Psykologiliitto

THE FINNISH PSYCHOLOGICAL ASSOCIATION AND THE FINNISH PSYCHOLOGICAL SOCIETY, SCIENTIFIC COMMITTEE

Psychological work in acute crisis situations – a recommendation for good practice

Definition

Psychological work in acute crises, here referred to as acute crisis work, means providing fast psychosocial support during a certain period of time to individuals and communities facing a sudden traumatic event. A sudden traumatic event generates a process of adaptation in all those involved. This adaptation process commands the use of all psychological, and even physical, resources. The consequences of such acute events are also felt by those close to the people involved and by the whole community.

The treatment of psychological damage caused by long-term traumatic experiences, such as abuse, maltreatment or neglect, or the psychological guidance or treatment related to developmental crises or difficult life situations are not regarded as acute crisis work.

In Finland, a specific working model has been developed for the implementation of acute crisis work. The working model is described in appendix 1. This recommendation deals with the implementation of the model and it is based on the expert data accumulated through it. The recommendation also integrates research data concerning acute crisis work (,reviewed in appendix 2). Appendix 3 presents evaluation data on the practical efficacy, effects and effectiveness of Finnish crisis work.

The implementation of and requirements for acute crisis work

1. Individuals who have been exposed to sudden, traumatic events or have suddenly lost a loved one should have access to psychological first aid.
2. Psychological first aid should be offered actively and it should be administered as soon after the event as possible.
3. When deemed appropriate in the situation, all those involved should be provided with the opportunity to discuss the traumatic event during a group session (early psychological debriefing).
4. The assessment of the situation should be carried out by experts with appropriate training and it should be based on experience and research evidence.
5. The efforts to help those involved deal with the sudden traumatic event must not become an additional burden on the participants.
6. Psychosocial support should be based on a mutual understanding with those in need of the help. The form in which and the extent to which the support is provided should match the nature of the event and the stage reached in the psychological adaptation process.
7. The psychological debriefing concerning the event and the thoughts and emotions raised by it should take place in natural groups and communities, such as a family, an extended family, a working community, a circle of friends, or a school class.The composition of the groups and how the participants are determined should be negotiated, in accordance with the situation, between the different parties, and the opportunity to participate should be actively offered.

Suomen Psykologiliitto ry
The Finnish Psychological Association
Bulevardi 30 B 3
00120 Helsinki
Tel. +358 9 6122 9122
Fax +358 9 6122 9161
www.psyli.fi
www.facebook.com/Psykologiliitto

8. While the support provided is based on the stage of the psychological adaptation process and the experience and research evidence related to it, individual paths and variation in adaptation should be recognized and taken into consideration.
9. When acute crisis work is extended to supporting the later stages of a participant's psychological adaptation process on an individual basis, this should be based on an assessment of the need for follow-up care and the formation of a mutually agreed client relationship.
10. Support in later, longer-term stages of the psychological adaptation process can also be realized as professionally guided peer support.
11. When the need for follow-up care has been established, the transition from acute crisis work to the psychosocial aftercare of a sudden traumatic event should be well planned and seamlessly carried out. Information should be transferred to the aftercare professionals in a flexible manner and in compliance with the client's right for the protection of his/her privacy.
12. As many social welfare and health care professionals as possible should have the skills and abilities required for administering psychological first aid as part of acute crisis work. Early psychological debriefing is a demanding method and it also requires, in particular, training in how to lead a group discussion.
13. The working methods used at the later stages of the psychological adaptation process require the ability to assess an individual's psychological status. The implementation of these methods requires that the professional has specialized training and knowledge in the methods of crisis and trauma therapy and in professionally lead peer support.

Recommendations for developing acute crisis work

1. Municipal service systems should guarantee sufficient financial resources and the special knowledge and skills required for providing immediate psychological crisis work. They should also be prepared to provide and direct additional resources as needed.
2. The research concerning sudden traumatic events should not only concentrate on the development of reactive disorders but should also involve studying the prerequisites for a successful process of psychological adaptation and the interventions supporting such prerequisites. Research methods and designs should be developed in such a way that the nature of the events and of acute crisis work are taken into consideration.
3. A centre for the development of crisis and trauma psychology work is needed in Finland. It could be established within the National Institute for Health and Welfare as proposed by the Working group of the Finnish Ministry of Social Affairs and Health. The centre should have adequate expertise in crisis and trauma psychology.
4. If a permanent working group of experts is set up within the Ministry of Social Affairs and Health, crisis psychologists should have adequate representation in it.
5. A basic knowledge of crisis and trauma psychology should be included in the training program requirements for all psychologists. This would guarantee that psychologists in all the different fields of application have knowledge and skills in crisis psychology.
6. The specialization training programs for psychologists should provide an opportunity for psychologists to specialize in crisis and trauma psychology.
7. The psychologists who do acute crisis work should be guaranteed the chance to continuously follow the developments in the field and to receive the supplementary training and work supervision that are required for maintaining their professional expertise and personal well-being.

Appendix 1
Salli Saari, Tuula Hynninen

A description of the psychological aid provided in Finland in the case of acute crises and traumatic situations

In this context, crises and traumatic situations refer to sudden traumatic events and to the psychological adaptation processes that follow such events. The actual crisis and trauma treatments are not discussed here. The phase under examination is called acute crisis work.

This presentation also covers, divided into two categories, the goals of the psychological interventions that are conducted at this phase: the psychological goals and the macro-level, i.e. societal, goals.

The way psychological crisis aid is implemented in Finland at the acute phase differs somewhat from the way crisis aid is implemented elsewhere in Europe or across the world. This presentation also provides a short overview of the most relevant of those differences.

The history of acute crisis work in Finland

Finland has a unique working model for acute crisis work in the case of accidents and other sudden traumatic events. A network of local (municipal) crisis groups covers the whole country and provides the victims of traumatic events with psychosocial support and services immediately after the event. In the work of the crisis groups, a major part of the attention is directed at traumatic events of the everyday life, but their work also covers major accidents and disaster situations. To our knowledge, no other country has an equivalent network of crisis groups designed specifically to handle everyday events.

A working model for crisis and disaster psychology was brought to Finland from Norway in the late 1980s and the early 1990s. The Norwegians had adopted the model from the United States and it was based on the development work conducted by Jeffrey T. Mitchell (Mitchell, 1983, 1993). In Norway, the CISD (Critical Incident Stress Debriefing) method developed by Mitchell was modified and its scope of use broadened by Atle Dyregrov, who in 1989 introduced the term ”psychological debriefing” (Dyregrov, 1989, 1994, 1997). The broadening of the scope of use meant that the method was from then on applied in handling the psychological reactions of the family members of victims who had died in accidents. When the method was adopted from Norway to Finland, its scope of use was broadened further. In Finland the debriefing method has been used in helping all the different groups of psychological victims of sudden traumatic events (Saari, 2000).

The first Finnish crisis group engaging in acute crisis work began its work in Pietarsaari on January 1, 1990, lead by Krister Andersson, a health centre psychologist. The working model quickly spread throughout the country, first to the Swedish- and Finnish-speaking parts of Ostrobothnia, the Oulu region, and North Carelia, and then to the rest of the country. The final breakthrough of crisis work happened after the sinking of M/S Estonia in 1994. The greatest number of crisis groups were founded around that year. The bigger cities of Finland, such as Turku, Tampere, Vantaa and Helsinki, were the last ones to get organized.

The central driving force behind the founding of local crisis groups has often been a traumatic local event. Examples of this include the school bus accident in Kitee and the hostage crises in Mikkeli and Lahti. By the end of the 1990s, a comprehensive network of municipal crisis groups had been created in Finland, most of the groups established in affiliation with local health centres. It could be said that no other working model has ever made as swift a breakthrough as the work of the crisis groups has. It is notable that the Finnish crisis groups are also prepared to respond to traumatic events of everyday life,

which enables a quick supply of aid and facilitates preventive work. Even Norway has not been able to create a network of crisis groups consisting of local authorities that is this comprehensive.

