Critical Incident Stress Management Foundation Australia Newsletter

Special edition

Volume 5, Issue 3 ***October 2003***

Psychological Debriefing: A Closer Look at the Facts

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1. Introduction

In modern times, Critical Incident Stress Management (CISM) has been one of the most positive and influential developments in the area of support for staff whose jobs expose them to psychological trauma. The CISM model recognises the strong coping skills of staff in occupations such as emergency services, hospitals, defence forces, corrective services, security and welfare. However, it also recognises that those jobs can become overwhelming. Early intervention can be of significant value in assisting people to cope and to return to work. Both individuals and organisations have derived benefits from staff support programs, based on the CISM model, leading to a proliferation of such programs in Australia in the last 15 years.

Nevertheless, there has been criticism of the CISM model and mostly of one of its components, Critical Incident Stress Debriefing (CISD). This criticism is predominantly based on a small number of studies that relate to a practice labelled 'debriefing' but which bears little or no resemblance to CISD and which, arguably, has been applied inappropriately to victims in the community. Additionally, the "key" studies have bad design flaws. Conclusions have been drawn from these studies, quite inappropriately, to debriefing as practised in the workplace as part of CISM programs. Some organisations are now being cautioned against the use of "debriefing".

It is to be expected that innovations will attract criticism. In and of itself, this can be healthy and enhance the development of a body of knowledge. What is concerning about the current criticism is that too much of it is based on misunderstandings of CISM and CISD and there is a failure to distinguish the essentially emergency service model from other applications.

An interesting outcome of the debate has been the elucidation of different beliefs that people have about what helps and harms those in the early aftermaths of trauma: to talk or not to talk, to be with friends, professionals or left alone; to enter therapy early or wait? (Ormerod, 2002). As debate has continued, terms are changing (eg the term "early intervention" is now tending to replace "crisis intervention"). The importance of some concepts is becoming apparent. For example, many writers now discuss the need for flexibility in providing intervention (as does this paper). Through these changing emphases, it is important to remember that provision of support will always need to be tailored to the needs of workers and organisations. Differences in practice and exceptions are part and parcel of working in complex and sometimes unchartered situations. For example, emergency service support programs may

be more structured, and to the outside observer less flexible, than CISM programs in other workplaces. What is regarded as "rigid practices" and unhelpful by some may be regarded as "structured" and useful by others.

The first purpose of this article is to affirm the value of properly implemented and practised CISM programs. The second purpose is to counter the claims made against debriefing, especially the negative outcome studies, the allegations that debriefing may harm people and the allegations of bad practice by CISM practitioners. Finally, some comments are made on support programs and how to evaluate them.

The article is divided into the following sections:

- The CISM Model and evidence for its value
- Negative outcome studies
- Allegations of possible harm
- Allegations of bad practice
- Misunderstandings of the CISM model
- Approaches to support programs
- Approaches to evaluation of support programs
- Tasks for the future

2. The CISM model and evidence for its value

The following are general comments about the CISM model. It is more fully described in Mitchell and Everly (2001), Everly and Mitchell (1999), Robinson and Murdoch (2003), Dyregrov (2003b), as well as numerous other writings.

Critical Incident Stress Management is a multi-component model that includes education, individual support, group meetings (one of which is CISD), organisational consultation, family support, referral and follow-up. It is grounded in the theory and practice of crisis intervention and the body of literature and research that belongs to that field. It is neither therapy nor treatment. This is an important point because negative outcome research has frequently conceptualised and tried to assess debriefing as if it were a treatment. CISM is specifically oriented towards people in the workplace, originating in occupations most exposed to traumatic or critical incidents, such as emergency services. Most CISM programs respond to distressing day-to-day incidents, as well as to major incidents and disasters, though there are differing protocols for these differing circumstances.

The providers of CISM services are mental health professionals (such as psychologists and social workers) and peers. Peers are specially selected and specially trained members of the workplace. They work in partnership with mental health professionals in ways that are specified in protocols. Peers and mental health professionals undergo initial training, then ongoing training, supervision and support. While peers are internal to organisations, mental health professionals may be internal or external. Protocols and policies should specify how particular systems work within organisations, including lines of accountability, lines of communication, quality control, record keeping and service evaluation.

There are variations in the way that the CISM model operates in practice. One set of reasons has to do with the evolution and adaptation of the model. For example, as the essentially emergency service model has been applied to similar workplaces, like hospitals and welfare organisations, changes have been made to suit the needs of personnel and the workplace. As well, the model itself has evolved over time; these days there is a greater use of defusings rather than debriefings and there tends to be more follow-up. Finally, within particular organisations, successful programs tend to evolve and develop over time.

