving efforts that persist are inefficient.
> 5. ***A limited duration*** People cannot exist in this state for long—it is unbearable. It will end and a state of equilibrium be regained within a maximum of six weeks.

By both definition and by presenting characteristics, our PHO's are in the business of crisis intervention or critical incident stress management (CISM). If you want to help someone prepare for PHO work, encourage them to get a degree in CISM. I wrote PCI in part to provide teachers and trainers a textbook for our area of expertise within the larger field of CISM, since at this point, our work is not recognized in CISM textbooks.

Not only should we identify with CISM as our professional field of work, we ought to see ourselves as leaders within this field. Why do I say this? Because pregnancy-related crisis is the most common experience of crisis in the world today.

Guttmacher's ***Fact Sheet, Global Incidence and Trends*** reports that "during 2010–14, an estimated 56 million induced abortions occurred each year worldwide." This number includes many estimates, not actual data. My review of the data suggests worldwide abortions are closer to 30 million a year than 56 million. But either way, it suggests that pregnancy-related crisis is the *most common* experience of crisis in the world today.

Remember, people generally will not live in a state of crisis more than 6 weeks before they take some action, even desperate action, to end the unbearable emotional disequilibrium that they are experiencing. Over 30 million women a year see abortion as the quickest way to end their pregnancy-induced crisis.

This is our mission field. You and your PHO are in the CISM business! Understanding the presenting characteristics of those in a pregnancy related crisis and understanding what to do and say when it matters most will determine your

effectiveness. Keep sharpening your training. Keep sharing your insights. That is how a crisis intervention movement grows into a profession.

LESSON 3: People experience crisis as a crisis of *faith*.

The most surprising discovery I made in researching textbook CISM and comparing it to our PHO work, was seeing that effective intervention, according to secular, professional standards, requires a sensitivity to spiritual thing. Why? Because all people experience crisis as a crisis of *faith*.

In the secular textbook, *Crisis Intervention Strategies*, we read:

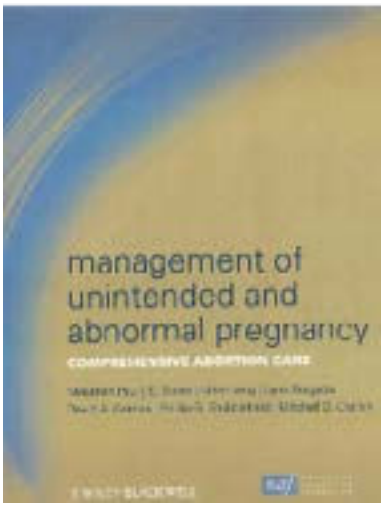
> Faith plays a huge role in the outcome of a crisis as people attempt to make sense of events that seemingly make no sense at all. Faith plays a large part in how people try to come to terms with a randomly cruel universe that crashes down on the notion of a supreme being that runs a just and moral world.
>
> Many human services workers regard it as an exposed electrical wire, not to be touched on pain of death for fear they will be seen as either proselytizing for their religion or insensitive to other spiritual beliefs[;] however, to deny or act as if religion, faith, or spirituality are not part of any crisis, is to neglect a large part of a crisis response for most people… it is interesting that little space is given to the effects that religion has in the counseling business. Yet for most people trauma is the ultimate challenge to meaning making, and for most people, that meaning making is attached to some kind of faith.

The critical truth here is that if you are going to help women and couples in crisis, you should be willing to ask or explore matters of faith. Not because your agenda is to proselytize, but because people in crisis are asking these questions and "faith plays a huge role in the outcome of a crisis."

According to the Bible, abortion is always a crisis of *faith*. "You want something but to not have it, so you kill. You do not have because you do not ask God. (James 4:2). Or as John Piper says, "Abortion is a substitute for prayer."

So much of pregnancy crisis comes down a basic struggle between fear and hope (faith). It comes down to "I see no way possible!" or "It will work out." (God will make a way). Why do people not abort twins? No one plans or prepares for them. Because outside of a crisis, people simply believe things will work out and they adjust. This is why people don't come home and kill one or two of their kids when the lose their job. They assume (have faith) that a new way will open for them to feed their kids, even if they cannot see it at the moment.

