CRISIS RESPONSE

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Protection Prevention Preparedness Response Resilience Recovery

CRISIS NEXUS:
FROM FLOODS TO FIREWALLS

France's urban logistics crisis | Automation vs authenticity | Nuclear speak | Behavioural psychology | M&S cyberattack

Publishing Editor
Luavut Zahid
luavut@crisis-response.com

Editorial Assistant
Zainab Farooqui
zainab@crisis-response.com

Executive Advisor
Andy Blackwell

Executive Advisor
Jeannie Barr

Editor Emeritus
Emily Hough
emily@crisis-response.com

Design & Production
Rizwan Ahmad
creativesdesign360@gmail.com

Subscriptions
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hello@crisis-response.com

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What makes a crisis? What links two or more together? And finally, what makes us notice?

These were the questions that stayed with me while putting this edition together. Our contributors have done a remarkable job of challenging how we define and respond to crises.

On pg 8, Sana Kardar's powerful comment highlights a crisis that hides in plain sight. Women's health continues to be sidelined, and its consequences extend far beyond women themselves.

Sometimes, what we call progress creates its own set of challenges. Naveed Kapadia examines this through the lens of artificial intelligence in aviation, exploring where it helps and where it fails us. On page 86, Amanda Coleman looks at authenticity in communication at a time when AI is shaping narratives faster than we can question them.

Jeannie Barr asks if the UK is truly prepared to be on a defence footing – reminding us that a whole-of-society approach is the only realistic path forward. Similarly, Kunwar Khuldune Shahid questions whether the world is taking steps towards preventing the next D-day or whether it is drifting closer.

This edition also rethinks the frameworks we depend on. Marcus Almeida (p 42) challenges traditional decision-making models, while Chris Needham-Bennett and Iman Chaudhry (p 46) revamp a risk matrix to propose one more dynamic. Richard FitzHugh adds to this reflection, pointing out that adaptation often stops at token gestures.

On human behaviour: Beverley Griffiths explores how people-focused management can strengthen resilience; Matt Ireland examines the subtle forces that shape how we prepare for and respond to crises.

Finally, Andrew B Brown's reflection on his humanitarian work reminds us that response looks different everywhere, but its essence remains: People helping people.

Every edition reminds us that resilience is rarely about avoiding crises, but about meeting them head-on. And our work to rebuild, rethink, and recover shall continue.

The critical hours:

Early psychological support for first responders

While early psychological interventions such as Psychological First Aid and psychological debriefing are widely used for first responders, their shortfalls demand tailored, evidence-based support approaches, writes **Erik de Soir**

First responders are inherently exposed to psychologically traumatic events, increasing their risk of developing mental health conditions, such as depression, anxiety, and post-traumatic stress disorder (PTSD). It is estimated that one in seven first responders experienced probable PTSD in response to their routine duties, and one in 12 first responders reported PTSD after responding to disasters.

In such cases, early psychological support interventions (that is, within the first few hours and days after exposure to a potentially traumatic event) and psychological debriefing have been used in an attempt to mitigate the various mental health effects of critical incidents on soldiers and first responders. Scientific research has long highlighted the importance of timely, tailored interventions to promote resilience, prevent mental health problems, and support recovery for first responders.

One such example includes psychological first aid (PFA), which is designed to provide immediate emotional support and practical assistance to individuals affected by potentially traumatic events. PFA is a process for helping people after they have experienced a collective emergency, disaster, or potentially traumatic event. It focuses on establishing safety, calming individuals, and connecting them with appropriate resources.

It is worth noting that PFA is not professional mental health care. In fact, it is often performed by laypeople (people without professional credentials). However, certain understandings about people's coping needs guide PFA, including the need to feel safe, connected, and hopeful; the need for access to support; and the need for self-reliance

Current PFA interventions are often based on the Conservation of Resources model (COR) by Hobfoll. The model is a resource-orientated model relying on the supposition that people strive to retain, project, and build resources and that what is threatening to them is the potential or actual loss of these valued resources.

PFA follows the following core actions:

- **Contact and engagement:** Making the initial contact with survivors;
- **Safety and comfort:** Ensuring people are safe and providing their physical needs;
- **Stabilisation:** Calming and orienting people who are emotionally overwhelmed;
- **Information gathering:** Identifying people's immediate needs and getting information to tailor interventions;
- **Practical assistance:** Offering practical help for immediate needs and concerns;
- **Connection with social support:** Establishing connections with sources of support, whether community, family, or friends;
- **Information on coping:** Talking about stress and emotional reactions to trauma, recommending coping skills, helping with anger management and sleep problems; and
- **Linking with collaborative services:** Providing referrals and direct links to services.

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In addition to PFA, structured psychological interventions are often conducted in group settings to help individuals process their experiences and emotions. These sessions encourage participants to share their thoughts and feelings in a supportive environment, promoting mutual understanding and validation. While psychological debriefing is not a substitute for therapy, it can serve as an early step towards identifying those who may need more specialised mental health support. However, there is a strong tendency in scientific research to caution against the systematic use of psychological debriefing.

A Cochrane review concluded that psychological debriefing does not prevent PTSD and may increase the risk of developing psychological disorders. It should be

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noted, however, that none of these studies focused on the use of psychological debriefing in a first responder population. Similarly, a meta-analysis found no consistent evidence that it reduces PTSD symptoms following work-related trauma. The study noted that methodological flaws in many trials prevented meaningful subgroup analyses, but overall, the evidence did not support the efficacy of psychological debriefing in this context. As a reaction to this, psychological debriefing practitioners in fire, rescue, and police services stated that it was never aimed at reducing PTSD symptoms, but rather at cognitive restructuring, group support, psychoeducation, screening for those at risk, and event closure. There is also evidence suggesting that psychological debriefing may impede natural recovery from trauma. However, a report published in *Psychological Science* noted that the finding rather seems to be the consequence of wrong use of debriefing (that is, without proper screening for hyperarousal or fragile individuals).