A second set of reasons why programs vary in their practice is that it is both impossible and unwise to specify how staff will respond to a particular critical incident or major event. Individuals differ in their responses to trauma and what may help them. Each situation should be assessed on its own merits and support responses tailored to staff needs. On some occasions,

there may be no action. On another occasion, peers may talk to staff individually. On still other occasions defusings and debriefings may be conducted.

Assessment and flexibility are central to early intervention and to CISM. A seminar was conducted by St Vincent's Hospital, Melbourne, on 4th April 2003. It featured presentations by several hospitals describing the support that was offered to their staff following major incidents such as the Bali bombings in October 2002. There were different reactions to peer support. In one hospital, the informal support offered by peers, sitting in tea-rooms and meandering around, was highly valued. In another hospital, the same peer behaviour was seen to be intrusive. This example illustrates how important it is to assess staff needs and be flexible in the development of the specifics of a support response.

There is a substantial and growing literature that demonstrates the value of CISM and CISD. The most comprehensive current list of studies is by Mitchell (2003), but there are also reviews by Everly, Flannery and Mitchell (1999) and Robinson (2000). Mitchell (2003) lists 61 positive outcome articles on CISD and CISM and a further 47 articles and books in support of early intervention. Positive outcome studies conclude that CISM programs, and the specific technique of CISD, reduce staff anxiety, facilitate coping skills, help employees to return to work, lead to cost-savings and other benefits for the individual and the organisation.

Flannery has published widely on his Assaulted Staff Action Program that demonstrates reduction in violence against staff, returning staff to work and cost saving to the organisation (Flannery, 1998). Independent evaluation of a CISM program introduced for nurses throughout rural Canada made cost assessments of stress (eg sick leave, workers compensation) before and after the introduction of a CISM program. This study found that for every dollar spent on the program (equivalent to approximately AUD$500,000), $7.06 was saved (Western Management Consultants, 1996). In Australia, Ott and Henry (1997) reported a 92% reduction in stress-related compensation costs over a year following the introduction of a staff care (CISM) program at Goulburn Correctional Centre in New South Wales. Leeman-Conley (1990) reported a 60% reduction in sick days and 68% reduction in compensation payments and disability payments leave following the introduction of a staff support program after hold-ups in the Commonwealth Bank of Australia. In other studies, Chemtob, Thomas, Law and Cremniter (1997) demonstrated a marked decrease in post-disaster stress symptoms amongst disaster workers who received a combination of CISD services and disaster stress education.

The positive outcome studies are not without their flaws. However, taken overall, a consistent picture is emerging of the value of these programs, to workplace individuals and organisations.

3. Negative outcome studies

3.1 History of the debriefing debate and early negative outcome studies

The earliest review that was critical of "debriefing" appeared in the British Medical Journal in 1995 (Raphael, Meldrum & McFarlane, 1995). The authors argue that debriefing may be ineffectual (citing a study by Deahl, Gillham, Thomas, Searle & Srinivasan, 1994) and also that it may be harmful (citing studies by Kenardy, Webster, Lewin, Carr, Hazell and Carter, 1996 and Watts, 1994). They state that "the possibility that debriefing may increase problems warrants further consideration", then speculate on possible reasons for an increase, such as inappropriate timing of debriefing and secondary traumatisation.

This often-cited article bases its conclusion that debriefing may be harmful on just two studies. These two studies are rarely cited as evidence in the modern anti-debriefing literature, presumably because of the fledgling nature of the research and flaws in methodology. Both studies assessed outcomes at 50 weeks post incident, a particularly unfortunate time because of the confounding effects of "anniversary" reactions. There were no pre-incident measures of the "debriefed" and "non-debriefed" groups, making comparisons

between the two groups, at 50 weeks, of minimum value. Kenardy et al (1996) could not adequately define the intervention they were studying and they wrote "there was no standardisation of debriefing services and procedures…we were not able to determine objectively the quality of the debriefing provided to each subject…we do not know the extent to which the debriefing matched the model of Mitchell." They state that they did not even know whether people in the 'debriefed group' had in fact received debriefing. Nevertheless, the authors do go on to make negative conclusions about debriefing. Importantly, whatever the findings of the Watts and Kenardy studies, be they positive, negative or inconclusive, they did not test the CISM model of debriefing. Both are Australian studies and both conducted prior to the introduction of CISM training in Australia. For further discussion of these studies, see Robinson (2000) and Robinson and Mitchell (1995).

Arguments against debriefing have continued to be put forward and new studies have been cited in support. Rebuttals and the publication of positive outcome research have also continued (see for example Everly et al, 1999; Mitchell and Everly, 1997; Robinson, 2002).

