Psychological First Response - Dr Simon Crisp

PSYCHOLOGICAL FIRST RESPONSE
ESSENTIAL SKILLS FOR OUTDOOR LEADERS

The positive psychological, social and educational contribution outdoor adventure experiences can make are often severely underestimated. However, the flip-side of such powerful experiences is they can also carry invisible risks for psychological harm. Despite the most carefully planned, organised and executed programs, these harms can occur through triggering or exacerbating existing psychological vulnerabilities or conditions. Further, outdoor programs have the potential to create new problems. Psychological issues in this way are analogous to medical issues. That is, in managing risk outdoor leaders need to plan programs with psychological risks in mind and be prepared to respond to unforseen emergencies.

We know that mental health problems in adolescence are prevalent. It is this phase with its rapid biological, cognitive and social changes and simultaneous increase in demands and stressors which makes the emerging young person especially vulnerable. So, it is no surprise that adolescence is a peak period for the development of psychological disorders, with 30 percent of young people having experienced a diagnosable disorder by age 18. Reliable estimates of Australian adolescents aged 13 to 18 suggest 18% of boys and 10% of girls have clinical levels psychological symptoms at any point in time. In any 12 month period, 10% have thought of ending their life and have planned to do so. Three percent of boys and 6% of girls have reached the point of making a serious suicide attempt. With the thankful exception of suicide attempts, more recent estimates put these prevalence figures higher.

Different problems and clinical disorders (adolescents aged 13-17)

Type of problem (self-rated)	Males(%)	Females(%)
Delinquent behaviour	11.5	12.4
Aggressive behaviour	6.2	9.1
Attention problems	7.1	6.6
Anxious / depressive symptoms	6.7	6.8
Somatic (physical) complaints	6.3	6.6
Social problems	3.4	3.5
Thought problems	3.3	2.7
Withdrawn behaviour	3.1	2.9
Type of Disorder (parent rated)		
Depressive Disorder	4.8	4.9
Conduct Disorder	3.8	1.0
ADHD	10.0	3.8

* reproduced from a study by Sawyer et al. of 4,500 children and adolescent across Australia (2000)

In a school context, this profile might transpose to a typical co-ed. class of 25 students thus:

- 2 students with clinical levels of depression and/or anxiety
- 5 students with delinquent or aggressive behaviour
- 1.5 boys + 0.75 girls with Attention Deficit Hyperactiviy Disorder (ADHD)
- 2-3 students planned suicide, 1 attempted within a 12 month period
- 5 students are regularly abusing alcohol, 2 regularly using marijuana
- 6 girls + 2 boys exercising to lose weight, 0.75 girls vomiting and abusing laxatives

However, more accurately, approximately between 2 to 5 students would have clinically serious issues made up of a proportionate combination of these sorts of problems. For example, this co-morbidity in just one individual could include being clinically depressed, having severe social/behavioural problems, having ADHD, attempting suicide within the last 12 months, excessive exercise and regular binge drinking and smoking marijuana. One of the most concerning statistics in this area is that **only one-in-four young people experiencing serious psychological disorders have any professional support** (Sawyer et al., 2000). Importantly, school counsellors are the most frequently used professionals by these young people.

The Critical Role of Outdoor Leaders

It cannot be over-stated that outdoor leaders are in an equal if not more prime position to detect and engage a young person at risk. In fact, due to the inherent demands of outdoor experiences, this can place the outdoor leader as the central person to do this. There are many factors including intense continuous living together with participants, high levels of trust that quickly develop in outdoor leaders, the often idealised "charismatic helper/rescuer" role that outdoor leaders can be perceived as, and that the relationship has a known end-point. Often young people disclose very sensitive information to outdoor leaders that they wouldn't feel able to tell any other person in their own world. Sometimes these "secrets" are very significant for that young person's development, wellbeing or safety. Disclosure of sexual abuse, domestic violence, substance abuse, suicidal thoughts or plans, self-harm, bullying, or severe family dysfunction are frequently disclosed in outdoor programs. Outdoor leaders are ideally placed to be the critical "bridge" between undetected and unsupported young people and appropriate professional support.

For these reasons alone, it implores program organisers to screen for psychological problems or potential for them prior to programs. However, this is in no way as easy as screening for medical problems or risks. Lack of awareness of problems by the participant or his/her parents and reluctance to disclose problems for fear of labelling or stigmatising a child are just a few of the more common reasons. It is most often impractical to clinically assess and screen participants prior to their participation. It would be very complex and problematic to set this sort of procedure up in any case. It is no surprise then that many undisclosed psychological, behavioural and social problems emerge once the participant has commenced the program. Virtually, no opportunities exist to assess their suitability to participate or plan ways to manage the risks they bring for themselves or others.. This routinely places a very significant responsibility on the outdoor leader in the field to be able to detect there is an issue, quickly assess its severity and inherent risks and then be able to devise and implement a management plan in the field. All without easy or immediate back-up support. So, having even basic skills in these areas seems essential, and further, important to have consistent policies and procedures within the organisations involved in how to manage these expected yet undetectable risks.