It is also notable that the development of crisis work took place without guidance from the legislation or the central government and without earmarked funding. The entire development of crisis work in Finland has taken place on the grass-root level, the drive for it generated in the field, following the ”bottom up” principle (Hynninen, 2007). Only afterwards, or partly side by side with the developments described, did recommendations, guidelines and the legislation supporting the work emerge. Crisis work had been active for almost ten years before the legislation requiring it entered into force in the form of the new Rescue Act and Degree in September 1999.

It is also worth noting that crisis work was developed in municipalities during or in the aftermath of economic depression – at a time when preventive mental health care work was generally overshadowed by the so-called remedying work.

At the moment, acute crisis work has been conducted in Finland for almost 20 years. The country has a comprehensive network of local crisis groups, which are for the most part affiliated with local health centres. A National Research and Development Centre for Welfare and Health (Stakes) study on the present-day state of the crisis intervention system states that in 2005 already 89 percent of the Finnish municipalities had organized acute crisis services principally so that the municipality had its own crisis group or shared one with the neighbouring (joint organization) municipalities (Hynninen & Upanne, 2006). In addition, Finland has 17 crisis centres organized by the Finnish Association for Mental Health and a few municipal crisis centres.

Today, organizing and providing psychosocial support and services in Finland is regulated by legislation. The Rescue Act (468/2003) and Decree (787/2003, section 6) lay down provisions on the organization of services: the offices and institutes responsible for different areas of authority within municipalities or joint municipal authorities are responsible, in accordance with their area of authority, with the division of work between different bodies, and with the legislation governing municipalities, for organizing, in cooperation with other experts, psychosocial support and services for those who as victims, as family members of victims, or as rescuers have been involved in an accident. More specific instructions have been provided in the working group memo 1/1998 of the Ministry of Social Affairs and Health, titled ”Psychosocial support and services in traumatic situations”. This memo has just been updated (*Psychosocial support and services in traumatic situations*, a working group memo, Ministry of Social Affairs and Health, reports 2009: 41).

The goals of acute crisis work

A. Psychological goals

The psychological goals of acute crisis work are determined from two directions. In general, studies show that the majority, about two thirds of people, can handle a sudden traumatic experience on their own and with the support given by the social network surrounding them without developing psychological dysfunctions or receiving help from experts. These survivors have resilience (Friborg & al., 2005; Masten, 2000; Bonanno, 2004; Agaibi & Wilson, 2005), i.e. mental stamina or persistence.

This we find when examining cross-sectional studies, but resilience is a trait that can be developed. For resilience to develop, the following is required:

- One experiences difficulties and setbacks in one’s life to a suitable extent

- When faced with a difficult situation, one receives sufficient guidance and support to deal with it
- One discovers that one can handle difficulties and develops confidence in one's ability to cope.

Each sudden traumatic event one lives through enables resilience to develop, if enough guidance and support are received.

A sudden traumatic event generates a process of adaptation that makes use of all mental, and even physical, resources. Such a situation can create uncertainty about the sufficiency of one's own resources to cope with it. One's self-confidence and self-esteem are under a lot of strain and can be easily shaken.

A sudden traumatic event can raise thoughts and feelings that are difficult, even impossible, to face and deal with. For this reason it is psychologically a very challenging task to try to integrate the experience into one's own life history and, through that, to make it into a sound part of one's own personality. Initiating and advancing this process of integration and reducing dissociation through it is what crisis aid aims to do.

In other words, the psychological goals of acute crisis work are:

- to develop resilience (mental stamina, persistence)
- to maintain and support self-confidence and self-esteem (self-efficacy, Bandura, 1997)
- to initiate and advance the integration of the traumatic experience

B. Societal goals

- to reduce human suffering
- to promote the ability to work and function and to reduce the need for sick leave
- to reduce the need for medication and to decrease drug costs
- to reduce the need to use health-care services
- to reduce temporary or permanent work disability

Description of the working principles and methods of acute crisis work

C. The working principles central to the efficiency and effectiveness of acute crisis aid are

- the right timing of the aid, requiring that
- help is actively offered by the first-line aid workers
  - the person is requested a permission to contact him/her later
  - no psychological needs assessment by the first-line aid workers
- the right approach at the right time
- the right "dosing" of help
  - the events are dealt with in accordance with the person's ability and willingness to process them at the time

D. The timing, choice of approach and dosing of acute crisis aid are based on the process and stages of psychological adaptation

The stages of the adaptation process are (Saari, 2000; Cullberg, 1991):

i. Psychological shock:

is a defence mechanism, which is almost always present when one is in a traumatic situation or hears something shocking

- a defence reaction of the mind: the mind protects itself against a piece of information or an experience that is too much for it handle
- lasts for as long as the stressful or threatening situation continues
- the ability to function is retained
- the duration of the state of shock is also determined by how traumatic the events are: the more traumatic the situation, the longer the state of shock will persist

ii. The reaction stage

- requires that one is safe
- one becomes aware of what really has happened and what it means to oneself and to one's life
- strong thoughts and emotions
- a lowered ability to function
- the mind is open; regular defences are not yet functioning

iii. The working-through stage

- the goal is to distance oneself from the traumatic experience; defences are functioning again
- the process is slowing down
- a thorough, time-consuming process of dealing with and working through one's thoughts and feelings
- the adjustment of goals and tasks to the lowered ability to function

E. Selecting the approaches and methods of crisis work in accordance with the stages of the adaptation process

i. The shock stage – psychological first aid

The following is essential to psychological first aid:

- The opportunity to go through the events in one's mind as many times as needed. This requires information about the event. It can be based on one's own experiences (one has been involved in the event) or on what one has heard from the authorities, the media, or others involved.
- Psychological support: active listening, being at the receiving end of reactions, containment, keeping the conversation open (questions open the conversation, whereas comforting, taking a stand or expressing an opinion may close it)
- Improving predictability by helping the person to prepare him/herself for events and reactions to come (psychoeducation)
- Concentrating on the support, not discussing feelings at length or depth

ii. The reaction stage – early intervention (early psychological debriefing)

Psychological group debriefing concerning the event and the feelings and thoughts it has given rise to, taking place in natural groups (a family, an extended family, a working community, a circle of friends, a school class etc.). The following is essential to early intervention:

- the right composition of the group, i.e. "the common denominators" between group members, for example being members of the same family, working at the same place, having had a similar role during the accident

- forming the groups based on exposure, on maximizing social support and on the importance and degree of difficulty of sharing
- identifying and responding to the needs of group members
- the courage and skills to deal with difficult thoughts and feelings and to dissolve cognitive fixations
- making use of the group process
- the right pacing of the group sessions, taking into consideration the participants' needs and their ability to receive input and work through things (the right dosing of aid); group sessions as needed
- identifying those who need further support and directing them to appropriate services
- very demanding in terms of the skills and abilities required of the group leaders

iii. The working-through period – crisis and trauma therapy, professionally lead peer support

Working through longer-term, partly subconscious and also physical, reactions and memories using the methods of trauma therapy.

- processing feelings that are not easily reached through speech (traumatic memories which have been saved in a non-lingual form) by means of, for instance, EMDR (Eye Movement Desensitization and Reprocessing, Shapiro, 1995)

Professionally lead peer support, which allows those who are in a similar position or have gone through similar experiences to share their experiences under the guidance of a crisis work professional (Saari, 2006; Dyregrov et al., 2009). Essential in this peer support:

- forming groups so that they are as homogenous as possible with respect to the experience, the participant's position in his/her family, age etc.