3.2 Single session, individual debriefing applied to members of the community

3.2.1 Overview

There are 7 or 8 studies that utilise randomised controlled design which are frequently quoted as demonstrating that debriefing is of no value or may harm people. These include studies by Bisson, Jenkins, Alexander and Bannister (1997), Hobbs, Mayou, Harrison and Worlock (1996), Mayou, Ehlers and Hobbs (2000) and Small, Lumley, Donohue, Potter and Waldenstrom (2000). Two main reviews of these studies are by Rose, Bisson and Wessely (2002), commonly referred to as the Cochrane review, and Van Emmerik, Kamphuis, Hulsbosch and Emmelkamp (2002). Bisson, McFarlane and Rose (2000) also review these studies in considering psychological debriefing as a treatment for Posttraumatic Stress Disorder. There are many problems with these studies, and the claims that emanate from them, which are addressed in the remainder of this section.

3.2.2 The studies are not applicable to CISD or CISM

The group of studies have the following features in common:

- They are all studies of civilian populations: eg burns victims, motor vehicle accident victims, women who give birth.
- They utilise one-to-one support (which they label debriefing)
- The nature of "debriefing" and the training of those who provide it are not adequately specified
- They utilise once-off intervention in isolation of other support
- They select treatment outcome variables, such as posttraumatic stress disorder and depression, in order to assess "debriefing".

The CISM model advocates

- application to people in the workplace;
- debriefing as a seven phase *group* process;
- training of all CISM team members, and
- never administering CISD as a stand alone intervention.

The interventions that are described in these studies are not only totally different from CISD/CISM. They also represent violations of CISM protocols, such as utilising once-off interventions. Nevertheless, detractors continue to apply conclusions from these studies to CISM practices. For example, Devilly and Cotton (2003) state that "A consensus of randomized controlled trials suggests that individual debriefing, using the CISD/CISM systems are noxious". Individual debriefing does not use the CISD/CISM system. Conclusions about CISD/CISM cannot be drawn from them.

The differences between group processes (CISD) and individual interactions (individual debriefing) are self evident. However, there are other important distinctions.

Support programs in the workplace are different from support services offered to civilian victims/survivors. In work-based programs, it is possible to educate staff about stress, trauma and support facilities; to track staff following incidents; to ensure that an assessment procedure is operating so that appropriate interventions can ensue; to follow up individuals and to refer them to ongoing counselling where appropriate. It can be ascertained that the providers of CISM interventions are properly trained in the first instance and appropriately supervised and themselves supported thereafter. In other words, it is a reasonably controlled environment aiming to assist people and "do no harm". This is very different, for example, than dealing with a group of people who are thrown together because they happen to be on the same flight that is hijacked or taking a neighbourhood group who happen to live on the same street that is ravaged by fire or dealing with people in a hospital who are there because they have suffered severe burns. Additionally, the needs of victims/survivors differ from caretakers such as nurses and emergency service personnel who have some preparation, training and expectation regarding the more difficult aspects of their job. CISM caters for them in their professional role. This is very different from being a primary victim/survivor.

Another difficulty arises when researchers conceptualise CISD as a treatment, look for treatment outcomes (such as posttraumatic stress disorder), then judge debriefing by those outcomes. Small et al. (2000) criticise debriefing because it fails to prevent depression in women who give birth. Debriefing, as developed in the original model of Mitchell, was never designed to deal with women who give birth and the application is clearly contrary to the original intentions of debriefing. When researchers make this kind of conceptual leap, then interpretation of findings should reflect the possibility that the intervention was misapplied. Small et al (2000) conclude that debriefing is ineffective. It could also be concluded that their assumptions about the applicability of debriefing to this group were misguided, that their assumptions that a crisis intervention technique could achieve a treatment outcome (prevention of depression) was misguided and that application of what is labelled 'debriefing' to populations it was never designed for does not test the CISM model. It is not sufficient for studies or critiquers to assume what they would like debriefing to achieve, then assess it by those criteria!

These confusions have found their way into the courts in cases of duty of care. As debriefing is not a treatment, it is appropriate to conclude that it does not prevent treatment outcomes, such as posttraumatic stress disorder. However it is not appropriate to conclude that debriefing is ineffective because, when incorporated into CISM programs, it achieves the kind of outcomes specified in crisis intervention.

3.2.3 There are serious design flaws in some of these studies

Research in new and complex areas will always be difficult and flaws can be found in several of the studies, be they describing positive or negative outcomes. However, there are particularly bad design flaws in some of the negative outcome studies including those used to support the most damning of arguments against debriefing; namely that debriefing may be harmful.

