European Network for Psycho-Social Aftercare in Case of Disaster

Target Group Intervention Programme
Manual I

Manual for implementing the Cologne Risk Index-Disaster in the context of major loss situations

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Preface

The Manual for implementing the Cologne Risk Index-Disaster (Booklet I) was driven forth within the scope of the project „European Guideline for Target Group Oriented Psychosocial Aftercare in Cases of Disaster (EUTOPA)“, which is promoted by the European Union. The main question of the project is: According to current state of research, what kind of crisis intervention measures have stand the test of stemming the risk of stress disorders following major loss situations? At this, the working group adopts the approach of implementing so-called „screenings“ for psychosocial aftercare, which allow identifying survivors bearing a high risk for developing a chronic stress disorder. By screening, we understand a combination of different survey parameters. Risk factors for developing a posttraumatic stress disorder, identifying peri-traumatic dissociation and elevation of symptom severity belong to the parameters. With this screening we do not claim to reach an assured diagnosis. It is about "setting the course" within the overall concept of the Target Group Intervention Programme (TGIP). The TGIP describes every intervention step from psychological primary care to indicated psychotherapy more specifically. In our manuals (I to III) we adapt the conception to the requirement profile of international major loss situations. Manual II contains the modules of the Target Group Intervention Programme. In manual III we present trauma-based psychoeducation as a manual. Our concept is based on the opinion that process-orientation and identification of risk-groups is successful in driving forth effective crisis intervention programmes. In the past, we developed this concept for different types of situations. With PLOT and EUTOPA, we aim to implement the concept in the European context by using the Internet. Therefore, we established the web pages www.eutopa-info.eu and www.plot-info.eu. The presented manual (I) focuses on a central element of TGIP. It concerns the theoretical and practical background for implementing the Cologne Risk Index. The manual is designed for professional helpers and is supposed to point out possibilities and limits of the method to this target group.

Literature on Target Group Intervention Program (TGIP)

Translations of the manual in English, French, Spanish and German are available at www.eutopa-info.eu

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Further information about the TGIP in association with psychosocial aftercare for victims of terrorist attacks and for soldiers after foreign assignments are available at:

www.ikpp-bundeswehr.de

www.plot-info.eu

1. Stressful experiences and ways of coping

1.1 The Time Course of Traumatic Stress

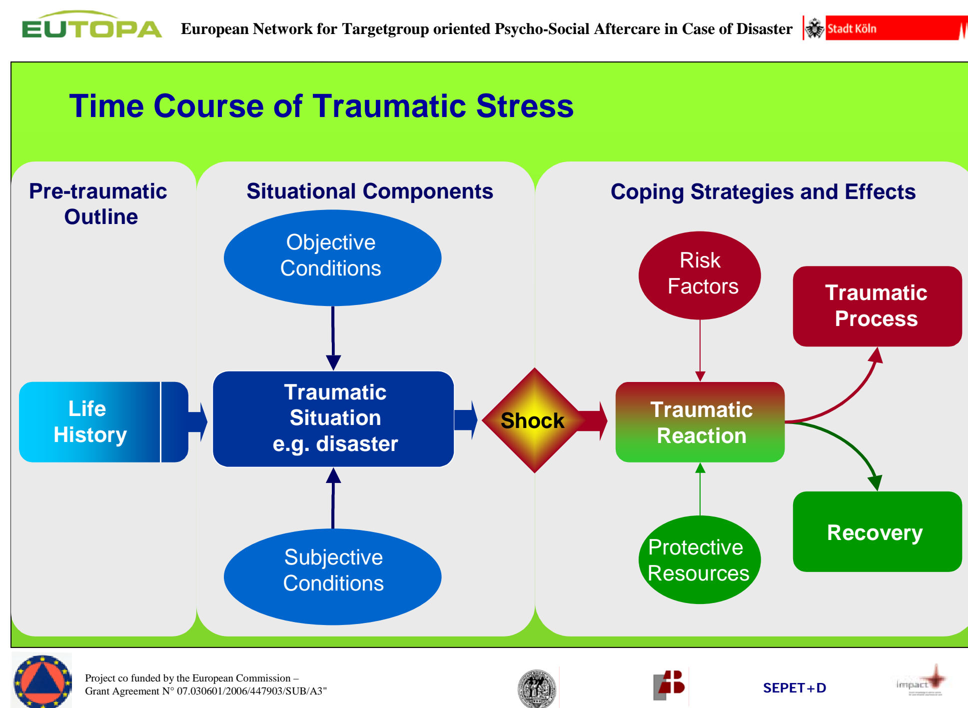

Figure 1: Time Course of Traumatic Stress (adapted from Fischer and Riedesser, 2003). Traumatic situation, reaction and traumatic process vs. recovery are described. Explanation: see text.

We look at psychosocial aftercare for victims of disasters on the basis of the Time Course of Traumatic Stress (see fig. 1). The Time Course analyses in detail the stages of (1) *traumatic situation*, (2) *traumatic reaction (stage of shock)* and (3) *effects*. A *traumatic process* emerges, if the transition into the post-exposure stage of recovery fails permanently. The development of a post-traumatic stress disorder (PTSD) is part of this, for example. The traumatic process can be subdivided into contemporary *latency stage* of trauma (up to approx. 14 days to 4 weeks post event) and the *stage of consolidation*.