Peer support requires that:

- there is a wealth of preliminary information on those participating in the peer support sessions
- the population is big enough to enable the forming of homogenous groups
- the peer support process is carefully planned with respect to choosing the meeting times, the central themes, the methods, etc.
- the group leaders have expertise and commitment

Phenomena on different levels of the psyche can be reached and dealt with at the different stages of the adaptation process and by using different methods of crisis work. Therefore, good crisis aid should at a minimum include the offering of psychological first aid and early intervention to all those individuals, who have been exposed to a sudden traumatic event or have suddenly lost a loved one. As for intervention at the working-through stage, an assessment for the need for it should be made based on the early intervention. An exception to this is peer support, which should be offered to all those involved.

On the significance of interaction during acute crisis work

Early intervention (psychological debriefing) is essentially group-based. Crisis aid that is given on an individual basis is lacking many of elements of good crisis aid. Through group sessions the victims get to experience that their reactions are not ”abnormal” but that instead many others may have the same type of reactions (normalisation). Sharing experiences with others who have been through the same or with people close to oneself is considered empowering. Group sessions have an important role in enhancing social support after a traumatic experience. Working through the events in natural groups (for example families) encourages and improves the ability of the family to discuss and work through the

events amongst themselves also in the future. Debriefing that takes place in a group may also be easier and less taxing than individually working through the events.

The effectiveness and efficiency of acute crisis aid require that the interaction between the crisis workers and those involved in the events works well. At the different stages, crisis workers have to accurately identify and pay attention to the needs of those involved. Those needs are different at the different stages of the adaptation process, meaning that also the interaction between crisis workers and those involved in the events is different at different stages.

During the shock stage, it is essential to give the person all the space possible. This can be achieved by listening actively and being present and ready to help. Central to this stage is that the worker must be able to deal with the strong feelings of those involved and to remain calm while receiving them, thus creating a feeling of safety to an anxiety-inducing situation (Saari et al., 2009).

During the reaction stage, it is essential that the crisis worker is able to identify the fixations and locks impeding the psychological processing of the events by those involved, that s/he has the courage to bring them up actively, and that s/he is thus able to help in working through these fixations and locks. At this stage, the crisis worker must be active and help those involved become aware of the reactions, thoughts and feelings generated by the traumatic experience. Since the experiences are usually worked through in groups, the crisis worker is also responsible for promoting the interaction and mutual support between the group members.

During the working-through phase the demands for the interaction are approaching, with reference to their nature, the kind of interaction that is in play during psychotherapy. In this case it is notable, however, that the focus is on the traumatic event and the feelings caused by it. People involved in traumatic events have the tendency to avoid mental suffering and they may therefore avoid dealing with the event. The crisis worker is responsible for making sure that the thoughts, feelings and physical reactions brought forth by the event are faced and worked through to a sufficient degree but in a safe manner.

The dangers/risks involved in acute crisis work

Effective and efficient acute crisis work is in many ways different from conventional mental health care work. The dangers involved in crisis work are different at the different stages of the adaptation process. Because different kind of help is required at different stages, the wrong timing of aid will make it ineffectual and will not feel good to those involved. The correct dosing of the aid is also important; big dosages of aid administered too soon will reduce the effectiveness of crisis help.

During the shock period, active listening, a peaceful presence, ”being there” and the ability to calm others down are helpful. The process of working through the trauma should not be initiated during the shock stage, because those involved are not yet capable of dealing with the events on a deeper level. If early intervention (psychological debriefing) is timed too early and during the shock period, it will be ineffective.

In professional crisis work the working-through process of a traumatic event is also not initiated when the threatening or stressful situation is still continuing. Doing so could harm the patient (the necessary defences are broken). If, for example, the patient is being treated at a hospital for a physical injury, the threatening and stressful situation is still continuing and the stage of shock is still persisting.

One of the central threats during the shock stage is that the helper may not be able to deal with the strong emotions of those involved but may instead start to invade the space by recounting his/her own

experiences, by taking a stand, or by giving comfort too early. This means that the individual involved in the traumatic event cannot sufficiently deal with his/her own thoughts and feelings and thus cannot work through them. Having inadequate skills in receiving and containing feelings and reactions makes it impossible to help others and may cause those involved to close up and feel hurt.

There is also a danger of turning cold and cynical, since the event has to be kept distant enough from oneself in order to cope with it. Aid workers may end up sheltering themselves from strong feelings in order to retain their own balance of mind.

During the reaction stage, problems can be caused by opposition to early intervention: the belief that most people survive on their own, resulting in help being offered only when a dysfunction has already been developed. Also, comprehensively reaching all those in need of help continues to be difficult. Harm can also be done by erroneous criticism targeted at crisis work; such criticism is a threat to the effectual, clinically proven mode of work, as the workers are afraid to act and those who need help are afraid to seek it.

Another possible problem at the reaction stage is passivity in offering aid. Today it is known that avoiding to face and work through a traumatic event is detrimental. A post-traumatic stress disorder turns chronic within three months and is then often accompanied by depression and other psychological disorders, most often alcohol abuse or dependency and anxiety disorder. A dysfunction that is caused by a fresh trauma is easier to treat than chronic or complex post-traumatic stress disorders. Help must therefore be offered actively and as early as possible.

In the case of early intervention (psychological debriefing) it is essential that the timing is right and that the intervention matches the needs of the person in need of help. It is equally important that the group sessions are correctly paced with reference to the participants' needs and their ability to receive and work through things (the correct dosing). The mechanical practice of offering one debriefing session to each family and after that a follow-up contact in about a month's time has long been prominent, but the correct dosing of crisis aid and the identification of the needs of those involved and of their ability to receive input may, in situations that are especially traumatic, mean that several sessions should be organized within a week, for example. If the timing and dosing fail, those involved may close up and withdraw from the sphere of help.

The right timing and identifying the needs of those involved and of their ability to receive input also means that crisis work professionals must be able to recognize strong anxiety and extreme defences (denial, for example), which signify that the trauma cannot yet be dealt with but instead the focus should be on calming the person down and strengthening his/her feeling of safety. On the other hand, if a crisis session is arranged too late, the participants may feel like their old wounds are being ripped open again. In such a case, those involved have already moved on to the working-through stage, during which the methods employed should include crisis and trauma therapies, grief groups, and professionally lead peer support.

The dangers at the reaction stage also include those related to the crisis worker's attitudes or actions that are too passive. Sometimes the workers do not have enough courage to confront the difficult experiences of those involved, leaving them undealt with.

Another problem is neglecting to assess the need for follow-up and further treatment. In Finland the aim of early intervention (psychological debriefing) is to find those in need of further help and direct them to the necessary care services. Correctly timed and sufficient follow-up is necessary for this goal to be reached.

Follow-up sessions should be arranged in accordance with the situation and the needs of those involved. The frequency and duration of the follow-up depend, among other things, on the severity of the exposure. Follow-up can also be handled over the phone with those whom the session leaders are worried about. In the most extreme cases it may be necessary to organize a follow-up contact or contacts six months after the event and also on its anniversary.

The competence of crisis workers is also very important for the quality and effectiveness of the work. Not everyone is capable of doing crisis work. Crisis work requires special skills and training; sound professional abilities play a central role. Not everyone is able to handle crisis work. It requires stress endurance, special commitment, the ability to deal with strong emotions, and a good grasp of situations. For knowledge and experience to accumulate into competence, one needs enough work experience in the field. On the other hand, one cannot continuously keep working in crisis aid, as that may reduce one's sensitivity.

The dangers that are present during the working-through stage are often similar to those present during the reaction stage: one is not able to sufficiently concentrate on dealing with the traumatic event but instead avoids causing psychological pain to a degree that interferes with the process. Often the crisis worker also does not have the means to cognitively handle the traumatic event.