Bisson et al (1997) looked at burns victims and administered individual debriefings following hospital admission. They state that they used a randomised controlled research design. They found that, at 13 months, 16 (26%) of the debriefed group had PTSD compared to 4 (9%) of the control group. However, the debriefed group also had "more severe dimensions of burn trauma". Severity of injury can be expected to influence recovery and to be a stronger predictor of recovery than a one-hour discussion within days of hospital admission. This is especially so given that the assessment was at 13 months. Not only may severity of injury be important to recovery in its own right, it might in turn influence coping strategies, interpersonal relationships and other factors that in turn impinge on recovery rates. Nevertheless, the researchers conclude: "this study seriously questions the wisdom of advocating once-off interventions post-trauma". Also, the status of this study as utilising a randomised controlled design is

maintained despite the lack of control of what may be a very important explanatory variable (severity of injury).

Hobbs et al (1996) instigated "debriefing" to victims of motor vehicle accidents using a randomised controlled design. "Debriefing" usually occurred between 24-48 hours after the accident. They found that at four months, the intervention group had a worse outcome on two subscales of the Brief Symptom Inventory. The intervention group also had a higher mean injury severity score and longer hospital stay (more than double that of the control group). A three-year-follow up (Mayou et al, 2000) showed a worse outcome for the debriefed group, i.e. for the more severely injured group. Again the authors fail to acknowledge the role of severity of injury and other factors that cannot be controlled over a three year period. They instead conclude that a one-hour debriefing session, within 48 hours of hospital admission, is responsible for poor recovery at three years.

These studies are criticised by others. Ormerod (2002) cites Parkinson as criticizing the Bisson study on the grounds that intervention sessions were too short (40 minutes), debriefers were nurses and his own staff trained in half a day and that those who were debriefed were self-selecting and involved in much worse incidents than those in the control group. Ormerod also cites Regel who states that "Bisson described psychological debriefing as intense imaginal exposure to a traumatic incident whereas psychological debriefing involves a discussion about the event". Ormerod quotes Regel as stating that Hobbs himself in a later publication reported that "after the first 10 subjects, the interventions were undertaken by the research assistant. The intervention therefore immediately followed the screening interview, with which it became merged to some degree, and interviewer "blindness" was inevitably compromised".

These two studies, with their longer term assessment, are cited as the major or sole basis for the argument that debriefing may harm people. It is the major evidence behind cautions regarding debriefings in the workplace.

In radio and press articles it has even been put that, although these studies are flawed, at least they are pointing us in the right direction. This is faulty logic. If the studies are so flawed as to be suggesting incorrect conclusions, then in fact they are pointing us in the wrong direction.

3.3 CISM in the workplace

There are a few studies of CISM programs in emergency services that are cited as evidence against the CISM model (for example Macnab, Russell, Lowe and Gagnon, 1999; Carlier, Lamberts, vanUchelen and Gersons, 1998; Carlier, Voerman and Gersons, 2000). The particular practices that are criticised need to be understood.

The Macnab et al (1999) study describes a situation where an ambulance plane went missing with two pilots, two paramedics and one doctor on board. During the 5 days when the fate of the plane was unknown, there was a series of defusings and debriefings which the authors state "followed the recommendations of Mitchell". The interventions themselves may have followed Mitchell's writings but the fact that group sessions even occurred is counter-indicated. Normally, there would be no group meetings while an incident was still occurring. The study found "negative" results in that paramedics were anxious at the 24-hour mark after the plane had gone missing. This is hardly surprising given that they did not know the fate of their colleagues. It is to be hoped that after the downed plane was discovered, on day 5, that support was offered. The report states that "the CISM team was not seen to be helpful", which would be consistent with inappropriate and ill-timed intervention.

The Carlier et al studies (1998; 2000) describe a system whereby police officers "automatically" have one-on-one discussions with a peer at 24 hours, 1 month and 3 months. This occurs for all staff who attend incidents that are listed as requiring intervention. This protocol appears to be enacted irrespective of individuals response to a job or need for assistance. From the study description, it would appear that intervention and its timing is devoid of assessment and/or consideration of staff needs. "Debriefing"

was individual, with peers, with sessions as brief as 5 minutes. This does not describe nor conform to the CISM model.

Other studies are cited as examples of CISM programs not working when in fact the studies support CISM principles and positive outcomes (Hytten & Hassle, 1989; Harris, Baloglu & Stacks, 2002). These and other examples illustrate the importance of looking at the details of studies before accepting the claims that they test the CISM model.

4. Allegations of possible harm

4.1 Overview

Statements that debriefing may be harmful have been put forward by several writers (Raphael et al 1995; Devilly & Cotton, 2003, Rose et al 2002, Bledsoe, 2002, Van Emmerick et al, 2002 and others).

Since all interventions have potential for harm, any allegations of harm or potential harm must be taken seriously. Such claims need to be substantiated by well-conducted research studies and convincing argument. They also need to satisfactorily counter the research and arguments of those who advocate for CISM. These conditions are not satisfied.