Target group orientated interventions in terms of risk assessment are geared to the Time Course of Traumatic Stress (see fig. 1).

Target Group Intervention Programme (TGIP) is geared to the Time Course of Traumatic Stress.

In the following, we take a close look at the individual elements of the Time Course of Traumatic Stress. The objective situational factors might vary greatly. The objective situational factors compile the factual conditions of major loss situations such as terrorist attacks, major fires, flood disasters, plane crashes, traffic accidents etc.. Disasters imply the need for supply for many directly or indirectly affected persons:

among these are survivors, relatives, bereaved persons, relief units, witnesses as well as the population of the affected commune.

The subjective appraisal of these traumatic situations is individually very different. Essential subjective aspects of traumatic situation are feelings of helplessness, powerlessness and threat to life or physical conditions. In the traumatic situation, dissociative processes of defence often begin. Dissociation means disorganizing the integration of perception, memory, emotions and activities. Changes in experiencing time, space and self might happen. Severity of traumatic situation and peri-traumatic dissociation in the traumatic situation are important risk factors for developing PTSD (Bering et al., 2007). Even in the immediate post-expository time, the stage of shock, victims might furthermore react with intense emotions. Panic and hyperexcitability might persist for hours up to several days. Other victims are in a state of complete numbness resp. emotional deafness (numbing).

In the latency stage intrusive experiences (e.g. intruding pictures, emotions and thoughts, nightmares) alternate with avoidance behaviour with denial including dissociative defence. For this process the pre-traumatic outline (antecedent element) bears an important meaning.

> Dissociation means the disorganisation the integration of perception, memory, emotions and activities.

During the traumatic process sleep disorders, depressive reactions, states of exhaustion, continuous rage, apathy and insensitivity, anxieties, disturbance of concentration and self-reproach might occur. Memories of the traumatic situation are only recalled to some extent in a fragmented or distorted way. It must be considered that these are normal reactions to very stressful experiences. They do not automatically imply chronic symptoms and the development of PTSD. Under favourable conditions, subsequent to the latency stage recovery follows. Symptoms become noticeably and permanently better. The “swing motion” between avoidance and intrusion decreases and a controlled management of traumatic contents becomes possible (cp. Horowitz, 1976). The victims learn to talk about the event without being overwhelmed by feelings or without having to defend their feelings with dissociation. Some factors are important for an early and successful coping of a traumatic reaction, the recovery and management of a traumatic experience. A secure, accommodating social environment, in which victims are able to talk about their experiences is very supportive for the healing process. Sufficient time for rest and retreat and also informing about traumatic courses and the transfer of stabilisation-, standoff- and relaxation techniques are necessary and helpful as well.

If this coping process does not succeed, the traumatic reaction will merge into a traumatic process with different courses. Continuity of exposure symptoms is for example part of this, resulting in the formation of PTSD. From this, further psychiatric disorders as concomitant or consequent disorders might develop. For example, an increased risk for addiction

development exists as an attempt of self-healing in order to numb intrusive experience by an increased alcohol-, drug or medication abuse. Prevalence of avoiding and dissociative resistance might result in depressive development. Chronic symptoms of hyper arousal lead to anxiety disorders for example. Quality of living might diminish dramatically and far-reaching psychosocial problems might occur in the following, like problems in partnership, loss of social contacts, limited working- and employment ability up to premature pension.

In case of infaust long-term traumatic processes, profound personality changes may develop, which are diagnosed in ICD-10 (F 62.0 Enduring personality change after catastrophic experience). In such chronic cases, a comprehensive psychological and medical treatment is needed. We know that out of a stressful situation, a wide range of psychiatric disorders might develop that have to be considered on principle. PTSD and personality change after catastrophic experiences are to be understood as prime examples that are especially well examined.

All measures of Target Group Intervention Programme
aim at supporting the self-regulating capabilities.

1.2 The risk groups: Group of Self-Recovery, Switchers and High-Risk

To what extent victims cope with a stressful experience and get over it successfully in the stage of recovery depends on various factors. Besides objective situational factors, predictive factors for the traumatic course are the way of peri-traumatic reaction, the reactions of environment after a stressful event and previous traumatic experiences. Based on a reasonable number of empirically verified factors, which are assessed with the *Cologne Risk Index*, estimating the risk of a traumatic process is therefore already possible in the latency stage.

According to psychotraumatological knowledge (Fischer et al., 1999; Bering, 2005; Bering et al., 2003, 2007, Schedlich et al., 2008), people who were exposed to stressful events from medium up to high degree of severity, might be subdivided into the following three groups:

Group of Self-Recovery: The group of trauma victims, that is able to cope with the trauma within the natural course of self-healing process over time without permanent impairment using their own resources and potentials.

Group of Switchers: The group of trauma victims that is able to manage the trauma within the natural coping process like the “Group of Self-Recovery”, if there are no further “disturbing factors” post-expository (e.g. negative consequences from the employer, family/social problems, re-traumatisation etc.). If those disturbing factors are added to the process of coping, the victims “switch” into the High-Risk Group, which is at a high risk of developing lasting symptoms and psychological impairments because of the trauma.

High-Risk Group: The group of victims, which is at a high risk of developing a

chronic posttraumatic stress disorder and/or co-morbid disorders like for example alcohol dependency, depression or anxiety disorders because of the trauma. This chronic traumatic process potentially might last for several years or an increase of symptoms occurs after years, for example because of supervening of further stressful factors or symptoms even occur for the first time after years (delayed PTSD).