What we know about the efficacy of the methods used in Finland

In conclusion, it can be said that acute crisis work conducted in Finland is based on a synthesis of scientific research in the field, international Current Care recommendations, consensus reports and, above all, a broad and multi-faceted clinical experience. No methodological starting point or method is based on research concerning just itself, but instead research findings (e.g. Holen, 1990; Dyregrov, 1998; Raphael, 1986; Yule & Joseph, 1997) have been used to further develop the methodology. This is also the case with, for example, the development of early intervention, along the course of which the findings on psychological debriefing presented in the Cochrane review have been considered, among other things (see e.g. Hobb et al., 1996; Bisson et al., 1997; Wahlbeck, 1999). Because of this, crisis work in Finland never consists of just one session. The timing of the session is paid special attention to and the issues, thoughts and feelings are only dealt with to a point that is allowed by the participants' psychological state. The ability of the session leaders to work through and handle thoughts and feelings is emphasized, as is their command of group dynamics. Thus, early crisis work in Finland contains a lot of the elements of cognitive psychotherapy, which research has found effective.

According to good practice, the timing and contents of crisis interventions in Finland are determined by the different stages of the psychological adaptation process. This process and its stages have been developed in accordance with the theory of the different stages of crisis developed by the Swedish psychiatrist Johan Cullberg (1991) on the basis of his clinical experience. These stages have in Finland been adapted to the adaptation process following sudden traumatic events. This theory has not been scientifically proven, either, but it has been shown to work in various situations where the process of adaptation has been monitored from the early hours. It has also been shown to work countless times during training sessions, during which people have been retrospectively going through their own experiences (client feedback).

The differences between Finnish and international practice

Finland is the only country where the events following a sudden traumatic event are, for the purposes of crisis work, broken down using the process and stages of psychological adaptation described above.

Internationally, it is customary to refer to "immediate reactions" and "long-term reactions", meaning that crisis work is described as immediate crisis help and mid-term and long-term help. Little, if any, attention is given to the correct timing of interventions, let alone the correct dosing. The connection of the methods used in the interventions to the crisis process is loose or non-existent. The methods are often used in a rigid manner, and the discourse is focused on whether a method should be used or not, not on how it should be further developed on the basis of research findings. This is certainly partially related the fact that the majority of those who do and are responsible for crisis work are not psychologists but social workers, priests and ministers, nurses, doctors, psychiatrists, rescue workers, and police officers, and they are thus not able to develop a foundation of psychological theory for the work or approaches and methods based on that foundation. Finland is the only country where psychologists occupy a leading position in crisis work.

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Appendix 3
Tuula Hynninen

What kind of evaluation data has been gathered on the practical efficacy, effects and effectiveness of Finnish crisis work?

Research on crisis and trauma phenomena is scattered and small in scale in Finland. However, there are individual, well-conducted targeted studies, research potential does exist and progress has also been made in the area of development. The research that has been conducted has been useful to the development of practices, but no single research group large enough and working on an international level has been created. (Lönnqvist, 2006; Lankinen et al., 2006).

So far, the crisis and trauma research done in Finland has been based on very small data sources. In addition, a majority of the research has been retrospective and has started out late. The need for research has often been generated *ad hoc* (cf. the factory explosion in Lapua, the sinking of M/S Estonia, the Myyrmanni bombing, and the tsunami of 2004), and various researchers and groups have conducted practical case reviews. The organization of a progressive follow-up study has so far not been successfully achieved in Finland. It is difficult for a small-scale ad hoc study to compare well on the international level. (Lönnqvist, 2006; Lankinen et al., 2006).

In Finland the responsibility for handling crisis situations is based on collaborative networks and the division of responsibility is rather disjointed. On the administrative level, the Ministry of Education and Culture is responsible for research, but it is not directly jointed to crisis or trauma situations. The Ministry of Social Affairs and Health has duties concerning the coordination of psychosocial support, and the Ministry of the Interior is responsible for administration in crisis situations. None of these authorities have thus far forcefully promoted the need to produce research on traumatic situations. (Lönnqvist, 2006; Lankinen et al., 2006).

The crisis and trauma research that has been done in Finland has not been based on randomized controlled group comparisons. Randomized experimental group comparisons do not lend themselves well to assessing psychological practice, one of the reasons for this being that it is not ethically acceptable to leave a person who has experienced a traumatic event without help. In their work, psychologists use methods of which the effects and successfulness have been demonstrated through clinical experience and other study designs and which can thus justifiably be offered to the aid of clients. Most Finnish studies concerning acute crisis work have produced results supporting crisis work (early crisis interventions).

Evaluation data on the practical efficacy, effects and effectiveness of Finnish crisis work

The following is a description of the existing evaluation data concerning the practical efficacy, effects and effectiveness of Finnish crisis work. The description is organized into the categories of good description practice as defined by the National Institute for Health and Welfare with reference to evaluation data (National Institute for Health and Welfare, 2009). Following this model, first to be described is the kind of *professional data*, i.e. views, experiences and evaluations obtained and formulated in the practice of crisis work, which have been documented by the crisis workers themselves or gathered through group interviews or surveys. Next described are the *clients'* or users' experiences, views and evaluations on the practices of crisis work; these are gathered e.g. in the context of client work or through group interviews and/or surveys. Thirdly, data produced through the methods of the *study of effectiveness and evaluation* on the practices of Finnish crisis work are described.

The following description provides examples of each type of evaluation data. It is thus not meant to cover all the existing evaluation data on Finnish crisis work. Where possible, the descriptions of evaluation data include the time when the data have been gathered, the phases of data gathering and the methods used in it, and information on what the data gathered on the practical efficacy, effects and/or effectiveness reveal (positive and negative results).

Professional data

Professional data include the documented views, experiences and evaluations generated in the practice of social or health care work, which have been gathered from the notes of the workers themselves and through group interviews and/or surveys. Included are the clinical experiences concerning the effects of early crisis interventions and professionally lead peer support on the receding of symptoms and on the pace of the psychological adaptation process following a traumatic event.

> **Example 1. A year after the catastrophic tsunami in Southeast Asia, clinical experience in Finland showed that those individuals who had received help in the form of early intervention were feeling better than those who had not received early crisis aid.**

Among the sources for experiences on the usefulness of early crisis aid were the crisis groups offering psychosocial support in Helsinki. Their experiences showed that those individuals who only started receiving crisis help six months after the accident or later were faring worse psychologically and were at much earlier stages of the psychological adaptation process than those who had started receiving crisis help soon or fairly soon after the accident (Halinen, 2005; Lankinen, 2006).

> **Example 2. Also the peer support organized by the Finnish Red Cross emergency group of psychologists after the disaster in Southeast Asia showed that those who had received help in the form of early intervention were faring better than those who had not received early crisis aid.**

The clients who only came to the second peer group session (held eight moths after the accident) were considerably behind in their process of psychological adaptation compared to those who had entered into the circle of peer support at the first session (approximately five months after the event) (Saari, 2006). The progress of the psychological adaptation process was clearly visible during the group sessions.

In the light of the experience that has been gained, peer support has proved to be successful when the participants have experienced the same traumatic event and when the small groups are homogenous with reference to the loss experienced, the participants' age, and their position within their families. For peer support to be successful, its planning and the leading of groups need to be carefully and professionally executed, the group leaders' level of expertise needs to be high and their psychological resilience strong, and the environment and circumstances need to be favourable and pleasant for both the participants and the group leaders (Saari, 2006; Lankinen, 2006).

Client/user data

Client and user data are constructed using the clients' or users' experiences, views and evaluations concerning the practice. These data can be gathered, for example, in the context of client work and by means of group interviews and/or surveys. The following presents clients' experiences and evaluations concerning the usefulness of professionally lead peer support after three major accidents in the 2000s.

