CRISIS INTERVENTION & CISM: A Research Summary

By

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Introduction:

This research and literature summary has been written in response to numerous requests to make available to the those interested in the field of crisis intervention, especially Critical Incident Stress Management (CISM), a quick reference list along with brief descriptions or critiques of pertinent materials.

Articles critical, or non-supportive, of crisis intervention/ emergency mental health, in general, or more specifically "debriefing," Critical Incident Stress Debriefing (CISD), or CISM are presented first in order to facilitate an understanding of the primary arguments against these interventions. **It should be noted that the majority of negative views are related to studies of single session "debriefings" (not to be confused with CISDs) provided to individuals (often single counseling sessions) or to studies which demonstrate a clear violation of the acceptable standards of practice within CISM (usually applying the group intervention protocols to individual counseling sessions).**

Single session "debriefings" are a collection of interventions that are, in fact, more accurately described as a form of psychotherapy provided to typically medical patients in a hospital. The providers of these therapies are

nurses, emergency department staff members and even medical students. It is doubtful that any of the providers have been trained in CISM. Although some of them loosely apply the steps of a CISD, the interventions are individual contacts only. They are not connected to follow up or other forms of intervention.

Single session debriefings have never been approved or endorsed by ICISF or any other organization such as the Red Cross, the National Organization of Victim's Assistance, The Association of Traumatic Stress Specialists or the American Academy of Experts in Traumatic Stress which is providing crisis intervention services. Not one of these well known providers of crisis intervention training or services has a training program which teaches people to provide "single session debriefings."

In instances as noted above (and as any first year research student could discern) investigators are not researching CISD as the group crisis intervention protocol it was intended to be, but rather they are investigating some pseudo-CISD variant nevertheless calling their interventions "CISD."

Unfortunately, many people have made inappropriate leaps from neutral or adverse data arising from poorly designed and badly executed studies to a condemnation of the entire field of CISM and/or one of its group interventions, CISD. Furthermore, many investigators have failed to study the small group crisis intervention (group CISD) within the proper context of a comprehensive, systematic and multi-tactic program or package of crisis interventions. Thus, the only legitimate conclusion that can be drawn from those studies is that CISD and CISM have not actually been studied within the context of such research efforts.

One of the main problems in researching the CISM field is that some researchers mistake crisis intervention services for psychotherapy. In doing so, they create inappropriate expectations for crisis intervention. **That core misunderstanding of the very nature of crisis intervention (and CISM) means that CISM and particularly one of its group interventions, CISD, is misapplied to people for whom it was never intended, such as individual patients in a medical facility. It is also applied by personnel with minimal or no formal training in crisis intervention, CISD, and/or CISM, who mistake it for some form of psychotherapy.** The non-standardized "debriefings" have been applied to people in the most inappropriate settings, frequently while people are in pain and often medicated. All of those applications violate the most essential standards of crisis intervention.

Another problem that exists within the entire field of crisis intervention is that some researchers insist that randomized controlled trials

(RCT) are the gold standard in research to the exclusion of all other forms of inquiry. Yet, in several studies claiming to be randomized controlled trials, the individuals who were given "debriefings" were quite different, at the pre-intervention point, compared to those who did not receive the "debriefing." The goal of randomization was not therefore achieved. (**It is curious to note that exclusive reliance upon RCTs has not been applied to the field of psychotherapy wherein case study empiricism, single case within subjects designs, and other quasi-experimental designs form the foundation for the empirical basis of psychotherapy. A similar condition exists with regard to employee assistance programs. Thus, a dual standard seems to be evident**.)

From my point of view every study presents a small window through which we can view the field of crisis intervention and even CISM. The fatal epistemological error made by those who see no value in crisis intervention is that one well-conducted outcome study showing positive results negates studies which argue against positive outcome. (It is certainly more common to fail to recognize something that actually exists rather than falsely recognize something that does not exist). **As the founder of American psychology William James once said, "To disprove the law that all crows are black, one need only find one crow that is white." Thus, to disprove the "law" that all crisis intervention, CISD, CISM are ineffectual, one need only find one well conducted study that shows positive outcome.** And, indeed, well-controlled studies do exist that support the effectiveness of crisis intervention, CISD, and CISM. Then, the more legitimate quest (one designed to serve knowledge and people) becomes identifying the reasons for the positive outcome in contrast to the negative outcome. The current debate around crisis intervention appears to have taken on a pseudo-intellectual "all or nothing" mentality. Each investigation tells us more about what works and what does not work. Even the negative studies tell us something. They tell us at least what we should not be doing if we wish to engage in helpful crisis intervention. We can learn from all forms of study. What we learn can then be applied to our practices in the field. CISM services that are based in well founded theoretical frameworks and supported by a broad range of studies can be properly applied by well trained professional and paraprofessional crisis interventionists.

The primary goals of the crisis intervention program entitled CISM are to mitigate the impact of a critical incident and to accelerate recovery processes of normal people who are having normal reactions to abnormal events (sometimes referred to as primary prevention). This is consistent with the expectations of the FEMA crisis counseling project.

CISM services perform well as screening opportunities that may be utilized to identify people who might need additional intervention or a professional referral. CISM may also serve to enhance group cohesion and unit performance. **It does not have as its goals the complete elimination of stress symptoms, depression or anxiety nor does CISM claim to be a cure for PTSD or other psychiatric disorders.** The positive research presented below demonstrates that CISM does, in fact, achieve its primary goals

This summary is not an all inclusive reference list. Instead, this list contains the most pertinent negative and positive references that relate to the CISM field or to early intervention.

For twenty eight years I have studied the theories, the studies, the reports and other relevant documents concerning crisis intervention, CISD, and CISM. In all that time I have not found any relevant documented evidence that has dissuaded me from the careful application of appropriate crisis intervention procedures for individuals and groups. I have fully realized that crisis intervention tactics, particularly the group tactics, are not simple. They are in fact more complex than most people realize. To be effective, crisis intervention must be applied by well trained and skillful interventionists. The various tactics must also be applied at the right time, in the right place and under the right circumstances. This is no different than the assumptions inherent in the field of "integrative psychotherapy." There are numerous factors which must be integrated to assure success in providing crisis intervention services.

Dr. Atle Dyregrov of Bergen, Norway stated in 1998, "In my opinion the debate on debriefing is not only a scientific but also a political debate. It entails power and positions in the therapeutic world." Indeed, the term "debriefing" appears to be a "straw man" symbolizing the entire field of early crisis intervention. The current debate surrounding "debriefing" is actually a debate about all crisis intervention. Unfortunately, opponents of crisis intervention have failed to offer a reasonable alternative that may be examined, not from the "ivory tower," but from the field. Recommendations to abandon early intervention ("debriefing") and resort to psychotherapy seem to lack sensitivity to actual field practicalities. Even when psychotherapy is offered pro bono, very few take advantage of the opportunity, far less than would seem to prosper from it. Logistically and practically, psychotherapy is no substitute for crisis intervention. Rather, psychotherapy is one point on a continuum of services, as is crisis intervention.

Negative Outcome Articles:

Note: The "n" after the number of the study simply refers to its grouping as a study with predominantly negative findings

1n) Bisson, J.I., Jenkins, P., Alexander, J., and Bannister, C. (1997). Randomized Controlled trial of psychological debriefings for victims of acute burn trauma. *British Journal of Psychiatry,* 171, 78-81.

About the study:

- Individual debriefing substituted for the group process. Individual and group interventions are not the same. One cannot generalize from individual interventions to group interventions or vice versa.
- Despite its randomization efforts the study groups turned out not to be equal to each other. *Parity of the study groups was not achieved by randomization.*
- The burned individuals receiving the "debriefing" had more serious burns, longer hospital stays and greater financial difficulties than the individuals not receiving the debriefing.
- The debriefing was given to individual burn patients in a hospital, frequently while they were in pain and on medications. It should be noted that the specific seven step group process of CISD was designed for teams of emergency workers, hospital employees and members of homogeneous groups who have experienced a traumatic event. It was never designed to be utilized on single severely injured primary victims.
- The debriefings were stand-alone ("one off") interventions not part of a comprehensive program. CISM requires that a debriefing be part of a package of interventions which includes at least follow-up.
- The debriefings were applied by apparently inadequately trained personnel. Well trained crisis interveners would have chosen a more appropriate approach.
- The debriefing was much shorter than standard debriefings (43 minutes on average).
- The debriefing sessions did not adhere to standards of practice in the CISM field.
- The debriefings were misapplied to inappropriate individuals. They were used on people for whom they were never intended.
- The interventions were provided under inappropriate condition such as in the patient's room within a burn center.