The early classification of victims to the respective group is important in so far as the predicted courses in the sense of TGIP need different offers of help and support for preventing a chronic process. The *Cologne Risk Index-Disaster* enables the classification of survivors of major loss situations after stressful events into one of the three groups. In the scope of psychosocial aftercare following major loss situations, target group orientated measures can be initiated due to this classification.

As an instrument of early diagnosis, the *Cologne Risk Index-Disaster* enables the victims' classification to one of the following groups: Group of Recovery, Switchers and High-Risk and thereby establishes the basis for the Target Group Intervention Programme.

2. The Cologne Risk Index- Disaster

2.1 Development of the Cologne Risk Index

The Cologne Risk Index has been developed to enable risk estimation of the traumatic proceeding. Early recognition of risk courses is an essential part of secondary prevention. The CRI has been designed and validated in the scope of the research project "Prevention of chronic disorders and disabilities in violent crime victims" – the "Kölner Opferhile-Modell" (KOM) – for the first time (compare Fischer et al., 1999). By gathering manageable situational factors such as severity of traumatic situation or peri-traumatic dissociation and existing resp. missing protective factors, the CRI enables the estimation of the risk of a disorder.

The Cologne police for example are using the validated version of the CRI for crime victims. Crime victims are assessed by trained police officers shortly after the act of violence has been committed and where necessary are referred to the Cologne counselling centre for victims of violent crimes and accidents. Since then, a variety of CRI versions have been developed, which are detailed in the following chapter (see table 1).

2.2 Predictive factors

Fischer et al. (1999) have validated the design of the Cologne Risk Index with a sample of violent crime and accident victims. As a result, they have advanced an important development in crisis intervention management. Analogously, Walter (2003) has realised a study concerning the identification of risk factors in bank robbery victims. Bering et al. (2003) have developed a risk index for the Federal Armed Forces, which is orientated by the specific situational dynamics of

humanitarian and military deployment of Bundeswehr soldiers. Hammel has adapted this concept in the scope of counselling survivors of the Eschede train wreck (Hammel, 2005). Bering & Kamp (2007) accomplished a CRI validation in the clinical context with a sample of diagnosed PTSD patients. The identified risk factors are listed in table 1. The methodical approach of all three studies is comparable. Varieties of CRI have been used, which were related to symptom scales for PTSD on the basis of a regression model. Between the different varieties of the CRI there are intersections that are reflected in the weighting of dispositional factors pre-traumatisation, situational factors and risk and protection factors in the stage of exposure. For this purpose, the individual factors were evaluated semi-quantitatively based on the point scores with which they flow into total evaluation and were marked with one to three stars. One star means a small weighting of the factor, two stars a medium and three stars stand for a large weighting of the factor in the respective version of CRI. This scale and the explication of the factors are about a rough classification that is merely intended for guidance. For approaching the target of listing the factors in a comparable figure, inaccuracies are accepted. The results indicate that the group of factors in table 1 have validity for the development of symptoms, which are associated with PTSD, for all of the three versions of CRI. In the following, the factors are itemised:

The item “female gender“ belongs to the dispositional factors. It has been identified as a risk factor in the study of soldiers of the German Federal Armed Forces as well as concerning bank employees. It remains unexplained whether the result is affected by dissimulation effects in men or whether it is really a matter of gender-related vulnerability. The items ›prior psycho-traumatic charge‹, ›unemployment‹ and ›school education‹ are factors of pre-traumatic personal history. The extent of pre-traumatisation takes an important position in all CRI versions. Family and medical doctors must pay particular attention to this factor.

The category ›unemployment‹, being a risk factor in CRI for violence and accident victims, is of course irrelevant for soldiers and bank employees, since the critical events take place in vocational surroundings. Furthermore, the risk factor of low school education in CRI for violent crime and accident victims was not retrieved in the other versions.

The situational factors may be subdivided into subjective and objective ones. The experienced fear of death resp. the subjective appraisal of the degree of exposure ranks among subjective factors that can be identified as an important factor in all three CRI versions. The extent of injury, duration of traumatic situation and familiarity with the offender are assigned to objective situational factors. For this item, partial overlapping emerged. Physical injuries play an important role for the German Federal Armed Forces and victims of violence and accidents and in the clinical sample. In bank hold-ups they are a rarity and are dropped for this reason.

The factors › familiarity with the offender ‹, ›duration of traumatic event‹, and ›persons harmed‹ show points of intersection in the different CRI versions. The factor ›peri-traumatic dissociation‹ shows a remarkable consistence. This factor has a particular

status in all CRI versions. Dealing with dissociative phenomena deserves particular attention. Among factors in the stage of exposure are risk- and protective factors, that in particular relate to reactions of social environment (family members, comrades, peers etc.) and superiors (bank managers, officers) resp. office-holders (investigators, insurance). It is made clear that negative reactions in social surroundings are related to stress disorder symptoms in all CRI versions. The category ›bad experience with office-holders, peers and comrades‹ shows a wide intersection as well. Furthermore, the risk factor ›difficulties to speak about the event‹ deserves particular attention. It was established in the sample of Bundeswehr soldiers as well as the clinical sample. For Psychotraumatology, this factor has a considerable relevance. We may draw the conclusion that cumulative psychotraumatic exposure, peritraumatic dissociation, objective severity of event, subjective evaluation of event and reaction of social and vocational environment are to be rated as ubiquitous factors which promote the development of stress disorders. Thus we must claim limitations. The degree of connection resp. the coefficient of determination, by which the symptom exposure might be reasoned from the discussed CRI items, is based on a mathematical model that only covers reality in an insufficient way. Psychometric inquiry instruments merely offer a clue. Knowing the causality relationship between event criterion and symptoms is linked to a psychotraumatological diagnostics that require one-on-one interviews in a clinical setting. For this reason, the predictors are to be set in a framework of dynamic relationship. Only this step animates the configuration analysis of every single case and makes an evaluation of dispositional, life historical, situational and risk resp. protective factors in the latency stage possible.