Example 1. In Finland, peer support was used for the first time in the context of a major accident after the explosion in the Myyrmanni shopping centre (Poijula, 2004). After the Myyrmanni events, peer support services were set up when the first survey of a study examining how the Myyrmanni victims had handled the crisis revealed that only a small percentage (5 %) of the respondents had received support from other victims. When the victims and family members expressed their need for a peer support meeting, the City of Vantaa assumed the responsibility for organizing it and in September 2003 the "Life after disaster" seminar was held for the victims of the Myyrmanni explosion and their family members. The seminar had 60 participants – victims and family members – 11 of whom were children or adolescents. The seminar program included a morning concert for the memory of those who had perished in the explosion, followed by introductory lectures by representatives of the City of Vantaa, the Myyrmäki Fund and the State Treasury and speeches by victims and family members. Also during the morning program, a picture letter sent by a victim living abroad was presented to the children, the results of the first part of a survey concerning the victims and their family members were introduced, and overviews of the rescue operation and the criminal investigation were given. In the afternoon the participants talked amongst themselves, and at the end of the day they compiled a statement for the media. A professionally lead trauma and grief intervention was provided for the children and adolescents, during which drawing and discussions in groups were used to go through the event, the feelings generated by it, and the topics of hope, recovery, and being helped.

Based on the feedback information received after the Myymanni explosion, those who had participated in the first peer support session considered it useful that an opportunity to meet had been arranged and were hoping for another similar opportunity to meet each other again. The second peer meeting of the victims and family members was organized in April 2004. Approximately 40 adults and 20 children participated in it.

Example 2. The Finnish Red Cross organized, for the first time, peer support sessions lead by crisis psychologists for the families of those who had died in the traffic accident in Konginkangas and for those who had been injured in the accident and their families. The number of casualties in the Konginkangas accident was so high that it was possible to arrange group support for their families.

The goals of the peer support following the accident in Konginkangas were to support healthy recovery in traumatic crisis and grief, to provide guidance on normal crisis reactions (psychoeducation), and the normalisation of the situation. In addition, the peer groups made it possible for family members in the same position to share their thoughts, feelings and experiences (Lankinen, 2006).

The working methods employed at the peer support meetings were professionally lead peer support groups and short talks given by the psychologists. The group compositions used were families, children, and groups based on the position of an adult family member (groups for mothers, fathers, siblings, and siblings' spouses). Summary discussions were also held in a large group consisting of all the participants. The peer support sessions were held 3 months, 7 months, 13 months and 26 months after the accident. Some of the peer groups that were formed and of their participants have met with each other also in between the peer support meetings.

The FRC received very positive feedback from the family members of those who died in the accident in Konginkangas and from those who were injured and their families. The family members were especially thankful for the active offering of help in a situation where their own psychological resources had been insufficient for actively seeking help themselves.

According to a study conducted by Riitta Kumpulainen on the efficacy of psychosocial support services after the accident in Konginkangas, the most active providers of continuing support were parishes and the FRC. According to the study, after the support provided by family, relatives and friends it was the peer support groups that were considered the best form of continuing support (Kumpulainen, 2006).

Example 3. The peer support organized by the Finnish Red Cross after the tsunami (Saari, 2006; Lankinen, 2006). In February 2005 the Finnish red Cross made an in-principle decision to channel its domestic aid into organizing peer support meetings for the family members of those who had perished or gone missing during the disaster in Asia. The tsunami disaster was an unusual event also from the domestic perspective: the victims of the traumatic event included not only those who had been in the catastrophe area but also the family members and close relatives in Finland whose loved ones had perished in the event.

Based on the great number of individuals who died in the tsunami, even a careful estimate would place the number of their family members and relatives in several hundreds around the country. However, no government ministry or other authority was preparing itself for working out and taking the responsibility for carrying out the arrangements for psychosocial support for these domestic victims. Because it was likely that the bereaved family members were living in different municipalities than those who had died, it was not possible for the crisis groups of any single municipality to reach and help them in a centralized way in dealing with the traumatic crisis. Some of the family members were victims themselves, having been rescued from the disaster area or injured in the tsunami. Reaching the close relatives and mapping out the need for help required investigative work the responsibility for which was vested in no authority in Finland. The Finnish Red Cross took the task upon itself.

The goal of the peer support meetings was to support a healthy coping process of the participants. The meetings provided the family members and close relatives with the framework for meeting others going through the same thing and with the opportunity to deal with the events and their own situations together with their peers. The goal of the peer support was to support the healthy progress of the personal recovery processes of the family members and relatives in traumatic grief and crisis (holding), to give an opportunity to deal with and compare traumatic events and emotional reactions in peer groups and thus normalise one's own reactions, feelings and thoughts at the different stages of recovery, to deliver information on the stages of recovering from a traumatic crisis and on traumatic grief (psychoeducation), to normalise reactions, to increase knowledge of self-care methods (calming the body, relaxation) and, when requested by a participant, to guide and help in assessing the individual need for therapy.

The principle for forming the groups was that those who had been in the disaster area and those who had been in Finland were always in separate groups. Adults, children and adolescents had their own peer groups. In addition, groups as homogenous as possible with reference to the participants' positions in their families, the nature of their loss and their life situations were formed. The following groups were formed: children who had been in the disaster area, children who had remained in Finland, those who had lost all their family members, parents who had lost a child, widows and widowers, mothers-grandmothers, fathers-grandfathers, siblings, siblings' spouses, and so on.

The peer support was realized through five weekend groups (Fri-Sun), each with approximately 60 family members or relatives of those who had died in the disaster. At least one family member of 70 % of those who had died in the disaster participated in the peer

support meetings. Each group met four times following a set schedule: the first meeting 5-8 months after the tsunami, the second meeting three months after the first meeting (8-11 months after the tsunami), the third meeting around the anniversary of the disaster, and the fourth meeting two years after the disaster. That means that, within two years, 20 weekend meetings were held altogether.

The methods used in the peer support were discussions in professionally lead peer groups and short introductory talks given by psychologists. Summary and feedback discussions were also held during meetings that were common to all participants. In the seminars each group session was started off with a short lecture lasting approximately 15 minutes. The lecture topics included, among others, the shock reaction and waiting, the grief over losing several family members, and the changing of roles in families and extended families. In addition, guidance and instruction were given on the methods of calming oneself (breathing, sanctuary, etc.). The majority of the time at the weekend meetings was dedicated to the peer group sessions lead by psychologists. A lot of rituals were also used in the meetings (Saari, 2006).

The members of the Finnish Red Cross emergency group of psychologists carried the responsibility for planning the meetings and their programs and for leading the meetings. Around 15 psychologists worked at each of the meetings. The Finnish Red Cross has covered all the expenses of the peer support meetings (the travel and all-inclusive accommodation costs of the participants, the psychologists' fees).

The feedback received on the peer meetings was very positive. Very few dropped out. During the project, many new families and family members wanted to join it after having heard other people's experiences regarding it. A quarter of the participants were children. The participants were very eager to have a fourth meeting – originally, the plan was to have only three meetings – and they themselves asked for it to be organized.

Clients' suggestions for helping those in crisis situations

In a three-part study of the Ministry of Social Affairs and Health and the National Research and Development Centre for Welfare and Health (Stakes), Harajärvi et al. (2007) studied the victims' need for and use of services after the natural disaster in Asia, and the experiences the victims and the victims' family members had on the help and services they had received. The following describes in more detail only the results of the second part of the study – a survey – with reference to the suggestions given by the interviewees for helping those in crisis situations.