2n) Carlier, I.V. E.., Voerman, A.E., and Gersons, B.P.R. (2000) The influence of occupational debriefing on post-traumatic stress symptomatology in traumatized police officers. *British Journal of Medical Psychology,*73, 87-98.

About the study:

- Individual interventions, not group debriefings. Individual and group interventions are not the same thing. When you use a model designed for group on individuals, you change the nature of the intervention.(Dyregrov, 1998)
- Some of these "debriefings" were as short as 5 minutes in length.
- These so called "debriefings" do not in any way correspond to the standards of practice for CISD.

3n) Conlon, L., Fahy, T.J., and Conroy, R. (1999). PTSD in ambulant RTA victims: A randomized controlled trial of debriefing. *Journal of Psychosomatic Research,* 46, 37-44.

About the study:

- Individual interventions instead of group. Studies of individual interventions do not measure the same thing as measurements of group interventions.
- Motor vehicle accident victims 16 to 65 years of age
- Had very low scores on first contact (not even within the range of clinical concern for PTSD)
- Single person, single intervention.
- "debriefing" lasted 30 minutes only
- CISD individuals reported higher initial symptoms than controls (more intense injuries and more distressed)

4n) Dolan, L. Bowyer, D, Freeman, C. and Little, K. Critical Incident Stress Debriefing after Trauma: Is it effective? (Unpublished study)

About the study:

- Unpublished study.
- Hospital emergency department patients.
- Those presenting with life-threatening or near life threatening experiences including road traffic accidents, house fires, industrial accidents
- Wide battery of tests to assess stress, general health symptoms and PTSD
- One-on-one interventions not group. Not measuring the same thing

5n) Hobbs, M., Mayou, R., Harrison, B and Worlock, P. (1996). A randomized controlled trial of psychological debriefings of road traffic accidents. *British Medical Journal,* 313, 1438-1439.

About the study:

- Individual debriefing was substituted for the standard group process. Individual and group interventions are not the same.

- The authors attempted to randomize the study participants into debriefed and non-debriefed groups. Equality of group was not established. The "debriefed" people had sustained more serious injuries than those who did not receive a "debriefing."
- The debriefings were stand alone and not part a comprehensive program. That fact violates the standards of practice in CISM
- The investigators and providers may not have been adequately trained in applying the model.
- The results on the post test (15.97) were not significantly different than those on the pre-test (15.13) nor were they clinically meaningful. *There was no statistically significant difference between those scores.* As a matter of fact the scores did not even approach the level of clinical concern in either case. A score of 26 would be required before it was considered clinically meaningful.
- The authors then conclude that the debriefing process is harmful. This conclusion defies reason. In summary, individuals who are not equal in the intensity of injuries sustained are compared by using non-standard interventions. Their scores are lower than those that would be clinically meaningful and their pre and post test scores are not statistically significant. Yet the authors conclude that the debriefing, but no other causative factors, is the culprit.
- It should be noted, however, that the authors did not study the specific group intervention CISD. No generalization beyond the procedures addressed in the study can be made. Any conclusion that suggests that the specific group CISD process is harmful would entail a quantum leap beyond the available data.

6n) Kenardy, J.A., Webster, R.A., Lewin, T.J., Carr, V.J., Hazell, P.L. and Carter, G.L. (1996). Stress Debriefing and patterns of recovery following a natural disaster. *Journal of Traumatic Stress*, 9, 37-49.

About the study:

- Study started after over one year had passed
- No baseline data was available
- Huge maturation effect (other things could have happened to them during that time)
- Individuals who were not part of homogeneous groups were assessed.
- People were asked if they had a debriefing or not a year after the incident. There was no way to verify participation.
- "Debriefing" process not defined in any way. "We were not able to influence the availability or nature of the debriefing…" (p.39).
- "…there were no controls over the debriefing processes" (p.47)
- The authors imply that there were several types of "debriefings" utilized
- Authors could only "assume" that those who said that they received a "debriefing" had actually received one. "It was assumed that all subjects in this study who reported having been debriefed did in fact receive posttrauma debriefing. However, there was no standardization of debriefing services…" (p.47). There was no proof that they were actually in a debriefing of any kind.

- Failure to insure the standardization and reliability of the independent variable (debriefing) renders the results of this investigation unintelligible and ungeneralizable.

7 n) Lavender, T. Walkinshaw, S.A. (1998). Can Midwives Reduce Postpartume Psychological Morbidity? A randomized trial. *Birth*, 25 (4): 215-219.

About the study:

- Mid-wives assisting child birth mothers provided individual contacts. Group contacts were not utilized.
- High proportion of single mothers in the study (68 were single compared to 43 married). That fact in itself could contribute to some of the post partum stress effects.
- Heterogeneous sample
- High level of psycho morbidity in the controls.
- Individual and group interventions are different. This fact cannot be ignored.
- Study designed to reduce the "the onset of depression rather than PTSD".
- Debriefings are not designed to reduce post partum debriefing in primary victims.

8 n) Lee, C., Slade, P., and Lygo, V (1996). The influence of psychological debriefing on emotional adaptation in women following early miscarriage. *British Journal of Psychiatry,* 69, 47-58.

About the study:

- No group debriefing was provided. The "debriefing" was of an individual nature. The individual interventions differ substantially from the group interventions. They are not the same. To argue that individual interventions are the same as group interventions defies the experience of clinical practice and the expertise of experts in the field (Yalom, I. (1970) *The Theory and Practice of Group Psychotherapy.* New York: Basic Books.)
- Women who had suffered a miscarriage were studied.
- Investigators and providers were not adequately trained to utilize the model
- Authors conclude that debriefing is ineffective as a treatment for the symptoms of depression.
- The originator of the CISD model (Mitchell, 1983) never suggested that it would be a treatment for clinical depression or any other psychiatric disorder.
- Furthermore, the utilization of the model as a treatment for any significant psychological disturbance is inappropriate since the model is crisis intervention and not psychotherapy.
- The people who received the "debriefing" should have been given therapy instead. It is beyond comprehension that such a horrific personal loss would be "treated" with a debriefing instead of therapy.

- The “debriefing” in this study was used by untrained people for an unintended purpose in inappropriate circumstances and for a population for whom it was not designed (individual patients in a hospital who were upset and depressed after a terrible personal loss and while some of them were being treated with medications).
- In the opinion of this author, the lack of sensitivity and professionalism toward the patients in this study by choosing the wrong intervention to be provided by inadequately trained staff is shocking.

9 n) Mayou, R.A., Ehlers, A. and Hobbs, M. (2000). Psychological debriefing for road Traffic accident victims: Three-year follow up of a randomized controlled trial. *British Journal of Psychiatry,* 176, 589-593.

About the study:

- This study was simply a 3-year follow-up of Hobbs, et al., (1996{see above}) thus it suffers from the same methodological flaws.
- Individuals were given interventions not groups. Group and individual interventions are different and need different approaches not the same approach. When you apply a tactic developed for groups to individuals you change the nature of the intervention (Dyregrov, 1997;1998).
- Those who received “debriefing” remained symptomatic. This is certainly a predictable result when they started off three years earlier with more serious injuries and then had a tactic applied to them which had never designed for such use.
- The study indicates a considerable misunderstanding of the substantial differences between crisis intervention and psychotherapy. (See the section in this paper that summarizes the differences between crisis intervention and psychotherapy below.)

10 n) McFarlane, A.C. (1988). The longitudinal course of posttraumatic morbidity. *Journal of Nervous and Mental Disease,* 176, 30-39.