Against this background it becomes apparent that the CRI conception is based on a “setting the course” function.

If the test person is assigned to the group of switchers or of high risk, the clinical diagnostics follow in further elements.

> We draw the conclusion that cumulative psychotraumatic exposure, peritraumatic dissociation, objective severity of event, subjective evaluation of event and reaction of social and vocational environment are to be rated as ubiquitous factors which promote the development of stress disorders. The results of our field studies are in line with meta-analyses conducted for this purpose.

In table 1 we have compiled the field studies that were conducted for validating the CRI. We point out that the risk factors are in line with meta-analyses, which have dealt with that question (Brewin et al., 2000, Ozer et al., 2003, Abresch & Bering, 2008). Following the convergence principle, two different methodical approaches show consistent results.

table 1.: Variants of the Cologne Risk Index				
Authors	**Fischer et al. (1999)**	**Walter (2003)**	**Bering (2005)**	**Bering & Kamp (2007)**
Variants of Cologne Risk Index	**victims of violence and accidents**	**victims of bank hold-ups**	**soldiers in foreign assignment**	**stationary PTSD patients**
dispositional factors				
female gender		*	*	
personal history factors				
low school education	*			
pre-traumatisation	**	**	**	*
unemployment	*			
situational factors				
threat to life and physical condition	*	*	*	
duration of traumatic events	*			
dissociation	***	**	***	**
physical injury	*		*	*
subjective experienced exposure	*	*	*	
familiarity with the offender (resp. proximity to the offender)	*	*		
persons harmed				*
factors in stage of exposure				
negative reactions of the social environment	*	**	**	**
limitation of home-contact			*	
bad experience with officeholders /peers/comrades	*	**	*	
difficulties to speak about the event			*	*
The chart conveys similarities among Cologne Risk indices, which may be summarised in a group of factors of disposition, pre-traumatisation, traumatic situation and of risk and protective factors. Differences derive from the specific psychotraumatology for victims of violence and accidents, victims of bank hold-ups and soldiers. The stars are a symbol of weighting. An empty field indicates an item that was not analysed in the study.				

2.3 Adaptation of CRI to major loss situations – the *Cologne Risk Index - Disaster*

By adapting the *Cologne Risk Index – Disaster* (CRI-D), considering the survivors' unique situation during a major loss situation was necessary. Since different traumatic situations, experiences and contexts show unique characters and different risks for developing long-term disorders, a separate consideration of those factors has to be made. We follow a two-time methodical approach. In the first step, we bring up factors that were approved by the inter-validation of CRI and in meta-analyses (see chart 1). In the second step, we consider factors that are under strong suspicion of having a specific relevance for survivors of major loss situations. At this, we base on current state of research.

Ad 1

Identifying risk factors has shown that in the latency stage, pre-traumatic life history, situational dynamics and risk and protective factors are to be considered. Therefore we have to distance ourselves from the emergency medicines' somatological paradigm and first aiders and therapists have to survey the entire course of the process in order to drive forth useful interventions. Using this requisite know-how, we want to attend to the disasters' situational dynamics.

Ad 2

The beginning of systematic research concerning natural disasters' mental sequelae is dated back to the 70s. Thus Barton (1969) for example verbalised, that sudden occurrence, duration and the councils' preparation have an influence on the development of victims' mental sequelae. In her longitudinal study after the flood disaster at Buffalo Creek 1972, Green (1990) extracted over 14 years of traumatogenic situational constellations for long-term development. The major part of psychotraumatological research about terrorist attacks' mental sequelae is based on studies about the aftermath of the attack at 11.9.2001 in New York. Studies prove that in particular those victims bear a high risk of developing a mental disorder, that were injured themselves or else were confronted to the sight of dead and distorted bodies as well (Desivilya, 1997; Grieger et al, 2004, 2005; Pfefferbaum et al., 2001; Ursano et al., 2003). Those factors are also relevant to first aiders' psychosocial aftercare (Fullerton et al, 2004; Philbrick, 2003; Ursano et al., 2003). According to studies, death of a loved-one is a predictive relevant factor for developing a long-term mental disorder for relatives (among others: Green 1990; Grieger et al., 2005). Following the studies' results, it must be assumed that of the objective situational factors, the disaster victims' extent of suffered and witnessed injuries is a prognostic relevant factor for the development of a psycho-traumatic disorder.
For the prognostic relevance of subjective situational factors, experienced fear of death and dissociative peri-traumatic defence as well as for the relevance of biographical risk and protective factors only a few results are available. Regarding the risk and protective factors of the transitional phase, we can recapitulate that we have to proceed on the assumption of both individual and collective traumatisation in case of a disaster. For the future, it has to be examined whether collective traumatisation is operating as a risk or