4.2 The studies used in evidence are flawed and limited in their focus

As described in section 3.2.3, the studies that are currently used to justify allegations of harm are very few and badly flawed. Even if those flaws did not exist, conclusions could only be drawn to the kinds of population and interventions that the studies themselves addressed. That is, they are not relevant to CISM in the workplace.

4.3 Explanations of harm are unconvincing

The most commonly cited explanations of harm are re-traumatisation, impediment to the natural recovery process and the talking process.

Rose et al (2002) put the case for re-traumatisation in describing debriefing as "clinician based re exposure to the event" which they state "in some individuals (can) serves as a further trauma, exacerbating their symptoms without assisting in emotional processing". It can as easily be argued that people continue to experiencing the thoughts and feelings that were generated by a trauma for many days and that the concept of "re-traumatisation" is meaningless. In line with this, defusings and debriefings enable people to think about and discuss their current experiences. As a safeguard, debriefings are usually not conducted more than 3 or 4 days post-incident, there is assessment as to whether or not a group meeting is appropriate and wanted by participants, and participants choose whether or not to attend.

Wessely argues that debriefing may impede the "natural recovery process" when he states that "talking to a stranger, whom one has never met before and will not meet again, may impede the normal process of recovery that utilizes one's own social network – family, friends, general practitioner and others who may be better able to place the trauma in the context of one's own life" (Wessely & Deahl, 2003). This misses the point that a fundamental aim of crisis intervention, including CISM, is to mobilise participants' own coping skills and their social networks.

The view that talking about stress creates it is put by several authors. Wessely states that "perhaps the process of debriefing, part of the function of which is to warn participants of emotional reactions that might be expected to develop over weeks and months, actually increases the occurrence of these symptoms" (Wessely & Deahl, 2003). Rose et al (2002) state that "debriefing, by increasing awareness of psychological distress, may paradoxically induce that distress in those who would otherwise not have developed it". Alternatively, many if not most people discuss the advantages of talking. They identify the value of expressing thoughts and feelings, of sharing experiences with others and of the opportunity to develop coping strategies. They favourably compare the opportunity to talk with times when this was less possible. Notwithstanding, the view on whether or not it is better to talk does not have to be an "either/or" argument. In one-on-one sessions for example, the helper can offer

to someone the opportunity to talk but if they choose not to, other options are available (e.g., to simply be with the person without talking about the event, to talk later rather than now, to help the worker with practical issues).

Explanations need to be provided for the assertion that debriefing may cause delayed trauma responses, years after a debriefing (McFarlane, 1986; McFarlane 1988; Mayou et al, 2000). For example, McFarlane's study of firefighters reports low correlation between debriefing and delayed trauma responses at 50 and 126 weeks. Before drawing conclusions that a one-hour discussion has potency, not at the time of the intervention, but years afterwards, much more information and exploration of other possible explanations is required.

For every explanation of harm, there is a counter argument. Clearly more research is needed to elucidate matters.

4.4 Reconciling the research and arguments of advocates of CISM

The positive outcome research has generally been dismissed on the grounds that studies have not utilised randomised controlled design and that some of the literature has been difficult to locate. The issue of randomised controlled design is taken up later. Accessibility of research reports posed problems in the earliest days of this field but that is not the case today. Literature searches will show over 40 articles in peer reviewed journals.

There has also been a tendency to discredit the consistent findings, even reported in negative outcome studies, that participants rate debriefing as helpful and advocate the continuation of support programs. Service providers and researchers need to pay attention to what the recipients of services say. In particular, recipients can articulate what is helpful (such as outreach, immediacy, practical assistance) and what is not. Self report should not be the only source of information in assessing CISM and CISD. But it is a legitimate piece of the knowledge jigsaw.

5. Allegations of bad practice

Through articles, public forums and the media, some "bad practices" have been attributed to CISM practitioners that will be considered below.

5.1 Uncontrolled presence of counsellors on-scene at disasters

Devilly and Cotton (2003), Bryant (2003) and others have described the emergence of helpers "on-scene" post September 11 and the undesirability of this response. This behaviour did not commence with September 11 and we have seen it in Melbourne, for example, following the Hoddle Street and the Queen Street shootings in 1987. CISM protocols for disaster response recognise the difficulty and undesirability of uncontrolled helping response and there are guidelines to prevent it. The value of these protocols was evident following Port Arthur where two support responses were mounted, one for the community and one for the Emergency Services. The former had many examples of unsolicited help and the latter did not because the protocols controlling helping resources were enacted (Richman 1998). It is quite inappropriate to blame the CISM model for the inappropriate behaviour of people who self-activate. In fact, the CISM model controls unsolicited help in those situations over which it has jurisdiction.