About the study:

- Victims of major bush fires in Australia
- 23% were injured and most lost property
- Unspecified, non-standardized “debriefings”
- In fact, neither Mitchell's CISD, nor Dyregrov's PD, had been taught to frontline rescuers at the time of either of these studies (R. Robinson, 2002, personal communication. Dr. Robinson is the Director of the Victorian Ambulance Service Counseling Service in Melbourne, Australia and the President of the Critical Incident Stress Management Foundation of Australia).
- Short term positive effect

- Long term effect called into question as pre-existing neuroticism interacted with "debriefing"
- Self selection bias in the study.
- PTSD was best predicted by pre-morbid, non-event related factors, such as family history of psychiatric disorders, concurrent avoidance and high levels of neuroticism and a tendency not to confront conflicts.
- The delayed PTSD group had higher pre-morbid neuroticism scores, greater property losses, and chose to attend the undefined "debriefings"
- The only time the negative effect of a non specific "debriefing" showed up was when the person had higher pre-morbid neuroticism scores.
- It was impossible to determine any influence of the "debriefing" because of the pre-existing psychopathology in the study participants.
- The delayed onset posttraumatic stress group not only had higher pre-morbid neuroticism scores, and greater property loss, but also attended the undefined debriefings. These factors were causally and inextricably intertwined.
- It is inappropriate to draw conclusion from this study since CISD as never studied.

11 n) Rose, S. and Bisson, J. (1998). Brief early psychological interventions following trauma: A systematic review of literature. *Journal of Traumatic Stress,* 11, 697-710.

About the study:

- For a "systematic" review of the literature there is a surprising dearth of citations of positive outcome studies and a preponderance of negative outcome studies (most of which are discussed separately in this section).
- A review of the literature that does not at least engage in a reasonable review of the available positive outcome studies is academically bankrupt.

12 n) Rose, S., Berwin, C.R., Andrews, B. and Kirk, M. (1999). A randomized controlled trial of individual psychological debriefing for victims of violent crime. *Psychological Medicine,* 29, 793-799.

About the study:

- Study done on physically and sexually assaulted victims.
- Individual interventions. Violates standard application of CISD
- Not part a comprehensive systematic approach.
- Out of 2,161 victims identified by police or the emergency department only 157 (7%) agreed to participate.
- Services were provided 21 days after the attack (This is quite late in CISD terms)
- Obviously much more going on with sexual assault victims than a CISD could be expected to handle. Evidence of intense disturbance can be seen in the fact that

only 11% of those who participated (only 7% of the total number of victims) agreed to follow up evaluation.

- Most evaluation contacts made by phone, mail or home visits. These contacts in no way resemble CISD or psychological debriefings.
- Misapplication of the CISD procedure in inappropriate circumstances to an inappropriate population by untrained personnel. It was not CISD.
- This is bad clinical practice, not CISD.

13 n) Rose, S., Bisson, J., & Wessely, S. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *The Cochrane Library*, Issue 1. Oxford, UK: Update Software.

- The latest review of single session debriefings recommends that they be stopped.
- ICISF could not agree more.
- Single session debriefings (one-on-ones with primary victims who receive a one shot contact with no follow-up and no other services) are a very bad practice and should never have been utilized by anyone.
- Note that neither ICISF nor anyone serious about early intervention has ever recommended single session debriefings.
- **Note: The most important conclusion:** The authors of the most recent Cochrane Review of psychological debriefing have concluded, "We are unable to comment on the use of group debriefing, nor the use of debriefing after mass traumas" (p.10).

14 n) Small, R., Lumley, J., Donohue, L., Potter, A. and Waldenstrom, U. (2000). Randomized controlled trial of midwife led debriefing to reduce maternal depression after operative childbirth. *British Medical Journal,* 321, 1043-1047.

About the study:

- 463 women subjected to Caesarean, forceps or vacuum delivery.
- Abandoned the standard group debriefing model for individual debriefing. Group interventions are not the same as individual interventions (Dyregrov, 1998, Yalom, 1970)
- Apparently inadequately trained midwives provided the "debriefing"
- No baseline measures
- "Debriefing" not clearly described other than a one-on-one discussion with the mid wife.
- "Debriefing" took place while women were in hospital recovering from the obstetrical surgery (often in pain and on medications)
- Assessment took place 6 months later
- No clear description of protocols for the "debriefing" process
- The intervention was found to be ineffective as a treatment for symptoms of depression. (It was never designed as a treatment for depression!)

- Of interest is the fact that 94% of the women (437 out of 463) reported the “debriefing” was either “helpful” or “very helpful”

15 n) (Stevens and Adshead) Hobbs G., Adshead, G. (1997). Preventive psychological intervention for road crash victims. In M. Mitchell (Ed.) *The aftermath of Road Accidents: Psychological, Social and Legal Perspectives,* 159-171. London, UK: Routledge

About the study:

- Auto accident victims
- Dog bit victims
- Assault victims
- One-on-one intervention with primary victims not with homogenous groups. Interventions for individuals and groups are different from one another.
- Non specific “debriefing” of individuals.

16 n) Van Emmerik, A.A.P., Kamphuis, J.H., Hulsbosch, A.M., Emmelkamp, P.M.G. (2002) Single session debriefing after psychological trauma: a meta-analysis. *Lancet,* 360, 766-771.

About the study:

- The authors confuse crisis intervention with psychotherapy. They are not the same.
- The terms “counseling,” “psychotherapy” and “crisis intervention” in the article are used as if they were synonymous.
- The authors mistakenly claim that single session debriefings are the standard of practice in the field. They are not the standard and never have been.
- The authors blend into their meta-analysis counseling or therapy sessions, individual consultations, group processes that are clearly not CISDs and interventions that are not even crisis intervention contacts. There are in the study things that the authors call “CISD” but instead they are group processes that violate the standard procedures in the field. There are even “debriefings” that are described by the authors as not being CISDs. The authors then proceed to describe all of these different types of interventions as if they were CISDs. They put everything under one label, “CISD.”
- *The most fatal flaw in the study is that the interventions assessed are not all the same thing.* If you are measuring different things within a study that erroneously claims that they are all the same then you cannot draw any legitimate conclusions. That is <u>THE STANDARD</u> of all meta-analyses. (See Mullen, 1989 citation above).
- Each of the studies in the meta-analysis is an older study which has already been review and critiqued. They are repeated in this section. There are no new studies in the *Lancet* meta-analysis. Each of the studies is seriously flawed. Putting them

all in a new wrapping does not improve the quality of the studies. They were gravely flawed when they were first written and they remain so now.

- The authors even state that they are unable to draw any conclusions regarding group interventions.

17 n) Wessely, S., Rose, S., & Bisson, J. (1998). A systematic review of brief psychological interventions (debriefing) for the treatment of immediate trauma related symptoms and the prevention of post traumatic stress disorder (Cochrane Review). *Cochrane Library*, Issue 3, Oxford, UK: Update Software.

About the study:

- This study is frequently referred to as the "Cochrane Report" or "Cochrane Review" and it is the basis of much of the negative reactions in the literature.
- The Cochrane Review is supposed to be completely independent. Yet two of its authors were primary investigators on two negative studies contained within the report. Independence is therefore compromised
- The term "debriefing" is used very inconsistently in the 11 studies which make up the report (They are reviewed in this section of the current article.) The different studies are not measuring the same things as noted earlier in this section.
- The "debriefings" described in each of the studies in the report in no way resemble the Critical Incident Stress Debriefing process as it is taught and practiced in the USA and other countries following the ICISF guidelines.
- The studies in the review were focused on individual patients in hospitals, in pain and often on medication. There were no applications with groups. The CISD was designed for groups of operations personnel or an organization's staff. The use of "debriefing" on heterogeneous individuals instead of homogenous groups is a clear violation of the standards of practice. This is especially so when the target populations are in the acute stages of medical distress.
- The interventions studied are one shot singular interventions. Stand alone or "one off" interventions violate the standards of practice of CISM. All debriefings should have at least follow-up contacts.
- Each of the studies in the review had serious methodological deficiencies
- <u>*NOTE*</u>: "We are unable to comment on the use of group debriefing, nor the use of debriefing after mass traumas."(p.14). The report draws no conclusions about group interventions. The studies are only exploring individual interventions. Yet, many have generalized negative results from individual interventions to group interventions. There is no data to suggest that the interventions are the same and generalizations to other types of debriefings cannot be made.
- The studies in the review violated the standards of practice for CISM and CISD. The investigators were never trained in the model. They then inadequately trained others to perform the interventions and gather data.