protective factor. Collective traumatisation might lead to high willingness of social support in population (Hobfoll et al. 2007). The collective trauma involves a collective solidarity. Effects of media presence and coverage as well as the role of policymakers are additional potential risk or protective factors in post-situational stage that have to be considered. It must be verified that media coverage using factual and appropriate information brokerage as an essential measure for rebuilding a relative safety (Hobfoll et al., 2007) might indeed account for protective power. Intrusive power of media coverage might strengthen the risk potential. The CRI validation version has integrated the mentioned factors and it will be available online (www.eutopa-info.eu) for corresponding relief agencies in their respective countries. The collected results form a basis for adapting a prognostic instrument as a foundation for the Target Group Intervention Programme. An early implementation in the traumatic course after remission from the stage of shock is permitted and useful, because the CRI does not emphasize gathering stress symptoms that might be high in the early time slot for the group of self-recovery, too. To implement a screening not until several weeks after the event is discussed frequently. We will not join this interpretation of screening, because a prognostic validity would go unused.

3. Implementation and briefing for *CRI-D*

Two versions of the *CRI-D* are available: a paper and an online version in four languages at www.eutopa-info.eu. The interview should be conducted with the assistance of a therapist. In case of major loss situations, this might be impossible. For this reason, we offer an internet-version of the CRI-D that submits support via Internet resp. assistance from network professionals.

> The CRI-D is available as a paper-pen and an online version (www.eutopa-info.eu).
> It should be implemented with the assistance of a trained professional.

3.1 The interview-guideline

The interview-guideline of *CRI-D* is an instrument for predicting existing risks for the development of stress disorders. It always should be used in association with an individual case consultation. A CRI-D realisation directly after the event is obsolete. The CRI-D is designed for being applied after first care and if possible after psychoeducation. Therefore, psychotraumatology consultants are able to refer to the option of using the Internet. In the sense of secondary prevention, implementation should take place preferably regionally. To ensure the correct implementation of CRI-D, interviewers need special training. This is primarily important to prevent further traumatisation of victims by talking about the stressful experience. In addition, a uniform implementation is the basis for meaningful results. We recommend implementing the CRI-D accompanied by a trained professional. The advantage lies in the direct rating-possibility by a trained

interviewer. Even trivialisation tendencies and dissociative defence can be recognized and approached here. Necessary measures based on risk-estimation can be discussed and initiated directly.

Framework conditions for implementing CRI-D

- The interview should be realised as an individual conversation in a calm and trustful atmosphere.
- Distance of time to experience is at least 72 hours.
- The location for the interview should preferably guarantee physical distance to the experience in order to convey sufficient safety
- Enough time should be included for the interview and discussion of suitable measures, at least 30 minutes, for individual cases longer. Because victims may speak about very stressful experiences, they need the possibility of being able to design the timing structure in terms of controlling own actions.

Interview introduction

- At first, making good contact with the interviewed person is essential
- Inform about the goal of the interview and introduce the CRI-D as an instrument of provision . Do not emphasize the estimation of risk but the assistance the test person can provide for planning and initialising adequate measures by answering the CRI-D. Especially while talking to test persons for whom a distinct tendency of dissimulation is to be assumed, verbalisations of emphasizing the implementation of an individual risk profile are to be avoided
  „Answering the questions assists me in estimating what offers we are able to make to you in order to manage your stressful experience as quickly as possible.“
  Victims' concerns should be discussed and if necessary, further explanations should be given. If concerns cannot be removed, the victim can decide to not take part in the examination.
- As a general rule, psychoeducation should be scheduled ahead of the interview (see Zurek et al., 2008). If this it is not the case, briefly inform about the natural course of processing in the event of psychological traumatisation. Common symptoms in the latency stage should be named. Explain that problems in the aftermath of stressful experiences are more based on features of the experienced situation than on the person's strength and will power. Often anxieties of being "pathologised" exist on the part of traumatised persons, including concerns in relation to career disadvantages.
- Inform about the interview procedure, meaning CRI-D should not be implemented in isolation but in association with TGIP modules. Following the interview, further risk-dependent interventions are planned (see Schedlich et al., 2008).
- Emphasise voluntariness of the interview and obtain agreement.
- Emphasise data privacy and discretion. Interview information must not be communicated to others (comrades, superiors or doctors) without agreement. Information about

confidential dealing with questionnaire results and indication of discretion are *absolutely* required in order to ensure the victims' collaboration.
- Enter date and code in the beginning. Concerning this, you will find detailed information on last page of the interview guideline.

Implementing the interview
- Adapt the conversation to respondents' verbal fluency at first. A conversation character should be dominant, do not interrogate the questionnaire schematically. This requires an adequate knowledge of items in order to specifically collect missing information during the conversation.
- Accept it if a person does not want to or is not able to talk about the experience or parts of it. Do not pressure them.
- The interviewee's subjective experience exclusively matters.
- Suspend your personal appraisal and do not discuss, but encourage the person to express her/his own estimation as frankly as possible.
- Avoid intensive talking about the experience, a "working through" of traumatic situation must not take place, this might have a re-traumatising effect. If respondents show a constant tendency of wanting to talk about the event incessantly, inform about possible additional exposure as a result and emphasise the first necessary ability of control and of self-determined distance.
- Adapt your speech to the interviewee, avoid technical language. Terms like "stressful experience" are better than "trauma".
- If you have doubts about what is meant by a certain question, you will find illustrations to individual questions subsequent to interview-guideline

Interview conclusion
- At the end of consultation, brief counselling should follow. Victims are informed about risk-estimation, trauma and trauma results. Deciding whether someone will use further offers of assistance is down to each individual in the end and has to remain in one's own judgement. Participating in risk-screening as well as deciding to implement further measures are voluntary. It is a matter of *offers* that allow each individual a personal choice.