5.2 CISM is a money making business

It has been implied that CISM practitioners are exploiting people for financial gain. Devilly and Cotton (2003) state that "the provision of debriefing services to organisations is now a multi-million dollar industry" and that "following harrowing experiences psychological debriefing providers frequently advise organisations to utilise their services asserting a number of claims about the effectiveness of debriefing". Firstly, there is nothing wrong with appropriate charging for services rendered. Secondly, there is everything wrong with exploitation. Such allegations should be substantiated and investigated by appropriate professional bodies and others who have responsibility for the ethical practices of helpers. Such statements of exploitation need to be balanced by the observation that most mental health professionals charge appropriately for their

services. It is not uncommon for them to render their assistance without charging and to forego income-earning activities in order to participate on CISM teams. Peers work on a voluntary basis. A more balanced picture is required in describing the work of professional people and peers who are involved in CISM.

5.3 CISM providers are scaring organisations into adopting debriefing using litigation arguments

Devilly and Cotton (2003) state that fear of litigation may be used by debriefers when negotiating services and that "a cursory search of Australian websites quickly demonstrates how (the legal case of Howell versus NSW rail) is currently being used as a reason why debriefing should always be advocated". There have been two Australian cases (Howell and Seedsman) in which payouts were granted to workers who were diagnosed with Posttraumatic Stress Disorder following exposure to trauma in the course of their duties. It is certainly arguable that litigation in the courts is influencing workplace practices. It is preferable that organisations be encouraged to adopt and enhance their staff support programs through education and not through fear of the consequences of litigation.

Kenardy (2003) discusses the "dilemma surrounding the virtual obligatory application of psychological debriefing as a means of meeting duty of care". No supporting evidence is offered for his assertion of obligatory application of debriefing. Devilly and Cotton (2003) state that "an argument is frequently made for psychological debriefing that reminds organisations that they have obligations under workplace health and safety commitments to provide for their staff when traumatic events occur in the workplace" and "following harrowing experiences psychological debriefing providers frequently advise organisations to utilise their services". If the authors mean by this that providers are scaring or threatening employers, then they need to provide evidence of this practice, and of its being "frequent".

5.4 Summary

A major concern with the above statements collectively is that they paint a general picture of exploitative, unethical behaviour by service providers. This is far from the truth. The vast majority of practitioners in this field are highly responsible, ethical and dedicated professionals who work hard to assist their clients. General, derogatory statements, if they are to be made against workers in this field, need to be substantiated.

6. Misunderstanding of the CISM model

A number of critics have launched attacks on CISM and CISD when it is clear that they have not understood the CISM model. This has led to spurious arguments about issues over which there is in fact agreement between the critics and proponents of the model.

To give an example: when CISD is mistakenly seen as an entire approach, rather than as part of CISM, then debriefing is argued to be ineffective and authors go on to propose "what should happen". They invariably outline practices that have already been described in the literature on crisis intervention and CISM. See, for example, Devilly and Cotton (2003) and Wessely (Wessley & Deahl, 2003).

A second example occurs when debriefing is defined as a treatment and found not to prevent PTSD. The argument against debriefing then becomes an argument about premature use of treatment and "medicalization" of trauma response. Principles of early intervention are espoused as if they are in opposition to those on which CISM is based.

Confusion has also arisen over the word "prevent". Prevention can be used in the context of crisis intervention programs and also to describe therapeutic outcomes. Thus, proponents of CISD and CISM would not assert that CISM interventions prevent treatment outcomes, such as therapy might aim to prevent posttraumatic stress disorder. They do however state that CISD and CISM aim to prevent those outcomes

that crisis intervention addresses, such as the worsening of a current situation, further de-stabilisation of the individual or the development of unresolved issues.

There are also misunderstandings about details of practice in CISD and CISM. It is espoused that the CISM model advocates compulsory debriefings. While compulsory debriefing is practised by some organisations, especially law enforcement agencies, this is not espoused as central to the CISM model. Also, it is argued that CISM practitioners, in the educational phase of CISD, instruct participants in stress symptoms in a way that is intrusive, predictive of stress response and/or "normalising" in a way that trivialises response. It has been argued that practitioners fail to recognise diversity of response between individuals and/or then minimise the impact on severely impacted persons by labelling their reactions as "normal". It is unclear where these misunderstandings arise from. It may reflect inadequate practice, or alleged inadequate practice, by some CISM practitioners that is then assumed by critics to be the norm. It may be that critics rely totally on the written word to understand practice whereas training is needed to impart the complexity of practice and to illustrate where flexibility is required but without violating the basic principles of the model. Rose et al (2002) state that "debriefing also assumes that there is a uniform, and to a certain extent predictable, pattern of reactions to trauma". Such criticisms indicate a lack of understanding of the CISM model and the training/supervision of CISM team members.