- Few positive controlled studies were reviewed despite the fact that they are more abundant than the negative studies.
- These facts suggest a lack of independent review.
- (See article by Olsen, 2001 for more information on Cochrane reviews. Olsen's Citation and a description of the study can be found below.)

A SUMMARY

The investigations above used the term "debriefing" to refer to an amalgam of interventions, but reflected primarily one-on-one counseling with medical patients. Such an application is in no way reflective of, or similar to, the clinical standard group crisis intervention (CISD). The table below summarizes some of the differences:

Negative Studies (1n-17n)	Standard CISD
- **One-on one** individual contacts	- homogeneous **groups**
- **Primary victims** such as dog bites, auto accident victims, rape victims, industrial accident victims	- **Secondary homogenous groups** such as emergency personnel, hospital staff, and employees
- 5 minutes up to one hour **(ave. 41 min**.)	- **one to three hours**
- **situation ongoing** or slowly resolving	- **situation complete** or resolved
- **different levels of exposure to various events**	- **roughly same exposure to the same event**
- exposure here is personal	- another person's trauma
- situations that produce **profound life alterations for the victims**	- someone else's traumatic events that are **distressing to work with** but which usually have little life altering effect on the workers
- **Poorly defined intervention**	**- Clearly defined protocols and procedures**
- **Inadequately trained single provider**	- **Well trained team** with a mental health professional

- **No planned follow-up**	- **follow-up required**
- **No integrated strategy**	- within a comprehensive, systematic and multi-component approach to managing traumatic stress within an organization (**clear strategy**)
- Goals appear to be the **complete elimination of PTSD symptoms** or to cure PTSD or to treat depression or to treat other disorders (all unrealistic)	- Goals are to (1) **mitigate impact**; **(2)Enhance normal recovery** of normal people having normal reactions to abnormal events; (3) **assess** those who may need additional assistance and **assure appropriate referrals.**

There is contamination in the pool of articles in the Cochrane library which are loosely labeled "CISD" studies. These studies have been used to generate virtually every negative outcome review to date. In summary, inadequately trained personnel are providing a hodgepodge of unstandardized, stand alone, interventions to individuals for whom the CISD process was never intended. They are applying these interventions, which are not truly CISD but are being called CISD, in circumstances in which the debriefing should not be applied. The crisis intervention processes that include debriefings are being mistaken for psychotherapy. In fact, debriefings are being substituted for psychotherapy and then criticized when they cannot achieve results which even psychotherapies would be hard pressed to achieve. There seems to be a double standard in play here. Why should a crisis intervention system be held to a higher standard than any psychotherapy? Furthermore the goals that the researchers are utilizing to measure the effectiveness of the so called debriefings are unrealistic and out of sync with the specific goals for CISD that have been clearly stated in the literature for many years.

Perhaps the words of Dr. Martin Deahl of St. Bartholomew's and Royal London School Medicine and Dentistry and the University of London would be helpful here. These words were written as a reaction to the Cochrane Review in September, 2000.

> "Outcome research into the effectiveness of acute interventions such as debriefing raises important questions about the ethics as well as the status of conventional RCT methodology as the imprimatur of Evidence Based Medicine (EBM). RCTs have become the dominant paradigm of treatment outcome studies to the virtual exclusion of observational or case studies. CISD was designed for groups of emergency services workers following traumatic events. Conducting a methodologically rigorous RCT of group debriefing would be extremely difficult given that group trauma generally only occurs in unpredictable

> and often chaotic circumstances such as war or disaster. In emergency situations such as these the operational imperative is paramount and investigators must do the best they can with the available material under difficult and at times extremely fraught circumstances. Irrespective of whether or not debriefing reduces long-term morbidity many individuals find it subjectively helpful at the time. Under these circumstances can it therefore be ethically justifiable to employ "non-intervention" controls denying individuals short term support whatever the long term outcome? In conflict, following disaster or accident, naturalistic studies, often conducted opportunistically remain useful and have considerable heuristic value despite methodological shortcomings particularly relating to sample selection and randomization to different treatment conditions. Applying the stringent criteria demanded by the arbiters of EBM such as the Cochrane library to trials of preventive interventions means that much useful work might go unpublished. Clinicians might well lament that in attempting to satisfy such rigorous methodological criteria RCTs have become so divorced from clinical reality that their findings become meaningless…RCTs are not the sine qua non of EBM and debriefing studies which challenge their hegemony and lend credibility to observational studies have important implications for the ways in which the quality and value of research evidence is assessed both in social psychiatry and empirical science in general." (p.26)

See also: Bisson, J and Deahl, M.P. (1994). Psychological debriefing and preventing post traumatic stress. *British Journal of Psychiatry*, 1656: 717-720

Positive Outcome Articles Regarding Crisis Intervention and CISM:

1) American Academy of Orthopaedic Surgeons, Department of Research and Scientific Affairs. (1996). Tales from the front: Huge response to sound off on CISD. *EMT Today*, 1, (2), Feb. / March, 3.

Key points and findings:

- 436 emergency medical responders were asked to assess their own experience with CISD
- 350 participated in the survey.
- Of the 350 a total of 314 (90.8%) responded that CISD was beneficial to them.

2) Amir, M., Weil, G. Kaplan, Z., Tocker, T. and Witzum, E. (1998). Debriefing with group psychotherapy in a homogenous group of non-injured victims of a terrorist attack: A prospective study. ***Acta Psychiatriaca Scandinavica,*** **98, 237-242.**

Key points and findings:

- 15 women non injured victims of a terrorist attack.
- Crisis intervention: a group debriefing at 2 days after incident. Then brief therapy once a week for 6 weeks plus a single meeting with their husbands
- Use of Impact of Events Scale (IES), PTSD Scale, SCL-90 repeated measures at 2 days, 2 months and 6 months
- Total IES scores showed a decrease in posttraumatic stress symptoms.

3) Blackwelder, N.L. (1995). ***Critical Incident Stress Debriefing for School Employees*****. Ann Arbor UMI Dissertation Services.**

Key points and findings:

- Trained providers of CISD performed better in providing CISD than did untrained personnel
- ICISF's position has always been that proper training is required to provide appropriate services.

4) Bohl, N. (1991). The effectiveness of brief psychological interventions in police officers after critical incidents. In J.T. Reese and J. Horn, and C. Dunning (Eds.) ***Critical Incidents in Policing, Revised (pp.31-38).*** **Washington, DC: Department of Justice.**

Key points and findings:

- Naturalistic randomized study
- 40 police officers who received CISD within 24 hours of a critical incident were compared to 31 who had not received CISD within 24 hours.
- The final evaluation took place at 3 months later.
- Those with CISD were less depressed.
- Those with CISD were less angry
- Those with CISD were less anxious
- Those with CISD had less posttraumatic stress symptoms.

5) Bohl, N. (1995). Measuring the effectiveness of CISD. ***Fire Engineering,*** **125-126.**

Key points and findings:

- Naturalistic randomized study

- Follow up investigation to the 1991 study.
- 30 firefighters who received CISD within 24 hours of a critical incident were compared to 35 who did not receive CISD
- The final evaluation took place at three months
- Anxiety symptoms were found to be less in the CISD group.
- Symptoms of stress were less in the CISD group than in the non-CISD group.

6) Burns, C. and Harm, I. (1993). Emergency nurses perceptions of critical incidents and stress debriefing. *Journal of Emergency Nursing,* 19 (5), 431-436.

Key points and findings:

- 219 Emergency Department nurses
- 193 reported that CISD process had been personally helpful to them
- positives and negatives about the CISD were cited
- 86.6% talking about critical incident helped
- 85.1% Realizing that "I was not alone in my responses to the incident helped"
- 83.0% "Hearing others talk of the incident helped"
- "It did not help if group leaders had no relevant experience" 26.9%
- "I was not comfortable with some people in the group" 23.1%
- "CISD came too long after the critical incident" 19.2%

7) Busuttil, W., Turnbull, G.J., Nal, L.A., Rollins, J., West, A.G., Blanch, N., and Herepath, R. (1995). Incorporating psychological debriefing techniques within a brief group psychotherapy programme for the treatment of post-traumatic stress disorder. *British Journal of Psychiatry,* 167, 495-502.