Further, outdoor programs induce stress. Some individuals are well equipped to respond to these challenges and gain great confidence and psychological growth in many ways from this. However, others bring with them histories of poor coping, poor or compromised development and others past traumas, or significant separation anxiety, and the like. These young people can find the dislocating impact of being on program and the stresses thrown at them - for all the right reasons - too much. They may struggle with ineffective coping strategies, may resort to past stress management strategies such as self-harm, or experience a re-emergence of post-traumatic symptoms such as hyper-arousal, insomnia, panic or emotional shut-down (or dissociation). The effect of this can be to re-traumatise and exacerbate their condition, or compound their non-coping.

Psychological First Response

Like medical first-aid training, there are tested procedures that can be deployed in the field once an issue has been detected, or a crisis occurs. This model - Psychological First Response® was first developed by the author in 2002 specifically for youth professionals. Since then, some hundreds of youth professionals around Australia have been trained in this model, from Outward Bound to many leading independent schools, Victorian government school nurses, and so on. It is currently undergoing adaptation to, and trials in schools in the USA. Importantly, it provides clear steps in how to approach, engage and respond to a young person in need and support their effective follow-up. Being confident and decisive in responding is an important element of gaining trust and confidence in a vulnerable young person. There are three important stages outlined on the following page.

Overview of the elements of Psychological First Response:

DETECTION	RESPONSE	REFERRAL
• High and low prevalence problems • 'Red Flags' • Critical signs & symptoms • Critical incidents	**P.R.E.P** **D**anger **R**eadiness & **R**esources **A**ct within role/expertise **B**rainstorm **C**onsult **D**ecide - if to refer on **Re-cap & Follow-up**	• Referral for assessment? • Counselling options • How to prepare participant &/or parents for effective referral • How to support the student to engage with the referral over time

Developed by Simon Crisp & Emma Lund (Crisp, 2002)

Case Study Illustration

"Elise" is a 13 year old girl with a history of being bullied in primary school. While on the third day of her school bushwalking trip, she had become isolated by other group members and was excluded from helping to put her group's tent up. This was the "last straw" for Elise. Very distressed, she ran-off crying into the bush. Her outdoor instructor Kylie was the first to find her now standing on top of a high cliff 200 metres away from camp. Elise now appeared extremely angry, and was screaming barely intelligible comments about how she was a "loser" and hated herself. She screamed she was "sick of this" and "wanted to die". She did not respond to requests to move back from the cliff or talk to Kylie. Kylie used the D.R.A.B.C.D. checklist to guide her decision making. She quickly considered the dangers to all parties, and took charge of the situation by getting the other instructor to quietly remove all other young participants from the surrounding area. Once Elise had privacy, Kylie sought to de-escalate Elise's heightened emotions through confident, calming and simple statements acknowledging the seriousness of Elise's concerns and feelings about what had happened. Kylie empathically asked questions about what had happened and why Elise was now feeling this way. Developing a collaborative view of the problem, Kylie explored the seriousness of Elise's intent to hurt herself, and reduced her risk by engaging her in exploring ways to sort out the problem that had precipitated this crisis in a solution-oriented way. Making note that Elise had alluded to past experiences of being bullied and excluded, Kylie decided to contain her questions to the immediate concerns and limit her discussion so she did not inadvertently begin opening up issues she was not trained nor had time to respond to. Soon some practical solutions had been tentatively agreed upon by Elise which helped shift her to a less angry and emotional state. Elise then agreed to walk back to camp with Kylie and discuss how to manage this dynamic in the group with the other instructor. At the end of the program, Kylie was able to gain Elise's agreement to meet with and discuss some of the broader background issues with the school counselor.

Conclusion

Outdoor leaders are in a unique position to prevent harm to vulnerable participants from outdoor experiences through prompt and effective first-response interventions. They also play a key role in the detection and referral-on of serious mental health problems in the participant groups they serve. Outdoor leaders trained in this model can gain greater confidence and effectiveness in the field and reduce disruption to the on-going provision of programs. Adopting a Psychological First Response® framework outdoor program providers and client organisations and schools can have a greater confidence in the prevention or escalation of serious psychological, behavioural or interpersonal issues in their participant clients.

References:

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