The second part of the study examined, through a structured survey, the individuals who had been brought home from the disaster area: their well-being and experiences of services. Under examination were the following issues: how the individuals who had been brought home from the disaster area were doing, which services they had used, what kind of experiences they had of receiving help and what kind of help they had found useful. The objective of the study was to find out whether being exposed to a disaster causes longer-term distress in comparison with the general population. The situation of those who had been brought back from the disaster area was compared to the population data of the Health 2000 survey. The survey for those who had been brought home from the disaster area also included an open question section, where the respondents were allowed to describe their experiences freely.

In their answers in the open question section, the study subjects gave the following suggestions, among others, for helping those in a crisis situation: It was hoped that municipalities and other public systems would be active in taking action and establishing contact. It was hoped that the authorities would be

actively in contact with the victims as soon as possible, so that seeking help would not rely on the individual's own efforts in a situation where it is not necessarily possible to assess one's own situation and whether help should be sought. One wish was that the well-being of those facing a crisis situation be monitored for a while, instead of having a one-off contact. Peer support was considered to have been a significant help and it was hoped that the public system would provide assistance in reaching one's peers. Better communications were hoped for, as well as better care services for family members and relatives. It was also suggested that it would be useful for travel guides and embassy workers at the location to be better prepared for how to act in a crisis situation.

The suggestions given by the research subjects were in line with those principles of acute crisis aid that crisis psychologists have been vocal about: help needs to be offered actively and as soon as possible after the traumatic event. Thus, the suggestions given by the research subjects support the professional knowledge that has accumulated in the context of acute crisis work. However, the research subjects take their suggestion even further than the professionals by suggesting that help needs to be offered again later, if it has been refused at the early stages. The significance of peer support was once again expressed.

Researcher/evaluator data (data produced by various methods of evaluation research)

The following is an overview of a number of studies conducted in Finland on acute crisis work. The studies selected for closer examination are, for the most part, ones that have studied acute crisis work that has been carried out using the Finnish crisis aid model. Studies that have evaluated on a general level the help received from the health care system and the recovery of the victims after an accident have been excluded from this examination. The studies are described in the order of their publication dates.

On the effectiveness of single debriefing sessions

On the morning of September 28, 1994, M/S Estonia sank near the coast of Finland. In the accident, 852 people were killed and 137 people survived. Lasse Nurmi (1999) studied the effects of single debriefing sessions among the Estonia rescue workers. Three groups of rescue workers (helicopter pilots, firefighters and police officers) who participated in single debriefing sessions in small groups 3-7 days after the sinking of Estonia were compared to a group of nurses, who had not participated in a debriefing session. The sessions were carried out in compliance with CISD criteria.

Of those who had participated in a session, 95 percent were satisfied with it and 5 percent were not. The study generated some evidence of the symptom-relieving effects of debriefing. Self-reported trauma symptom scores were lower with those who had participated in a debriefing session (helicopter pilots, firefighters and police officers) than with those who had not participated (nurses). However, a fully dependable conclusion on the symptom-relieving effects of debriefing cannot be drawn based on these results, because, due to the limitations of the research design, there is no clear certainty on what caused the results. The groups studied were different (the test groups consisted of men, the control group consisted of women) and symptoms were not measured before the debriefing session.

On the effects of a debriefing session on the structuring of a traumatic event

In the context of the Estonia accident, Eränen et al. (1999) compared the experiences of individuals who had participated in psychological debriefing to the experiences of individuals who had not. The study drew comparisons between the groups concerning how logical the narratives written by the study subjects were and how they had structured their experiences. The research materials were part of a

wider pool of survey results, which had been gathered six months after the sinking of M/S Estonia in cooperation with the Finnish Seamen's Union.

The research survey was sent to those members of the Finnish Seamen's Union who had been working on ships on the Baltic sea when the accident happened. A total of 1500 survey forms were sent out to personnel who, according to the register, had been working on the ships participating in the M/S Estonia rescue efforts, and to the personnel of a ship that had been chosen as a control group. For the most part, the survey consisted of quantitative measures and questions, but the respondents were also asked to write a short narrative of their experiences related to the Estonia disaster. Of the surveys sent out, 636 (42,4 %) were returned. The forms including written narratives were taken aside. The research material contained 231 narratives in all.

The group of respondents was divided into two based on whether the respondent had participated in a debriefing session or not. The research method used was content analysis. Narratives written by those respondents who had not been on their ships when the accident occurred were not included in the analysis. The narratives written by the groups thus created were then compared to each other. The analysis included 43 narratives by individuals who had participated in debriefing and an equal 43 by those who had not.

The hypotesis was that the level of efficiency and success with which the individual has, on a psychological level, been able to process the memories and experiences related to the traumatic event s/he has experienced is reflected in the narratives s/he produces on the event. According to the preliminary research analyses, no statistically significant difference, measured by the two measures of symptoms used, was found between the group that had participated in debriefing and the group that had not (Eränen L, an unpublished observation). The measures used were the Beck Depression Inventory and the Symptom Check List-90-R, both widely used in trauma research.

Instead, differences between the groups were found when analysing the respondents' narratives and the structures of those narratives. The results showed that the individuals who had participated in the debriefing sessions had a more structured overall understanding of the course of events and the factors related to it. The narratives written by the respondents who had not participated in debriefing sessions were more fragmented and their overall image of the events was less structured. On the basis of the results, the researchers concluded that psychological debriefing helps impose structure on events.

According to the researchers, when evaluating the results one should take into account that studies concerning psychological debriefing have usually measured the quantity or extent of the respondents' symptoms by using various measures or compared the quantity or extent of symptoms expressed through those measures at different times between those who have participated in debriefing and those who have not. These studies have produced conflicting results.

While symptoms have been measured and compared in several studies, not much attention has been given to considering what the reported extent of symptoms truly conveys and how this should be interpreted. However, Dyregrov (1996) has expressed his doubts on whether the number of symptoms is the best way to evaluate the successfulness of psychological debriefing or whether it is possible that the measured results are related to how aware the respondents are of their symptoms and how willing they are to report the symptoms they have experienced.

In the study described here the aim was to examine the effects of debriefing by using not just the usual, standardized measures but also other means, basing the hypotheses on trauma-related memory research and theoretical assumptions concerning the mechanisms of effect involved in psychological debriefing.

The results seem to suggest that the effects of psychological debriefing may be more significant with regard to processing the experience, assessing one's values and adapting one's schemata than is apparent from a direct measurement of psychological symptoms. Previous research on debriefing has usually limited itself to the measuring of symptoms. This study sought to capture and examine the successfulness of psychological processing and to compare, with regard to that concept, the individuals who had participated in psychological debriefing to those who had not.

Among the reasons why these results can be considered important and interesting is the fact that one of the objectives of a debriefing session is precisely to create an overall understanding of the situation. The researchers state that several studies like this, utilizing qualitative methods, are needed in the future in order to capture also those effects of crisis interventions that are not revealed when symptoms are measured. In their view, what should be avoided when conducting further studies on the subject is allowing a selected group of respondents, a common weakness, which is also present in the studies described here. The sampling of those who have participated in debriefing and those who have not should be random, so that the bias caused by forming groups based on the respondent's choice could be avoided. The researchers also propose the use of matched controls, which could be possible in carefully designed research settings.

On the effects of early crisis interventions after the suicide of a schoolmate

Poijula et al. (2001) studied the effect of crisis intervention in three secondary schools after the suicides of five pupils. Their study examined the connection between crisis intervention and suicide contagion. The hypothesis that a suicide committed by one individual increases the risk of suicide for others was supported by the study. During the year following a schoolmate's suicide, the probability of a pupil in the schools in question committing suicide was significantly higher than that of the rest of the age group. The hypothesis that crisis interventions help prevent suicide contagion also gained support. No new suicides occurred during the four-year follow-up period in the schools where mental health care professionals provided appropriate psychological first aid and lead debriefing sessions after the suicide of a pupil.