Key points and findings:

- 34 Royal Air Force personnel with traumatic exposures with symptoms of PTSD
- 12 day residential treatment program. Comprehensive, multi-tactic program.
- Attendees had experienced a broad range of traumatic situations including combat.
- Psychological group debriefing was a main therapeutic feature.
- Psycho education and cognitive restructuring
- One day group follow up sessions were held 6 weeks, 6 months and one year during the course of a year.
- Highly significant improvement demonstrated at all follow up points on all psychometric measures.
- Conclusion: psychological debriefing may be useful in the treatment of PTSD even long after the traumatic exposure occurred.
- Only 5 of 34 cases had significant PTSD symptoms at one year.

8) Busuttil, A and Busuttil, W. (1995). Psychological debriefing. *British Journal of Psychiatry.* 166, 676-677.

Key points and findings:

- Emphasizes a multi-component approach in which debriefing plays a role.
- The group debriefing when combined with other interventions had a powerful effect.
- Participants experienced reduction in posttraumatic stress symptoms.

9) Campfield, K. & Hills, A. (2001). Effect of timing of critical Incident Stress Debriefing (CISD) on posttraumatic symptoms. *Journal of Traumatic Stress*, 14, 327-340.

Key points and findings:

- ***** ***This was a Randomized Controlled Trial (RCT)*** *****
- 77 robbery victims
- CISD provided to a group of bank workers at less than 10 hours compared to CISD provided to a group of bank workers at greater than 48 hours.
- Victims were assessed at 2 days, 4 days, and 2 weeks.
- Post Traumatic Stress symptoms *decline* was significantly greater for the group with the more immediate CISD. Not only did thy have fewer symptoms, but they also had less severe posttraumatic stress symptoms in each of the four different measurements over the two weeks.

10) Chemtob, C., Tomas, S., Law, W., and Cremniter, D. (1997). Post disaster psychosocial intervention. *American Journal of Psychiatry*, 134, 415-417.

Key points and findings:

- 41 crisis response workers in Hurricane Iniki
- time-lagged controlled study design (one group finished their work as the other started theirs)
- Groups were provided both a group debriefing and an educational program
- Pre-intervention test for second group was concurrent with post-intervention assessment of the first group.
- Impact of Events Scale (IES)
- Psychometrically assessed posttraumatic stress was significantly reduced in both groups after CISD and an educational program was presented
- True study of CISM (multi-tactic approach).

11) Deahl, M., Srinivasan, M., Jones, N., Thomas, J., Neblett, C., and Jolly, A. (2000). Preventing psychological trauma in soldiers. The role of operational stress training and psychological debriefing. *British Journal of Medical Psychology*, *73*, 77-85.

Key points and findings:

- ******* <u>This was a Randomized Controlled Trial (RCT)</u>*******
- 106 British soldiers involved in a United Nations peacekeeping operation in Bosnia
- All soldiers received an Operational Stress Training Package
- Random selection into group receiving CISD or no CISD
- At 6 month follow-up, CISD group had significantly lower prevalence of alcohol abuse than no-CISD group
- CISD group members had lower scores on psychometrically assessed anxiety than no-CISD group
- CISD group members had lower scores on psychometrically assessed depression than no-CISD group
- CISD group members had lower scores on psychometrically assessed PTSD symptoms
- A study of CISM because it had more than one intervention combined

12) Deahl, M.P., Srinivasan, M., Jones, N., Neblett, C, and Jolly, A. (2001). Evaluating psychological debriefing: Are we measuring the right outcomes? *Journal of Traumatic Stress,* 14, 527-529.

Key points and findings:

- British soldiers in Bosnia had significant reduction in alcohol abuse
- Researchers recommended a broader range of outcome measures in future trials of debriefing.
- Sick leave, alcohol use, group morale, motivation to work and ability to function at work should be measured instead of PTSD symptoms.
- Authors express concern that the wrong dependent variables are being explored and that we should not be using dependent variables that are psychotherapy oriented when we are providing crisis intervention services. What you can expect crisis intervention to achieve will be less than what one should expect that psychotherapy can achieve. Mixing those up means that faulty interpretations of findings are more likely. Caution in research design and methodology is urged.

13) Dyregrov, A. and Mitchell, J.T. (1992). Work with traumatized children – psychological effects and coping strategies. *Journal of traumatic Stress*, 5, 5-17.

Key points and findings:

- Injured or dead children have enormously powerful effects on emergency personnel

- Many emergency personnel suffer short and long term traumatic stress effects of dealing with children in pain or family members who have suffered the loss of a child.
- There are many helpful tactics that can be employed to assist emergency operations personnel in managing their stress.
- The critical incident stress debriefing is helpful
- Personnel in the group feel listened to
- Emergency personnel report that it is helpful to hear the view points of their colleagues

14) Dyregrov, A. (1997). The process in critical incident stress debriefing. *Journal of Traumatic Stress.* 10, 589-605.

Key points and findings:

- There are many factors which might impair or enhance the success of a critical incident stress debriefing
- Some of the factors include training, skill and leadership style of the group leaders
- The nature of the traumatic experience will be a factor that can impact a debriefing group
- The make up of the group and whether or not it is homogenous and ready for assistance may be a powerful influence in the debriefing process.

15) Dyregrov, A. (1998). Psychological debriefing: An effective method? *TRAUMATOLOGYe*, *4*, (2), Article 1.

Key points and finding:

- Review of the literature
- Qualitative analysis suggests that multi-component program is effective
- "In my opinion the debate on debriefing is not only a scientific but also a political debate. It entails power and positions in the therapeutic world. As a technique…[debriefing] represents a threat to the psychiatric elite."
- Appropriate training is required to insure CISM effectiveness
- When implemented as prescribed, CISM appears to be an effective crisis intervention, capable of reducing signs and symptoms of distress associated with an acute psychological crisis.
- When providers are not properly trained and experienced and when the debriefing is provided as a stand-alone intervention, it is likely to ineffectual and perhaps harmful.
- When providers apply CISM tactics to individuals for whom it was never intended under circumstances for which it was never designed and with a complete disregard for standardization and quality assurance the interventions may be ineffective and possibly harmful.

16) Dyregrov, A. (1999). Helpful and hurtful aspects of psychological debriefing groups. *International Journal of Emergency Mental Health,* 3, 175-181.

Key points and findings:

- Good leadership in groups helps immensely. Poor leadership hurts.
- Group work is complex
- Homogenous groups are the best. Much more danger in mixing group members
- The situation must be under control for people to benefit from a debriefing
- The group members must have had roughly the same level of exposure to a traumatic circumstance to benefit from a group process like the critical incident stress debriefing.

17) Dyregrov, A. (2003). *Psychological Debriefing: A leader's guide to small group crisis interventions.* Ellicott City, MD: Chevron Publishing Corp.

Key points and findings:

- Methodological weaknesses of the negative studies pointed out.
- Negative studies analyze interventions that are not truly psychological debriefings
- Several negative studies have self selection into intervention or non intervention
- In the negative studies, the debriefing is not defined.
- In the negative studies, the timing of the interventions is variable and often outside of the recommended time frame.
- The authors of the negative studies may have chosen the wrong type of intervention considering the nature of the traumatic event that was experienced.
- The background and training of the persons who provided the interventions is unclear and possibly inadequate
- The groups in the negative studies are not adequately matched
- Debriefing in the negative studies is investigated in isolation, and not as part of an integrated chain of assistance as is recommended in CISM.
- "Impressively, however, it seems that when multi-component traumatic stress strategies (CISM) that include carefully conducted CISDs as one of several interventions are used, the results are consistently positive." (manuscript p.20)
- Dr. Dyregrov criticizes the individual debriefings that are the basis of the negative studies on debriefing. The major studies that have been used to criticize the use of debriefings have been based on a single intervention with individual patients and not the group intervention that PD is really intended to be. In addition, the individual interventions have been too short to be clinically effective . The average time is about 43 minutes. Some are as short as 5 minutes. Dr. Dyregrov says that it is a wonder how the negative study authors expect to do sound clinical work with such a minimum of time. There is insufficient time even to allow adequate time to establish rapport.
- It is unwise to provide debriefings to those who are physically injured. Physical healing frequently takes precedence over emotional healing.