In the current practices of most peer support teams in Europe, practitioners have learnt about the potential harm of psychological debriefing when first responders are still under pressure and emotionally affected after a critical intervention. It must be mentioned that the basic training and education of these peer supporters is entirely different from what 'debriefers' in scientific studies have received. Therefore, it is important to distinguish between different types of victims, as experienced first responders require a different approach compared to other victims and their families. This difference should also be made in applied scientific research, instead of extrapolating knowledge gained from studies among primary victims to first responders and personnel of uniformed services.

Building on the shortcomings of PFA and psychological debriefing, many support groups across Europe have explored alternative psychological support interventions, psychological triage, and other approaches.

Psychological triage, in particular, helps peer support officers and mental health professionals with managing their activities aimed at prevention, care, and aftercare. It uses a psychosocial model, known as the 'Crash' model, consisting of three types of intervention: potentially traumatic, potentially depressing and potentially exhausting. This leads to a categorisation in different groups of involved personnel based upon primary, secondary, or tertiary exposure (as a function of the level of exposure). The management of emotionally disturbing events is then expressed in terms of primary, secondary, and tertiary prevention of post-event sequelae. Primary victims are directly exposed to the traumatic event, secondary victims are indirectly affected (for example, witnesses), and tertiary victims are those who experience vicarious trauma through their professional roles, such as first responders.

This serves as the greatest asset of utilising psychological triage, as it provides an understanding of the effects of an event. Victims of traumatic events may exhibit different psychological responses, such as hyperarousal or emotional and/or physical exhaustion. Hyperarousal is characterised by heightened alertness owing to the level of threat experienced and may be followed by anxiety and irritability, while emotional and/or physical exhaustion may manifest as fatigue, detachment, and depressive symptoms.

Such identification, then, allows for the categorisation of victims and effective tailored interventions, supported by the Crash model. Qualitative research with first responders over the last decades in the wake of large-scale accidents and natural or technological disasters has learnt that overall interventions can be categorised as potentially traumatic, depressing, or exhausting. For instance, individuals exhibiting hyperarousal should receive interventions inspired by PFA that focus on grounding techniques, relaxation strategies, and normalising stress responses. Conversely, those displaying signs of emotional depression may benefit from interventions that address emotional numbing, promote engagement, and encourage social connections, while those showing symptoms of physical exhaustion should first be guided toward physical recuperation and quick recovery. These tailored approaches are supported by research indicating that early interventions can help prevent the development of PTSD, particularly when they are responsive to the individual's specific symptoms.

The practical case studies highlight the significance of implementing these psychological support interventions. Fire stress teams (FiST) in Belgium and the Unités de Soutien Psychologique (USP) have long utilised the principles of PFA and psychological triage to make a difference between types of interventions and events.

For instance, in the Critical Incident Stress Management (CISM) model, introduced in first responder services, the first psychological support was provided through a series of support interventions, such as one-on-one (peer-to-peer support), demobilisation (upon return from the field), psychological defusing, and debriefing. Psychological defusing, in this case, refers to a brief, structured intervention conducted shortly after a potentially traumatic or high-stress incident, such as a disaster, accident, or violent event. Its purpose is to help individuals begin processing the event, reduce acute stress reactions, and restore a sense of control. During defusing, participants are encouraged to share their initial thoughts, reactions, and emotions in a supportive environment, which aims to normalise their responses and prevent the buildup of more severe psychological distress. It is typically a less formal and shorter support intervention than a full seven-stage psychological debriefing and is often used within the first few hours following the incident.

> After major crisis situations, first responders will stay together, share experiences, and support each other

Moreover, for several years, after exceptional or critical interventions, peer support teams have organised initial support sessions (individual or collective) that aim to define the target, type, timing, and resources required for a quick recovery and recuperation (physically and emotionally). Individual or group support is tailored to the type of intervention. Within the FiST, the Five Questions Rest Information Transition Session (Five Qs RITS) is such a tailored intervention that evaluation is based on the

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following five questions: What did you do/what was your role or function? How do you evaluate your action (self-efficacy/control)? What was the most difficult part of the intervention (self-assessment/resilience check)? How are you now? Would it be useful to provide a more extensive operational stress debriefing?

However, despite these advances in peer support, psychological debriefing has historically remained a widely used method, even though mounting evidence questions its effectiveness and raises concerns about potential harm. Even when this position is based on an incorrect overgeneralisation of results, healthcare providers and organisations should continue to develop alternative, evidence-based interventions to support individuals following critical, potentially traumatic events. The domain of first responders is a special one, and it is not imaginable that group support and operational (stress) debrief sessions would be prohibited in the wake of shocking interventions.

The problem is that up until today, there is not a single guideline that states what should be done to support uniformed services personnel in the first golden hours after exposure to critical, potentially traumatic events. Researchers lack field experience, and field workers lack scientific knowledge, but one thing is certain: After major crisis situations, first responders will stay together, share experiences, and support each other. It seems ethical to offer immediate institutional and professional support to channel emotions and restore group effectiveness. CRJ

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Author

ERIK DE SOIR, PhD, *is a Fire and Rescue Psychologist based in Belgium, Associate Professor in Psychotraumatology, and a member of* CRJ*'s Advisory Panel*

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