On the basis of this study, it was recommended that when a suicide occurs in a school, an appropriate crisis intervention be implemented in order to prevent suicide contagion. The limitation of the study was its small data pool. The natural experiment design used in the study produced, regardless of its limitations, new information on the phenomenon, on the basis of which hypotheses can be formed for further study. The results of the study can be considered directional.

In the late 1990s, Poijula et al. (2001) studied the effects of early crisis intervention in a school class after a classmate had committed suicide. The study concerned three secondary schools after five pupils of those schools had committed suicide. It examined the risk for post-traumatic stress disorder, measured using the IES (Impact of Event Scale), and the risk for high-intensity grief, measured using the Hogan Sibling Inventory of Bereavement, in 89 classmates. The crisis interventions directed at the pupils varied: some pupils received no crisis help, some had psychological first-aid conversations and some also participated in debriefing sessions.

Six months after the suicides 30 percent of the classmates received scores indicating a post-traumatic stress disorder and 9.8 percent received scores indicating high-intesity grief. A friendship with the classmate who had committed suicide predicted the occurrence of post-traumatic disorder and high-intensity grief. Crisis interventions that had been found inadequate increased the risk for high-intensity grief. Based on these results, appropriate crisis intervention, screening, and focused trauma therapy were recommended after the suicide of a schoolmate.

The researchers state that contolled group comparions measuring the effects of crisis interventions are rarely possible in practice. In schools, for example, one would have to be certain that the interventions thus carried out would not harm the pupils. The natural experiment design used in this study did not allow making comparisons between the crisis intervention methods used. The researchers were of the view that a more restricted research design would have made it easier to draw conclusions on the effectiveness of intervention methds.

On the experiences and mental well-being of individuals who have participated in a debriefing session

Fröberg (2005) used structured in-depth interview to study the experiences, regarding the method and the session, of individuals who had participated in a debriefing session. The frame of the interview was built upon the goals of the debriefing session, taking into consideration the factors that influence the course of the session. In addition, the interviewees were asked to convey feelings and experiences relating to the session. The interviewees' mental well-being was also examined using two quantitative measures, the *Impact of Event Scale* (IES) and the *Brief Symptom Inventory* (BSI).

The interviewees were selected from a pool of individuals who had participated in the debriefing sessions of the Pietarsaari crisis group in 1998 by employing certain criteria (Swedish as a native tongue; the loss/event had to be "close" or affective enough – DSM-IV criterion A; no severe mental problems). There were 11 interviewees altogether, of whom 7 were women and 4 were men.

The results showed that a majority of the interviewees were satisfied or highly satisfied with the help they had gotten through the debriefing session. Some of the study subjects clearly identified some elements of the session, which had been helpful to them (e.g. the opportunity to talk about one's experiences and reactions; the session made it easier to talk about the events also afterwards). None of the interviewees felt that the session had caused them harm and none felt that they had started feeling worse after it. In the case of the BSI scores, the results of the quantitative measurements were better than expected and in part even suprising: according to them, the mental well-being of the interviewees on average compared favourably to that of the general population. The IES scores were as expected: some of the subjects scored rather high, whereas others scored very low. It was notable, however, that the average scores for both men and women were well below the level indicating post-traumatic stress disorder.

Thus, the hypothesis that individuals who have experienced a traumatic event benefit from participating in a debriefing session gained support in the study. However, in the researcher's view, an important condition for achieving positive results is that the debriefing manual is carefully followed and that conscientiousness is exercised with matters essential to a successful session.

The study was carefully executed and documented and its results can be considered directional. As for the generalisability of the results, the small sample and the study being restricted to sessions carried out in one municipality only are obvious problems. Therefore, the researcher suggests that a similar study be conducted nationwide.

On the efficacy of and outcomes achieved by the Finnish crisis intervention system

Hynninen and Upanne (2006) used a survey to study the Finnish crisis intervention system and the experiences concerning its efficacy and outcomes in municipalities in 2002 and 2005. The first survey, titled "The organisation, execution and scope of crisis work in municipalities in 2001" (Kriisityön organisointi, toteutustapa ja laajuus kunnissa 2001), was sent to all Finnish municipalities in the winter

of 2002. In all, 378 out of 446 municipalities responded, the response rate being 85 percent. The responses received were quite evenly spread out between different parts of the country. The second survey was a concise update of the first one and it was conducted as an online survey at the beginning of 2005. The latter survey did not include an assessment on the outcome of crisis work.

For the most part, the results of the study gave a very positive image of the efficacy of crisis work. The work has been organised comprehensively in Finland. In 2002, 92 percent of municipalities had organized crisis services, primarily operated through their own municipal crisis groups. The corresponding percentage in 2005 was 89 percent. For the most part, crisis work in municipalities is an official function, reinforced by administration, and trained social and health care professionals in cooperation with other experts are responsible for it. Crisis work is targeted at the whole population – children, adolescents and adults alike.

According to the study, the crisis work system was thought to function well or very well in a little over half of the municipalities. It was notable that the most critical evaluations concerning the efficacy of the crisis work service system was given by those respondents who themselves were members of crisis groups. The experiences of crisis work were very positive in municipalities. The feedback from clients concerning the work of the crisis groups was mainly positive in 91 percent of the municipalities. Of the municipalities which responded to the survey, 84 percent reported good outcomes in crisis work in the sense that positive effects were perceptible in people's lives and well-being. Among the visible results that were reported were a decrease in sick leaves, the faster recovery of the ability to function and return to work, the relief of traumatic symptoms, and a decrease in severe post-traumatic symptoms (PTSD can be avoided, fewer incidences of depression).

The study also revealed shortcomings in the functioning and working circumstances of the crisis intervention system, and based on the results, proposals for development were drawn. Even though crisis work was found to be quite comprehensively organized throughout the country, in some municipalities crisis groups were not accessible enough. Only a good third of the municipalities responding to the survey in 2002, and less than a half in 2005, had arranged crisis services to be available outside office hours. The study also revealed obvious shortcomings concerning the status of the crisis groups and the necessary resources for their proper functioning, the most blatant examples of these being the absence of overtime compensation, the unavailability of regular work supervision, and a shortage of personnel resources.

Based on the study, there were two areas of weakness that concerned the content of crisis work: crisis interventions did not cover all the stages of traumatic crisis in all municipalities and the follow-up on debriefing sessions was partly inadequate. Only less than a third of the crisis groups in 2002 and approximately half of the crisis groups in 2005 were able to offer immediate psychological first aid during the first 24 hours after a traumatic event had occured. Also, the percentages of municipalities conducting follow-up on debriefing and directing clients to further care services had decreased during the span of the study. Some 40 % of debriefing sessions were not followed up on in 2002.

The response rate of the 2002 survey was exceptionally high (85 %), especially considering that the survey was sent to the municipal boards of health and social affairs and delivered to the subjects through them. Thus, the results can be considered to reflect the realities of the Finnish crisis intervention system comprehensively. Since a majority (83 %) of the respondents in the study were crisis group members and leaders, the descriptions and evaluations presented of the efficacy of the crisis intervention system and of the outcomes achieved through the work are thus *mainly descriptions, experiences and evaluations reported and given by crisis work professionals*. Since the members of the crisis groups know the crisis aid system closely, the image the study reflects of the crisis work service system and its status and realities in Finland can be considered dependable.

The dependability of the (crisis workers') evaluations concerning the outcomes achieved through the work is reinforced by the fact that also those respondents (17 %) who were not crisis workers themselves provided similar – albeit a little more conservative – assessments concerning the practical effects of the work.

On the outcome of short-term crisis work and the factors related to it

Ollikainen (2009) studied the outcome of short-term crisis work and the factors related to it in the crisis centres of the Finnish Association for Mental Health. The study examined which changes can be perceived in a client's psychological symptoms during and after crisis work, whether some factors related to the client, the crisis worker or the nature of the working alliance explain the perceived changes in symptoms, and whether the crisis worker's competence is linked to the outcome of the work.