- "Much research in the last decade has demonstrated a relation between dissociation and PTSD. By providing an early opportunity for calibrating the mental apparatus and getting in touch with emotional and cognitive reactions, debriefing may prevent a continuation of a dissociative reaction." (manuscript p. 97)

18) Everly, G.S., Jr. and Boyle, S. (1999). Critical Incident Stress Debriefing (CISD): A meta-analysis. *International Journal of Emergency Mental Health,* 1, 165-168.

Key points and findings:

- 5 peer reviewed studies of group CISD were subjected to meta-analysis
- 341 subjects
- Specific "Mitchell Model" CISD was utilized in groups
- Various self report measures of psychological symptoms were utilized
- Cohen's D (measure of effectiveness of an intervention) =.86 that represents a high positive effect of specific "Mitchell Model" debriefings (CISD)

19) Everly, G.S., Jr., Boyle, S. and Lating (1999). Effectiveness of psychological debriefing with vicarious trauma: A meta-analysis. *Stress Medicine,*15, 229-233.

Key points and findings:

- 10 peer reviewed studies
- 698 subjects
- Group psychological debriefings were evaluated.
- Various self report psychological measures were utilized
- Cohen's D (measure of effectiveness of an intervention) = .54 That represents a modest positive effect of group debriefings

20) Everly, G.S., Jr., and Eyler, V.A. (2000, April). Sufficiency Criterion in Empirically-validated Psychological Interventions: The case of Critical Incident Stress Management. Invited paper, Third International Conference, Psychological and Social services in a Changing Society, Kuwait City, State of Kuwait.

Key points and findings:

- Meta-analytic scrutiny in an effort to reduce the likelihood of systematic error across quasi-experimental research designs in CISM research
- 7 CISM studies were included in the meta-analysis
- Minimal sufficiency criterion is 45
- This meta-analysis yielded a sufficiency criterion of 868

- This number is far in excess of the minimum required to deem CISM an effective crisis intervention.
- Future research should stop asking if CISM works or does not work.
- Instead, the questions ought to be, "WHAT CISM intervention, administered by WHOM is the most effective intervention for an individual or group in this particular critical incident.

21) Everly, G. S., Jr. and Quatrano-Piacentini, A. (1999, March). The effects of CISD on stress and trauma symptoms: A meta-analysis. APA-NIOSH Conference, Baltimore

Key points and findings:

- 6 peer reviewed studies were subjected to meta-analysis
- 406 subjects.
- Specific "Mitchell Model" CISD applied
- Various self report measures of stress and trauma symptoms were measurement instruments utilized.
- Cohen's D (measure of effectiveness of an intervention) = 1.04 That represents a very high positive effect of CISD on the reduction of symptoms of stress and trauma

22) Everly, G.S., Jr., Flannery, R. B., Jr., Eyler, V. and Mitchell, J.T. (2001) Sufficiency analysis of an integrated multicomponent approach to crisis intervention: Critical Incident Stress Management. *Advances in Mind-Body Medicine*, 17, 174-183.

Key points or findings:

- The combined interventions of CISM had greater positive effect than the single intervention of CISD
- A statistical "sufficiency analysis" of CISM argues strongly that CISM may be considered an empirically validated clinical intervention

23) Flannery, R. B. Jr. (1998). *The Assaulted Staff Action Program (ASAP): Coping with the psychological aftermath of violence.* Ellicott City, MD: Chevron Publishing Corporation.

Key points or findings:

- Book describes in detail the background, development and maintenance of a comprehensive CISM program called the "Assaulted Staff Action Program (ASAP)" for hospital employees in state psychiatric hospitals.
- Details regarding the first year's experience with the peer support program are included

24) Flannery, R.B., Jr. (1999).Critical Incident Stress Management and the Assaulted staff Action Program. *International Journal of Emergency Mental Health,* 1999, 2, 103-108.

Key points and findings:

- A comprehensive CISM program lowered sick time utilization
- The three hospitals in the study experienced less premature loss of staff
- There were less disability claims against the employer after the comprehensive CISM program was in place.
- Violent episodes decreased in each of the hospitals. This was an unexpected result and is linked to staff who are feeling more supported and thus less likely to inadvertently trigger violence from their patients.

25) Flannery, R.B., Jr. Fulton, P. Tausch, J., and DeLoffi, A. (1991). A program to help staff cope with the psychological sequelae of assaults by patients. *Hospital and Community Psychiatry*, 42, 935-938.

Key points or findings:

- Implementation of a CSIM crisis intervention program lowered sick time utilization in traumatized hospital employees
- Decreases in premature departures from the job were realized after CISM program put in place
- Hospitals were less often the object of disability claims after program strarted.

26) Flannery, R. Hanson, M. Penk, W. Flannery, G, and Gallagher, C. (1995). The Assaulted Staff Action Program: An approach to coping with the aftermath of *violence* in the workplace. In L. Murphy, J Hurrell, S. Sauter and G.P. Keita (Eds.) *Job Stress Interventions* (pp.199-211). Washington, DC: American Psychological Association.

Key points and findings:

- CISM model utilized but under ASAP name.
- Assessment at 22 months after program instituted
- Comparison between assaults and staff attrition measured
- Also noted that assaults declined after insertion of program
- Assaults 30 occurred pre CISM but only 11 occurred after CISM
- Staff attrition was 15 in a year before CISM but only 1 in a year after CISM was developed.

27) Flannery, R.B., Jr., Hanson, M.A., Penk, W.E., Goldfinger, S., Pastva, G.P. and Navon, M.A. (1998). Replicated declines in assault rates after the implementation of the Assaulted Staff Action Program. *Psychiatric Services*, 49, 241-243.

Key points and findings:

- Staggered start-up multiple baseline initiative in 3 state psychiatric hospitals
- CISM program under ASAP name
- Measure of physical assaults on staff
- Before CISM 31 assaults per month were the average
- Mean post-test (four follow-ups) 2.44 assaults per month

28) Flannery, R.B, Jr. Penk, W. and Corrigan, M. (1999). Assaulted Staff Action Program (ASAP) and a decline in assault rate: Community based replication. *International Journal of Emergency Mental Health,* 1, 19-22.

Key points and findings:

- CISM program under the name of ASAP
- Measures of assaults on staff
- For four months before initiation of program = 11.25 assaults per month
- Eighteen month follow up study after ASAP program = 1 assault per month

Note: The following points represent a summary of all Flannery and Flannery and others articles above.

Key points or findings:

- 170 team members of CISM teams known as the Assaulted Staff Action Program (ASAP) responded to over 600 assaults and provided 250,000 hours of volunteer services to their state hospital facilities
- fright, anger, hyper-vigilance, sleep disturbance, and intrusive memories resolved within 3-10 days instead of months after CISM
- Assaults in one state hospital facility declined from 30 to 11 per month.
- Assault rates in two other state hospital facilities dropped from an average of 32 a month to 7 per month.
- In one unit the assaults declined from 3.25 per month to 1 for the first 18 months after the ASAP program was implemented.
- In the first hospital with an ASAP program 15 employees left the facility per year before the ASAP program was implemented. After it was installed only one left the facility.
- Savings in replacement of staff was estimated at $268,000 over two years.
- Less medical injuries occurred, less sick time and fewer industrial accident claims were used, medical and legal expenses declined

- All declines were statistically significant.

29) Ford, J.D., Shaw, D., Sennhauser, S, Greaves, D. Thacker, B, Chandler, P, Scwarta, L. and McClain, V. (1993). Psychological debriefing after operation desert storm: marital and family assessment and intervention. *Journal of Social Issues,* 49, 73-102.