Professionals within CISM recognize that people are religious in nature and that for many people their faith is a big part of how they are processing the crisis. Women in pregnancy crisis are, more often than not, praying, pleading, bargaining with God. They are full of God-questions regarding right and wrong and guilt and shame and what God is doing in their lives.



It is not required of us to ask questions like, "Tell me about your faith. Where is God in this crisis?" But it is entirely appropriate to do so and good crisis counselors will feel free to do so.

Exploring matters of faith, beliefs, heart-values, even praying with or providing biblical promises where appropriate and as requested are a legitimate part of good CISM. That what the textbooks say. That is what love also teaches us to do.

LESSON 4: Abortion Training textbooks know what is ethically required in counseling prior to abortion. Though abortion businesses do not follow their guidelines, we should.

Finally, let's consider what the abortion training textbooks teach about pregnancy crisis intervention counseling.

For example, consider *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*. This major textbook is endorsed by the National Abortion Federation. There are two lessons that seem especially relevant to us, and even more powerful coming from abortion-training textbooks.

#1: The principle (doctrine) of informed consent is the ethical foundation for all medical procedures.

Conversely, despite the disquieting elements of a medical procedure and its risks, it is unethical to withhold or shield

people from a full explanation of treatment and establish explicit consent.

So says the textbook, *Comprehensive Abortion Care*:

> Informed consent must include three elements: (1) patients must have the capacity to make decisions about their care; (2) their participation in these decisions must be *without coercion or manipulation*; and (3) patients must be *given appropriate information* germane to making the particular decision. The goal of the informed consent process is to protect personal well-being and individual autonomy by providing information on the procedure, risks, and alternatives to the medical intervention being considered.

Grounding your counseling in the principle of informed consent not only justifies educating women and couples considering abortion about the procedure and possible negative physical and emotional consequences, it *obligates* us to do so. It also makes it right for us to assure women that it is illegal and unethical to be *forced* into a medical treatment they do not want (consent to).

The pressure imposed on a woman to abort is a major risk factor for PTSD according to abortion training textbooks. If she is being threatened or coerced, or if she perceives that she is being manipulated into doing what she does not truly want to do, then she is exposed to a much higher risk of trauma after the abortion. Mandy's story should never happen.

> My boyfriend did not change his opinion with regards to my pregnancy: I was to have an abortion…A *doctor* joined and he too said: 'It is better to have it done…the father does not want it.' I was not to think about myself, not to be selfish… When I finally got the strength to get up and leave, I felt broken.

#2: Proper pregnancy counseling requires screening for risk factors predictive of after-abortion trauma.

Comprehensive Abortion Care has a section titled, "Risk Factors for Negative Emotional Sequelae" It lists 18 risk factors that should be screened for as part of pre-abortion counseling, all of which are predictors of after-abortion trauma.

Among the 18 risk factors there are 2 that are especially noteworthy for PCI counselors. The first one has already been mentioned, **"Perceived coercion to have an abortion."** I will only add the insight of Dr. Martha Shuping. She writes, "Studies show 11% to 64% of women experience coercion or pressure in abortion decision. If 11% of abortions are coerced, that would mean that more than 6 million abortions in U.S. have been coerced since 1973."

The second noteworthy risk factor that abortionists are trained to screen for is **"Attachment to the pregnancy."** Maternal-Fetal Attachment (MFA) refers to the "emotional tie or bond that normally develops between the pregnant woman and her unborn infant." Over seventy years of research, involving women from diverse cultures, confirm that MFA is a universal experience, even for those intending abortion. Dr. Martha Shuping survey of MFA reaches the same conclusion that abortion training textbooks warns about. "The degree of bonding that is established during pregnancy is predictive of the degree of emotional distress and trauma symptoms that are experienced after the abortion."

There are further insights from CISM textbooks that I have not introduced here, but ought to be integrated into your training. There are also a few corrective lessons from textbook CISM that we ought to listen to and discuss as a PHO movement. To learn more, see is *Pregnancy Crisis Intervention: What to Do and Say When It Matters Most* (Hendrickson, 2019).

John Ensor is president of PassionLife, where he trains missionaries and indigenous Christian leaders in biblical bioethics and pregnancy crisis intervention in countries suffering the highest rates of abortion worldwide. His newest book is Pregnancy Crisis Intervention: What to Do and Say When It Matters Most.