The study was carried out within the frame of normal crisis work. The study subjects were 70 crisis centre clients in six (out of the 17) crisis centres of the Finnish Association for Mental Health, who had each been individual clients in the centres between the spring of 2006 and January 2007. Participation in the study was voluntary for the clients. The data were gathered by 21 crisis workers who had received training in data gathering. Based on a pilot survey directed to the heads of the crisis centres, the research subjects matched their idea of the typical crisis centre clientele with reference to their gender and age distribution and their reasons for coming to the centre.

The outcome of crisis work was measured by using symptom questionnaires (BDI-II, BSI-53, IES-22) and the WAI-R questionnaire, which measures the quality of the working alliance. The measuring was carried out at the beginning and at the end of the client relationship and six months after the client relationship had ended. For the most part, the clients had appointments once a week. The most typical number of sessions held was five. In addition, information was gathered on the clients and crisis workers through questionnaires created for the purposes of this study. The follow-up questionnaire was returned by 59 people (84 %), which can be considered a good response rate for a study like this.

Based on the results, it was concluded that crisis work implemented through individual sessions at the crisis centres produced very good outcomes for the majority of crisis clients. A considerable decrease in depression symptoms and in psychological symptoms on a more general level took place during the crisis work process. The decrease in symptoms was visible both throughout all the study materials and in specific groups. The symptoms continued to decrease during the follow-up period, but the change was not significant. When the study subjects were examined with reference to their reasons for coming to the centres, three distinct groups of clients emerged: the life situation crisis group, the traumatic crisis group, and the mental health problem group. The decrease of symptoms was the slowest among the traumatic crisis group members. The decrease was, however, significant even among that group, and the same applied to the crisis and trauma symptoms measured through the IES (Impact of Event Scale) questionnaire.

Variables connected to good outcome were not found when examining the data as a whole, but there were differences between the different groups. For the traumatic crisis group, both the client's assessment of the *therapeutic alliance* and his/her assessment of the *crisis worker's professional expertise* were in some parts connected to the outcome of the work. The study concluded that clients facing a traumatic crisis need a good working alliance with the therapist in order to recover and that they also rate the significance of the crisis worker high with reference to benefiting from the sessions.

Assessed through the methods used, some ten percent of the clients did not benefit from the short-term crisis aid. Most of these clients came to the crisis centres for reasons related to domestic or sexual

violence. The study also gathered plenty of data concerning the clients' experiences of visiting the crisis centres and the crisis workers' opinions on their own professional practice. A strong correlation was found between the strain the workers were experiencing and the amount of crisis work done.

The researcher discussed the question of determining the length of the follow-up period so that one could find out whether the effects are truly permanent. A six-month follow-up was decided upon for the study described here, on the one hand because the client relationships in a crisis centre are so short that a longer follow-up would have felt excessive in comparison, and on the other because the outcome of crisis work was examined only through the decrease of symptoms and not through deeper changes, in which case there would been grounds for a longer follow-up period.

The discussion section of the study presents suggestions for how crisis work should be organized, based of these results, in order to produce good outcomes. Based on the results, some prognoses on the clients' recovery are presented with reference to the clients' reason for coming to the centres. According to the results, those who had faced a traumatic crisis took the longest time to recover, and that is why, in the researcher's opinion, special attention should be paid to time resources when planning the crisis work to help such individuals. Based on the results, individuals facing a traumatic crisis need a high quality alliance relationship in order to recover. Also significant is the trauma client's perception of the crisis worker's professional expertise.

In this study, the individuals who had experienced domestic or sexual violence benefited from short-term crisis aid the least. According to the researcher, in the case of these clients it should be assessed, already at an early stage, whether the crisis centre can provide sufficient expertise and enough visits for the client. If that is not the case, it is recommended that the clients be directed elsewhere, for example to services of specialized medical care and/or psychotherapy.

Even though the level of education was not significantly connected to the outcome of the work, the data gatherers in this study were, on average, highly educated, the most typical training and educational background being that of a psychologist. The workers themselves considered training to be a primary factor contributing to their expertise. Based on the study, it is recommended that attention be paid, both in recruitment and for the purposes of of supplementary training, to the personnel's level of education and training and that clients be directed to employees whose levels of training and experience match the levels of challenge presented by the clients' cases.

In the study the strain that the employees reported experiencing had a strong connection to the amount of client work done. It is therefore recommended that the amount of direct crisis work employees do be restricted by the use of workplace-specific and individual guidelines.

The conclusions of the study also state that in all the client relationships of all crisis workers attention should be paid to the development of a good alliance relationship. The worker and the client should strive to find a shared view of the tasks and goals concerned, and the crisis worker has the important duty to attempt to create a safe and well-functioning working alliance. It is also recommended that the client's well-being be monitored throughout the process. The discussion section of the study brings up Lambert's (2008) view that the key to producing good outcome in work conducted in the public service area is the continuous and systematic monitoring of the client's well-being and a change of professional action in situations where the client does not seem to be benefiting from the help. Referring to this, the study asks how such monitoring of well-being could be developed within the crisis work framework.

The study provides interesting and important new information on the outcome of individually implemented crisis work in crisis centres. In the case of individuals who have faced a traumatic crisis, three factors related to the outcome of the work emerge: the sufficient time resources in crisis work, the

significance of a good working alliance, and the worker's professional expertise. The significance of professional expertise has, not surprisingly, also emerged in the context of group-based acute crisis work.

The research material in this study is rather small in scale, especially with respect to the distinct groups emerging from it. Traumatic crisis, for example, was the reason for coming to the centre for 23 of the clients participating in the study. What also raises questions is that two crisis centres are heavily weighed in the research data: almost two thirds of the data is based on their clients (there are 17 crisis centres in all, six of which were included in the study). The study does not provide information on the reasons for this, nor does it include a discussion on how this may have influenced the results and their generalizability. The study also has a very uneven gender distribution: 62 of the study subjects are women and 8 are men. Even though gender did not correlate with the outcome of crisis work, it still would have been appropriate to discuss its significance to the results, as 80 percent of the study subjects were women. As the study does not examine group-based crisis work, it does not shed additional light on the issue of the outcome achieved through crisis work in that area. Nevetheless, it is important to keep the results of this study in mind and, where applicable, to take them into consideration also in the context of group-based crisis work.

CONCLUDING REMARKS

As discussed above, Finnish evaluation and research information concerning crisis- and trauma-related phenomena is scant for the time being. Few studies have been conducted and they have mainly been small in scale. The research designs raise questions, especially in the case of acute crisis work. Among crisis psychologists, randomized controlled group comparisons are not regarded as ethically justified in studying the interventions that are used to help individuals who have experienced a sudden traumatic event and, on the whole, they are not considered to capture the nature and effect of the psychological adaptation process and acute crisis work in a sufficient manner.

However, the evaluation data that have so far been gathered on acute crisis work in Finland, both in clinical contexts and through actual studies, have been supportive of crisis work. Based on the accumulated data, crisis interventions have not been detrimental to those who have participated in them and the feedback received for the work has primarily been very positive. Based on the evaluation data, crisis interventions seem to promote psychological adaptation and recovery from a traumatic event. Data gathered from clients also support the view, prevalent among crisis work professionals, that services should be actively offered to those involved in traumatic events.

More research data are needed on the practical effects of acute crisis work, specifically of that conducted in Finland. The challenge thus set for the development of research work is related to research methods and designs in particular. How and with what kind of research designs should the efficacy, effects and effectiveness of acute, group-intervention-based crisis work be studied in order to uncover all the real effects of the work and for the research designs to meet the ethical demands at the same time?

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