Usually, interviewees experience the consultation as a supportive measure and feel taken seriously in their experiences. Asking for qualities of the event makes it easier for victims to speak about aspects of their experiences in a structured form and thereby getting closer to one of the essential modes of processing, the ability to verbalise. In particular cases, the interview might be experienced as too stressful despite all precautionary measures so that so-called flashbacks might occur.

Dealing with flashbacks

- Speak directly to the person with a raised voice and using clear words. Tell the person where they are, that the event happened in the past and that they are sitting next to you and are in safety now.
- Ask what time, day, date, etc. it currently is.
- Make irritating remarks, for example address the person by the wrong name
- Ask apparently senseless questions like “How much is 100 minus 7”? After the person answers, continue with “How much is 93 minus 7?” etc. Questions like that irritate the person and they might actually react with anger. This reaction helps them return to reality.
- Motivate the person to concentrate on their body and feel their feet touching the ground or their back touching the back of the chair, etc.

If flashbacks occur during conversation, the interview will be cancelled and the person will be treated as a person with a high-risk estimation. A follow-up conversation with a consulting character is arranged in order to clarify further measures.

3.2 Implementation of CRI-D online

The CRI-D is available in German, English, French and Spanish via www.eutopa-info.eu. The questionnaire via Internet (www.eutopa-info.eu) serves for coordination and synchronisation at different places of action in the aftermath of disasters. It helps to optimise procedures while being confronted with many victims resp. a small capacity of personnel. In the first step chose the suitable language. The button “interactive” can be seen in the taskbar. The next step requires a “log in” that is reserved for professionals who have received an introduction to the concept. Using indication of personal data, we are able to realise a plausibility check. Implementation of CRI-D online is subject to regulations that should be of interest.

Framework conditions

- Distance of time to experience is at least 72 hours.
- The location of the interview should preferably guarantee physical distance to the experience in order to convey sufficient safety.
- Enough time should be included for filling in the questionnaire, approx. 20 minutes.

Instruction for implementing CRI-D online

- Implementation of CRI-D online requires an adequate introduction.
- Make sure you have access to a professional.
- Be aware that the CRI-D is an instrument of precaution. It enables to drive forth an adequate assistance.

„Answering the questions assists me in estimating what offers we are able to make to you in order to manage your stressful experience as quickly as possible.““

- Schedule a brief psychoeducational measure ahead resp. use psychoeducation for victims in order to inform about the natural course of processing in the event of psychological traumatisation
- The CRI-D is not an instrument for making a diagnosis. A clinical diagnosis always requires consultation of a clinical therapist.
- The CRI-D is about "setting the course"

Interview conclusion

- The respondents will be referred to individual contact in order to find out their result in the online questionnaire and for recommendation of further measures.
- The individual risk profile should be communicated *never other* than in individual contact. Only by doing so, a stigmatisation within the group and effects of dissimulation can be prevented.
- If victims feel very stressed by being interviewed, the interview should be cancelled.

Implementation of CRI-D is reserved for trained personnel. The questionnaire via Internet (www.eutopa-info.eu) serves for coordination and synchronisation at different places of action in the aftermath of disasters. It helps to optimise procedures while being confronted with many victims resp. a small capacity of personnel.

3.3 Assessment on the symptom level

The C*RI-D* covers predictive factors of life history, of objective and subjective situational factors, of peri-traumatic situation and of the balance between risk and protective factors. PTSD symptoms are left blank. This has a reason: In the latency stage, many victims show stress disorder symptoms in the scope of the self-recovery process without developing a chronic form of a stress disorder. Only the process will show whether a posttraumatic stress disorder grows out of these symptoms or not. Therefore, inquiry of symptoms during latency stage (4 up to 6 weeks after traumatic situation) is not a valid predictor for PTSD development. Nevertheless, we recommend to endorse diagnostics with an orientated symptom assessment using the PTSS-10. In the validation study, the PTSS-10 showed the best correlation with CRI's total score (Bering et al., 2003). Because of this, the concept of assessing predictor variables merges with the concept of assessing stress symptoms following the approach of Schüffel et al. (1999). Subsequent to PTSS-10 the PDEQ is implemented. It serves for assessing peritraumatic dissociation.

During implementation of CRI-D, a symptom scale should always be assessed as well, for example the **PTSS-10**. Peri-traumatic dissociation should be measured separately by using the **PDEQ**.

4. Evaluation of Cologne Risk Index – Disaster

The CRI-D, being an instrument of precaution, performs a risk estimation of psychotraumatic disorders. It is not an instrument for making a diagnosis of mental disorders in the aftermath of disasters. The index expresses a cumulation of risk factors, being in a condition-framework and is the result of totalling of the different factors. The model is based on the assumption that the factors are standing to each other in a row-of-addition relation. According to the degree of exposure, identified items are matched with point values between 0 and 1. The resulting point values are aggregated in order to identify the total score of exposure. Based on the obtained total score of exposure, an assignment of victims to one of the three groups – group of self-recovery, group of switchers, high risk group – is made.