A particularly bad misunderstanding of the CISM model is the assertion by Devilly and Cotton (2003) that there is no difference between the multi-component Critical Incident Stress Management model and the single intervention of Critical Incident Stress Debriefing. They state that "for now we can only conclude that CISD may or may not be one component of CISM...the two terms should now be treated synonymously". Effectively, they are asserting that a single intervention is the same as a multi-component approach. It is like saying that systematic de-sensitisation is the same as Cognitive Behaviour Therapy or that homework exercises are the same as Rational Emotive Therapy. Dr Jeffrey Mitchell, as early as 1983 in the article that first described debriefing, identified other interventions that he recommended should be included such as one-to-one support, family support and field education (Mitchell, 1983). His approach has always been a multi-component one. There was some initial confusion over the term Critical Incident Stress Debriefing in the late 1980's when the term was used to refer to the specific seven-phase group debriefing process as well as the generic approach. However, Mitchell has repeatedly clarified these terms since the early nineties. For example, he encouraged support teams to call themselves CISM not CISD teams from the 1990's on and a major text that Mitchell has continued to revise over time clearly makes the distinction in its second edition (Mitchell & Everly, 1996).

Negative outcome studies have recognised that debriefing is part of CISM: for example Carlier et al, 1998, in the first paragraph of his article states that "debriefing is meant to be just one component of a comprehensive critical incident stress management program". Richards (2001) reports a study that compares two post-trauma support systems following armed robberies: CISD as a stand-alone intervention and CISD integrated into CISM support (the latter, incidentally doing better). There are many other examples. A definitive statement about a field, as this article purports to be, should at the very least be able to accurately describe core concepts and definitions as proposed by the authors of the model.

7. Approaches to support programs

Most modern-day programs of early intervention are multi-component and emphasise the importance of information, support, practical assistance, mobilising the resources of the person and their social network. These are the principles of crisis intervention, the CISM model and other programs such as that described by the Red

Cross (Armstrong, O'Callahan & Marmar, 1991). Integrated multi-component systems are advocated by the International Critical Incident Stress Foundation, NSW Disaster Mental Health, Federal Emergency Management Agency, USA, Salvation Army, Red Cross, USA and Florida Green Cross.

The integration between early intervention programs and therapy programs needs not be seen as in conflict or competition with one another other but rather as complementary. They have different aims and processes that reflect the needs of clients over a time span.

There are differences of opinion, that might continue for some time, on who should provide early support (family and friends or "helpers", be they peers and/or mental health professionals) and in the appropriate timing of interventions, with some advocating "going in soon" and others "waiting until a month or so".

Dyregrov (2003a) outlines 3 general approaches to the timing of intervention
(a) let the social network take care of people
(b) wait and screen for impact (at one month?) then refer those with unresolved issues into therapy programs, and
(c) early intervention.

The first option of "doing nothing" is probably untenable given our knowledge of crisis intervention. While those with strong social network might do well, it leaves personal recovery too much to chance. As well, when a workplace is hit by major incidents, the informal helping network can be all but struck out and other appropriate assistance is needed.

Bryant (Bryant, 1995; Bryant & Harvey, 1998) has argued the approach of waiting one month (so as not to over-professionalise response in the early aftermath), assessing people, then encouraging those still affected into therapy. This leaves the problem of what happens in that first month, the issue of an 'assessment and therapy" approach in organisations that pride themselves on their coping skills, and an approach that only focuses on the most severely impacted (the minority). There is also the problem of getting those who would benefit from therapy into therapy. Richards (2001) has argued that "the view against the provision of immediate services for all victims – suggesting instead a symptom monitoring system to pick up cases at one month post trauma – is unlikely to engage victims in therapy unless initial contact has been made with victims earlier." He notes that "given the choice, the traumatised do not readily volunteer for assistance." He suggests that early intervention like CISD and CISM will enhance the opportunity for treatment for those who need it. In contrast, Bryant (1995) writes that early intervention programs do not achieve this goal and he states that "this author regularly receives referrals for management of traumatised individuals who have received initial debriefing and, despite significant symptomotology, have been informed that their adjustment is appropriate."

The case for early intervention includes the following. Early intervention may be requested by the organisation and/or by workers themselves. Advice to management, discussion with workers, early support to those who are very distressed can be achieved. Since CISM programs incorporate peer support, there is not an over professionalization that many writers caution against. This approach also enables assessment of impact across the board and it enables the early practical assistance and information that many find so useful. For those people who show high impact, it facilitates access to professional assistance. Though this will usually be the exception rather than the rule, programs need to be able to refer workers to professional assistance whenever it is appropriate for the client.

8. Approaches to evaluation of support programs

Approaches to evaluation in this complex area need to be broader than randomised controlled trials.

Devilly and Cotton (2003) assert that "there has never been a randomly controlled trial

of group CISM and therefore its efficacy has not been demonstrated". Wessely states that "the only reliable method we have of knowing whether a treatment does more good than harm (is) the randomised controlled trial" (Wessely & Deahl, 2003).