Key points and findings:

- Psychological debriefing had positive effect for the participants.
- Debriefings were used to assist family members
- Marital discord declined after interventions

30) Hanneman, M.F. (1994) *Evaluation of Critical Incident Stress Debriefing as Perceived by Volunteer Firefighters in Nova Scotia. Ann Arbor: UMI Dissertation Services.*

Key points and findings:

- Firefighters offer insights into the effects of CISD in this positive outcome qualitative analysis
- Reasons why the CISD was perceived to work are presented as well as approaches to avoid because they were perceived to be less helpful.

31) Harbert, K. (1992). *The development and use of CISM team within a rural tertiary hospital.* Poster and paper presented at the meeting of the Agency for Health Policy and Research, Atlanta, Georgia.

Key points and findings:

- After three year trial, it was found that the CISM team, using early and appropriate interventions, did significantly reduce the psychological impact of critical incidents.

32) Harris, M.B., Baloglu, M., and Stacks, J.R. (2002). Mental Health of Trauma-exposed firefighters and Critical Incident Stress Debriefing. *Journal of Loss and Trauma*, 7, 223-238.

Key points and findings:

- Study started 6 months after exposure.
- 264 firefighters had been offered CISD and apparently chose to participate in CISD
- 396 firefighters were either not offered CISD or choose not to participate in CISD
- Those who had CISD had less negative affectivity when measured at 6 months. This was significant at the $p>.01$ level. That means the potential of that outcome

occurring by chance is only 1 in 100. Please note that this is a <u>positive</u> finding of the effect of CISD.

- Those who had CISD had more positive beliefs and positive affect (emotion) when measured at 6 months. This was significant at the p>.05 level. That means that the potential of that outcome occurring by chance is 5 in 100. Please note that this is a <u>positive</u> finding of the effect of CISD.
- The exact quote is: "The parameter estimates were significant for an inverse relationship between negative affectivity and CISD (critical ratio (c.r. = 3.04, p > .01) and a positive relationship between world assumptions and CISD (c.r. =2.07, p>.05)." (p.230)
- Please keep in mind that the study started 6 months after critical incidents. There is a maturation effect that must be taken into consideration. That means that many other things could have happened in the 6 months since the critical incident. People might have had an illness, a divorce, family conflict, a sick child or problems on the job. Or they could be happier then ever in life before. Anything could have happened to them during the 6 months. Conclusions about a relatively immediate crisis intervention tactic that was applied in the acute phase of crisis reaction, but was not measured until several months after it was provided are essentially irrelevant.
- At 6 months most of the symptoms of acute distress effects would have dissipated and would not be easily measurable unless they were persistent and extreme. This is especially important in light of the fact that there were no baseline data. Since this is a post test only design, the group is essentially being compared to itself and not to another group. Since there is no baseline data, there is no way to tell what they were like when the critical incident occurred or shortly after its occurrence.
- The authors state on page 224 that "One problem with research on CISD is lack of clear demonstration by proponents and practitioners of the specific disorders CISD is intended to ameliorate, demonstration in the fire service at a base rate sufficient to warrant large-scale interventions…" Then, on the very next page, the authors cite no less than 17 references that indicate the specific disorders that CISD is designed to ameliorate. This is an amazing contradiction within one page in the article.
- It should be noted that this authors go through great pains to describe positive findings in a negative light. There is little mention of the positive studies that have been done in the CISM field and published in peer reviewed journals. Additionally, there are numerous references to the flawed studies described in the negative outcome studies section of this summary.
- The authors appear to base their negative views of their own positive findings on an article by Carlier (1996). (See commentaries in negative outcome studies in the first section of this summary.)
- The statements by the authors on page 227 that there are no studies that attest to any substantive effect of CISD which appear in peer reviewed (refereed professionals journals) is *simply untrue* as indicated by the numerous peer reviewed studies cited in this summary. There are two truly randomized studies that are described in the positive section of this summary above. There are numerous other studies in peer reviewed journals that attest to the positive

influence of CISD or CISM on those who received these services. Such a blanket negative statement about the lack of peer reviewed studies in the CISM field suggests either a bias on the part of the authors or a lack of essential knowledge of the literature in the CISM field.

- What that means is one of several things may be going on in this study a) the authors are misinterpreting their results b) The authors are prejudiced against CISD and have worked hard to camouflage positive findings. In fact, the positive results are written off by the authors as if they were of no value.
- The authors dismiss the findings as representative of traits (permanent conditions / dispositions) when they are actually states (temporary conditions).
- This is a "blame the victim" approach. It says we will not give any credence to the fact that you experienced a traumatic event and that the event might have changed you or that the intervention benefited you. We will only give credence to the idea that you are not quite right for the job and should have been screened out better.
- Here is an interesting direct quote from the article that stands out in stark contrast to much of the negative verbiage. [emphasis added] *"Clinical wisdom might suggest that there is inherent value in the provision of support and psychological instruction during the postexposure period, and empirical evidence from this study does not contradict that notion." (p.233)*
- Note: So, here is a "CISD study" with significant positive outcome on two measures for which there is statistically significant evidence that the positive outcomes are related to participation in a CISD. The authors disregard the positive effects and say instead that poor screening of personnel for the job led to the results. One must be either baffled by or amazed by such a discussion of the results of this study.

33) Hiley-Young, B and Gerrity, E.T. (1994).Critical Incident Stress Debriefing (CISD): Value and limitations in disaster response. *NCP Clinical Quarterly,* 4, 17-19.

Key points and findings:

- "We recognize that CISD procedures may help some disaster victims. We are concerned, however, that an unreasonable expectation of CISD usefulness may be developing among field practitioners." (p.17)
- Personal losses and traumatic experiences may make the CISD less helpful by it self.
- If a person has pre-incident psychopathology, the CISD by itself will not be effective. Therapy will be necessary.

34) Hokanson, M. (1997) *Evaluation of the Effectiveness of the Critical Incident Stress management Program for the Los Angeles County Fire Department.* Los Angeles, CA: LACoFD.

Key points and findings:

- Fire service personnel in Los Angeles County, California
- 3000 surveys distributed
- 2124 (70.8%) completed
- 600 of the 2124 firefighters had participated in a group CISD
- Goals of the LACoFD CISM program were to Accelerate the recovery process after traumatic events
- To reduce the psychological impact of the event
- 56.3% of respondents experienced a significant reduction of trauma-related symptoms with 72 hours of the CISD compared to only 45.5% indicating reduction of symptoms without CISD
- The 72 hour incremental recovery utility for CISD was 10.8% beyond the personnel in the groups that did not receive CISD
- 74.1% of the respondents experienced a significant reduction of trauma-related symptoms within one week after the CISD compared to only 65.5% of the personnel in the groups that did not receive CISD.
- The one week incremental recovery utility for CISD was 8.6%
- Those firefighters who participated in a CISD had 19.4% less reported symptoms one week after the incident than firefighters without a CISD who had worked at the same event.
- The reduction in symptoms after CISD has implications for medical care, sick leave utilization and workers compensation claims.
- In addition the CISD process was effective in facilitating the amelioration of trauma-related symptoms.
- Of the respondents only 13.9% indicated that they had persistent trauma-related symptoms more than 6 months after the trauma and the CISD.
- The personnel in groups not receiving CISD who reported persistent trauma-related symptoms was 16.5%
- The incremental recovery utility was 2.6% for the CISD in this analysis
- These findings have implications for workers' compensation disability claims and the incidence of early retirement and turnover.

35) Jenkins, S.R. (1996). Social support and debriefing efficacy among emergency medical workers after a mass shooting incident. *Journal of Social Behavior and Personality* 11, 447-492.

Key points and findings:

- 29 emergency medical personnel were studied subsequent to a mass shooting in Kileen, Texas. 23 died and another 32 were wounded
- A group of 15 EMS personnel were given CISD within 24 hours
- Another 14 EMS personnel had no-CISD
- Repeated assessments 8-10 days after CISD and at 1 month

- Recovery from the trauma most strongly associated with participation in the CISD process.
- CISD was useful in reducing symptoms of stress, depression and anxiety for those who participated in the CISD compared to those who did not.
- Trauma related symptoms decreased in CISD group

36) Jarero, I. and Artigas, L. (2002). ***Traumatic Stress After Natural or Human Provoked Disaster: The seven phase model: An approach for mental health interventions in Disaster situations.*** **Mexico City, Mexico: Asociacion**

Mexicana paraAyuda Mental en Crisis, A.C. (Mexican Association for Crisis Therapy).