If the CRI was filled in online, information about the results is sent to the trained professional. Up to now, the CRI-D is calibrated on an inter-validation level. The CRI-D validation process is still ongoing and is adjusted continuously. For this reason, we are limited to communicating individual results via Internet. Possibly, future major loss situations provide valuable results for improving the validation process. For this reason, we refrain from publishing an evaluation formula on the level of individual items at the present point in time.

The CRI-D validation process is still ongoing and is adjusted continuously. For this reason, we are limited to communicating individual results via Internet.

5. Results of EUTOPA Workshops „Risk factors and Screening“

At the conference in Cologne (29.11. until 1.12.2007) as well as at the conference in Amsterdam (25./26.9.2008) workshops concerning the topic “Risk factors and Screening” were performed in the scope of the research project EUTOPA. Workshops were moderated by Ask Elklit and Robert Bering. For elaborate description we refer to the homepage www.eutopa-info.eu.

The workshop results can be summarized to the following guiding principles:

1. Delegates agreed in considering a “screening” after disaster in the scope of psychosocial aftercare usefully.
2. „Screening instruments“ should be distinguished in instruments that assess either level of symptoms, level of factors or level of functions.
3. After interviewing of delegates, the following risk factors were mentioned in graduated relevance: lack of social support, pre-traumatisation, peritraumatic dissociation, low economic status, extent of traumatic event, mental disorders, female gender, personality traits, education, experienced violence, problematic coping, helplessness, loss, high/young age, experienced negative feelings, injuries, fear of death, duration of traumatic event, low self-confidence and attachment disorder before traumatisation.
4. Future studies should investigate dynamics and interaction between risk factors.
5. Future studies should further consider protective factors resp. posttraumatic integration.
6. Future studies should improve consideration of systemic aspects of psycho-traumatisation for example in families or working groups.

7. In the future, more „baseline studies“ should be realised in order to being able to better evaluate comparabilities before and after traumatisation.
8. Future studies should consider influence of personality- and control-styles.
9. Future studies should integrate the meaning of biological risk factors in psychological models.
10. Future studies should examine the question of dissociation being a risk factor in a differentiated way. In doing so, everyday life dissociation, traumatic, peri-trauamtic and persistent dissociation have to be distinguished.
11. Different opinions about when a screening should be implemented were stated. Predominantly, the concept of an alert observation was represented.
12. A common opinion about risk factors relevant for children did not exist among delegates.

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7. Appendix

- Cologne Risk Index for victims in case of disaster (CRI-D)

Cologne Risk Index - Desaster (CRI-D)

for victims in case of disaster

PIN: ____________________ **date:**_____________

A.	**Your age:**		**sex:**	❑ female	❑ male
B.	**Marital status:**	❑ single	❑ married / partnership	❑ divorced / separated	❑ widowed
C.	**Do you have children?**		❑ yes thereof living in your own household:	❑ no	age:
D.	**Do you have siblings?**		❑ yes/ number:_____	❑ no	age:
E.	**Level of school education**	❑ no diploma (drop out)	❑ GCSE-Exam	❑ A-Level-Exam	❑ international baccalaureate
E.	**Professional training**	❑ none	❑ finished apprenticeship	❑ undergraduate degree (BA, BSc, etc.)	❑ postgraduate degree (MA, MBA, etc.)
		❑ NVQ, SVQ, BTEC			
F.	**Last employment**	❑ semi-skilled occupation ❑ self-employed person	❑ skilled employee/ apprenticeship ❑ student / pupil	❑ company employee ❑ housewife	❑ graduate occupation
G.	**Current employment** ❑ student / pupil	❑ semiskilled occupation ❑ housewife	❑ skilled employee/ apprenticeship ❑ retired person	❑ graduate occupation ❑ incapable of working	❑ self-employed person ❑ unemployed
H.	**Kind of housing:**	❑ flat/ house for rent	❑ own flat / house	❑ city ❑ in the country	❑ on my own ❑ flat share ❑ family/partner ❑ parents
I.	**Have you ever been in psychiatric treatment?**		❑ no ❑ yes: ↳ if so:	❑ 1 time ❑ 2-3 times ❑ 4-6 times ❑ 7- 10 times ❑ more than 10 First admission was _________ month ago Last admission was _________ month ago.	
J.	**Have you ever consulted a psychotherapist?**		❑ no ❑ yes ↳ if so:	❑ up to 50 hours ❑ up to 80 hours ❑ more than 80 hours Therapy was____ month ago.	
K.	Are there any **mental-health problems** existing in your **family**?		❑ no ❑ yes		
L.	Do you feel **discriminated by society** because of your ethnic affiliation (e. g. religion, colour of the skin, nationality)?		❑ no ❑ yes		

The following questions relate to the time directly before and after the disaster