The evaluation literature (now three decades old) has long advocated that methods of enquiry should suit the purpose of study and not vice-versa. In other words, advocating a design (like randomised controlled trials) simply because it is a design begs the question of what one is trying to find out. The evaluation literature also suggests that complex situations (such as complex human behaviour) is best approached using multiple designs. Thus the argument for the randomised controlled trials as the only acceptable or desirable way to acquire knowledge is misguided.

There is value in studying the complexity of situations, and not attempting to control them. To give an example, if the value of debriefing is influenced by colleague acceptance (or otherwise) of CISM programs, then these are "interactive" effects that need to be better understood. The skills of the people running debriefings and defusings are important to understand. By way of example, the writer undertook to assess the validity of a study in Eye Movement Desensitisation Reprocessing (EMDR), a therapeutic model. In training programs, counsellors are taught to integrate EMDR within their own skills and practices and that a client's well-being is always paramount. If, for example, a client wishes to cease the eye movement procedure, then this is to be respected. The evaluation study of EMDR being reviewed was a session where the client asked the therapist to cease the procedure mid-way. However, since the procedure could not be assessed if it was incomplete, the therapist/researcher continued with the protocol with detrimental outcomes to the client (who dissociated). How easy it was to conclude that the procedure harmed the client (and that was what pre-assessment compared to post-assessment appeared to show). The point is that service/therapy delivery is an important component in the success or otherwise of the intervention being studied. Randomised controlled trails are common and appropriate in a medical model setting where isolating one variable and assessing its effects may be realised. In complex human interactions, this aim may not be so readily achievable and it is of more interest to understand interactive effects.

A successful randomised controlled trial, even if desirable, is unlikely to be achieved. It would require the following. After a disaster or major incident, assessment would need to have been given to the people involved in the incident prior to the disaster (requiring a miraculous prediction of the disaster, who would be involved and a willingness of the people in the midst of anticipating a disaster to be tested). Then post-incident, half (at random) would be debriefed and half not. Then they would be re-assessed. Clearly, these conditions are unlikely to be achieved. Also the quasi-experimental designs, that are implemented in an attempt to approximate randomised controlled trials, bring with them their own set of problems as they fail to fit the parent model.

There are ethical issues as well, for if you believe that debriefing is helpful, it is unethical to withhold support and if you believe that debriefing is harmful, then it is unethical to administer it. Single intervention with no follow-up as described in some of the negative outcome studies also pose ethical problems.

Other approaches need to be examined. The evaluation literature is rich with examples. Qualitative methods such as open-ended questions on questionnaires and in interviews, narratives and case studies can give insight and understanding of complexities and are very useful in determining how interventions are both helpful and unhelpful. Such approaches can be combined with what is often described as "rigorous" research. .For example Brinkerhoff (2003) describes *the success case* method which enables assessment of what is working and what is not working in programs, based on narratives of success that are supported by evidence: it "blends the ancient art of storytelling with more modern methods of rigorous evaluative enquiry and research". Every method will bring with it advantages and disadvantages. Casting the net wide

will provide the greatest opportunity to build on the picture of knowledge and give answers to the researchers' and practitioners' questions.

9 Tasks for the future

Clarify terminology

Care is needed in the use of the word "debriefing". Studies that examine other than the Mitchell defined CISD need to acknowledge this and specify the processes and populations to which their conclusions relate.

Distinguish work place programs from other applications of debriefing

It is very important to separate work-based programs from community programs; single interventions from multi-component programs; group from individual interventions and the like.

Clarify points of misunderstanding and spurious arguments

It is important to clarify points of disagreement and misunderstanding that do not reflect real differences of opinion. They are clouding the issues and the debate. Hopefully this article will contribute to clarification.

Clarify conceptual differences

Views on how best to assist people following exposure to trauma and how best to assess support programs may reflect real differences in belief. However, by broadening the focus of programs to multi-component ones and broadening the focus of evaluation to incorporate multiple design approaches, it may to possible to move ahead. Adhering to randomised controlled trials as the only way of assessing interventions and programs will hold back understanding.

Recognise positive outcome studies

Positive outcome studies and reports of participants' satisfaction with CISM need to be acknowledged.

Allegations of harm and bad practice need to be substantiated

It is not acceptable to continue to allege that CISD may harm people or that organisations should discontinue debriefing without substantiating these allegations, in line with the arguments presented in this article. At the very least, evidence needs to be provided that a properly run CISD, led by a team of trained practitioners, as part of a CISM response, has resulted in harm to a participant.

It is totally unacceptable to allege, without substantiation, that those who practice CISM employ bad and unethical practices.

Encourage good research

Much more well designed and well implemented research is needed in order to answer the questions that face this field.

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