1.	Were you under **stress before** the disaster due to other life circumstances (e. g. family-related or financial problems etc.)? ↳ if so: stress had emerged more than one year before stress appeared shortly before the disaster stress is persistent	❑ no ❑ yes
2.	Were your **important social contacts restricted** during the initial time **after** the disaster?	❑ no ❑ yes
3.	Did you feel **restricted** due to **other living conditions after** the disaster? (e.g. crowded housing, no electricity, etc..)?	❑ no ❑ yes
4.	Did your accounts **among friends and family** about the stressful experience meet with negative reactions such as lack of interest, lack of understanding, undue or cumbering curiosity, victim accusation or disparaging remarks?	❑ no ❑ yes
5.	Did you have **negative experiences with institutions**? ↳ if so: police rescue workers doctors / hospitals public authorities others	❑ no ❑ yes
6.	Did you experience **less support** by your family, friends or relatives in your situation than you had expected ?	❑ no ❑ yes
7.	Did you experience **(expected) support by your direct superiors** during time **after** the stressful/ traumatic experience?	❑ no ❑ yes
8.	Is it difficult for you to **talk openly** about the consequences the disaster had on your life?	❑ no ❑ yes

The following questions relate directly to the disaster!

9.	**When** and **where** did the disaster happen?			**month / year:** **location:** _______________________		
	What happened?____					
10.	How much of a burden was **this experience** for you altogether? **Burden**:	extreme (2) ❑	heavy(2) ❑	rather heavy(1) ❑	rather light(1) ❑	light(0) ❑

11.	**Did you experience the stressful incident in a (partially) unusual way?**	
	a) as if you had not been part of the incident	❑ no ❑ yes
	b) You acted automatically (e. g. screamed)without making a conscious decision to do so.	❑ no ❑ yes
	c) Your experience of time was changed, e. g. faster or slower (slow motion).	❑ no ❑ yes
	d) It was experienced as unreal (like in a movie or a dream).	❑ no ❑ yes

e) You were confused or you had trouble orientating yourself in time and space.	❑ no ❑ yes
f) It was as if your own body had not been affected or pain or entire parts of the body were not perceived or your physical feeling was changed in any other way.	❑ no ❑ yes
g) It was as if you were floating above it.	❑ no ❑ yes
h) You only have fragmented, incomplete memories.	❑ no ❑ yes
i) Your field of vision was considerably restricted, like in a tunnel.	❑ no ❑ yes
j) Other changed perceptions / realizations, which ones?	❑ no ❑ yes

12. **What were the characteristics of the most stressful incident?**

a) Did the stressful incident **occur completely surprisingly and unexpectedly?**	❑ no ❑ yes
b) Was it **longer than half an hour** until you were in a safe place?	❑ no ❑ yes
c) Did you experience **a threat to your life or physical condition**? Did you experience subjective **fear of death**?	❑ no ❑ yes
d) Did you watch **a threat to life or physical condition** for one or several other person(s)?	❑ no ❑ yes
e) Were you **severely injured?**	❑ no ❑ yes
f) Do you expect **permanent injuries** (scars, movement restrictions, incapacity to work etc.)?	❑ no ❑ yes
g) Did you **observe severe injuries of others**? ↳ if so: . stranger(s) . strangers: child(ren), woman(en), old person(s) . acquaintance(s) . close friend(s) . family member(s)	❑ no ❑ yes
h) Did one or several person(s) **die**? ↳ if so: . stranger(s) . stranger: child(ren), woman(en), old person(s) . acquaintance(s) . close friend(s) . family member(s)	❑ no ❑ yes
i) In case of dead people, could all deceased be identified?	❑ no ❑ yes ❑ no idea
j) Were you confronted with the sight of a **severely injured or dead person**?	❑ no ❑ yes
k) Did you lose property (e.g. house, flat, furnishing, car, clothes)	❑ no ❑ yes
l) Did you sustain financial loss?	❑ no ❑ yes

13.	**Have you had other very stressful experiences before the disaster?**	
	a) threat/ being held at gunpoint (e. g. robbery)	❑ no ❑ yes
	b) experiences of physical violence (e. g. fistfight)	❑ no ❑ yes
	c) rape, sexual abuse	❑ no ❑ yes
	d) accident	❑ no ❑ yes
	e) early or sudden loss of a beloved person	❑ no ❑ yes
	f) burglary	❑ no ❑ yes
	h) other previous stressful experience(s) if so, such as?____	❑ no ❑ yes
14.	**The following questions relate to the governments' and the media's exposure to the disaster**	
	a) Do you feel sufficiently informed by media?	❑ no ❑ yes
	b) Do you feel burdened by press coverage and needlessly reminded of the event and the resulting consequences for your life?	❑ no ❑ yes
	c) Do you believe the disaster could have been prevented?	❑ no ❑ yes
	d) Do you hold politicians responsible for the disaster and/or do you believe that politicians are at fault?	❑ no ❑ yes
	e) Do you feel supported by the government?	❑ no ❑ yes
	f) Did you get financial support from the government?	❑ no ❑ yes

In addition to the previous questionnaire, we ask you to please describe in your own words your experiences and then to give an account of what is important to you in the following questions:

1. Which part of your experience is most significant for you?

2. During the experience, what was most stressful to you?

3. What occurrences **after the disaster** did you consider as positive and supportive?

4. What occurrences **after the disaster** did you consider as additionally stressful ?

5. Did you consult a therapist? If so, how helpful has this been for you?

6. What was helpful for coping with your experience after the disaster?

7. What kind of help would you have wished for and what else could have helped?

8. Has the image of yourself - in your opinion - changed since the disaster?

9. How are you experiencing your environment since the disaster?

10. What else is important for you to mention?