Key points and findings:

- Utilized an integrated, comprehensive and multi-tactic CISM approach.
- Appropriate therapeutic follow-up services were applied as required by the needs of the people.
- Children were the largest percentage of participants.
- Men and women were also participating in the interventions.
- Participants came from various regions in Mexico and also from Nicaragua, Colombia, Venezuela, and El Salvador,
- Significant reductions in scores on subsequent assessments were realized in all groups (children and adults) after CISM interventions were utilized.

37) Lanning, J.K.S. (1987). ***Post Trauma Recovery of Public Safety Workers for the Delta 191 crash: Debriefing , Personal Characteristics and Social Systems.*** **Ann Arbor, MI: UMI Dissertation Services.**

Key points and findings:

- CISD was helpful to emergency personnel after working at the Delta 191 crash.
- Personnel reported that hearing from others who had experienced the same event and were experiencing similar symptoms was helpful.
- Sharing of ideas of how to manage stress by the group participants was helpful
- Guidelines given by the team members for stress management were also perceived to be helpful.

38) Larsson, G., Tedfelt, E.L., and Anderson, B. (1999). Conditions affecting experiences of the quality of psychological debriefings: Preliminary findings from a grounded theory study. ***International Journal of Emergency Mental Health, 1, 91-97.***

Key points and findings:

- Points out importance of organizational and administrative support for the debriefing process or its effects may be dampened.
- The managers must present the idea that the debriefing is an important thing or it is more likely to fail.
- Other conditions necessary for positive outcome debriefings are listed by the authors.
- Strongly emphasizes the importance of leadership in a debriefing
- Describes the characteristics which help a leader to run a debriefing group

39) Leeman-Conley, (1990). After a violent robbery. *Criminology Australia,* April /May, 4-6.

Key points and findings:

- Bank employees in Australia.
- Compared one year without a CISM program to a year with a CISM program.
- 107 employees in each year.
- In the year without assistance there were 281 sick days within a week of the robbery. There were 668 sick days taken over the next six months. These numbers are much higher than average lost days when there have been no robberies. Average cost of medical benefits and other workers compensation was $18,488.
- After the CISM program (called the "Post Hold-up Support Program") was instituted, the sick time utilization was 112 sick days within a week and 265 days during the next six months. This occurred despite the fact that there were more robberies in the year when help was available. Average medical and other workers compensation costs dropped to $6, 326.
- 60% reduction in sick time utilization over year without assistance
- 66% reduction in workers compensation payouts over year without assistance.

40) Manzi, L.A. (1995). *Evaluation of the On Site Academy's Residential Program.* Research investigation submitted to Boston College.

Key points and findings:

- Week-long residential CISM program
- Serves severely distressed Emergency Services personnel who have been through significant critical incidents.
- 108 participants were surveyed. 45 (41.7%) of surveys were completed
- The 45 who completed surveys were out of the On Site Academy for an average of 10 months
- 100% said it had helped them meet their goals
- 100% of survey participants indicated that they would recommend the On Site Academy for seriously distressed emergency personnel.
- Symptoms were assessed by using a retrospective pre-test post-test design

- Analysis indicated significant decreases cognitive, physical, emotional and behavioral stress symptom patterns.
- Over 90% of those who attended the On Site program were able to return to work even though they had been out of work a range of 4 months to 4 and ½ years.

41) Meehan, D. (1996) Critical Incident Stress Debriefing. *Navy Medicine*, 35, 4-7.

Key points and findings:

- CISD helpful to Navy personnel after traumatic events
- Naval personal felt that the debriefings helped to inform and instruct
- Personnel reported lowered symptoms

42) Mitchell, J.T., Schiller, G., Eyler,V.E. and Everly, G.S. Jr. (1999). Community Crisis Intervention: the Coldenham tragedy revisited. *International Journal of Emergency Mental health,* 1, 227-236.

Key points and findings:

- Firefighters who worked in a tornado damaged school in which 9 children were killed.
- 3.5 years passed before adequate help was instituted for the firefighters.
- Although it was very much delayed, help in the form of crisis intervention tactics was brought to the fire service at their request.
- At 2 years, Dr. Paulette Muni, a local psychologist, had assessed that 100% of the 18 firefighters who served inside the internal perimeter had lingering symptoms of posttraumatic stress
- At 3.5 years 17 (94%) of the 18 personnel still had symptoms of PTSD similar to those found by Muni at the 2nd year.
- 8 (44%) of the 18 met all of the criteria for a diagnosis of PTSD
- 9 others (50%) had at least two of the symptom domains for PTSD
- A comprehensive package of crisis interventions were instituted
- Three follow up sessions were utilized. The last was completed at five months after the CISM interventions.
- Recommendations for therapy were accepted by several of the firefighters
- McNemar Change Test was conducted to see if the interventions had contributed to the change or if they were merely by chance.
- After CISM interventions were completed only 7 (39%) firefighters continued to experience symptoms from one or more of the symptom domains.
- The p value was .004. The probability of that occurring simply by chance was only 4 in 1000 cases.
- Four firefighters were successfully talked into accepting therapy. Three completed a course of long term therapy. One, unfortunately, dropped out of therapy after only a few sessions.

- Six fire fighters had left service after the tragedy. After intervention 5 of the 6 returned to firefighting duties.

43) North, C.S., Tivis, L., McMillen, J.C., Pfefferbaum, B., Cox, J., Spitznagel, E.L., Bunch, K., Schorr, J. and Smith, E.M.. (2002). Coping, functioning, and adjustment of rescue workers after the Oklahoma City Bombing. *Journal of Traumatic Stress*, 15(3), 171-175.

Key points or findings:

- 181 firefighters who worked at the Oklahoma City Bombing
- Greater number of days at site was associated with lower current job satisfaction
- Contact with remains of children was most distressing experience for majority
- Support of family or friends was most common coping technique
- Use of Alcohol was second most common coping technique
- 92% had defusings and / debriefings
- Two thirds of the group expressed satisfaction with interventions
- Participants with psychological disorders (other than PTSD) were less satisfied
- 89% said they would recommend those CISM interventions for their colleagues

44) Nurmi, L. (1999). The sinking of the Estonia: The effects of Critical Incident Stress Debriefing on Rescuers. *International Journal of Emergency Mental Health,* 1, 23-32.

Key points and findings:

- Sinking of *Estonia,* a large ferry boat. 994 killed.
- 105 emergency response personnel who retrieved bodies were compared to 28 emergency department nurses who received bodies at their hospitals.
- CISD provided to emergency response personnel
- Supervisor support only service provided to the nurses
- Impact of Events Scale utilized and Penn Inventory
- Psychometrically assessed trauma symptoms were consistently lower in CISD groups compared to control group.
- Self reported satisfaction with CISD ranged from 63% to 84%.

45) Ott, K., and Henry, P. (1997). *Critical Incident Stress Management at Goulburn Correctional Centre: A report.* Goulburn, NSW, Australia: NSW Department of Corrective Services.

Key points and findings:

- CISM program installed in 1995
- Peer support and mental health professionals
- 90% reduction in costs of assisting stress employees

- Lowered sick time utilization, turnover of personnel and premature retirements

46) Richards, D. (2001). A field study of critical incident stress debriefing versus critical incident stress management. *Journal of Mental Health*, *10*, 351-362.

Key points and findings:

- Assessment of the Critical Incident Stress Debriefing (CISD) tactic versus Critical Incident Stress Management (CISM) comprehensive program.
- After robberies
- 225 people received only CISD
- 299 people received a comprehensive program including CISD
- Services were initiated 3 days after the event
- Used Impact of Events Scale, General Health Questionnaire and Posttraumatic Stress Disorder scale.
- Assessed at 3 days, 1 month and 6-12 months
- Both interventions were found to be very helpful
- But comprehensive CISM was far more effective than CISD alone when evaluated on the follow-ups

47) Richman, M. (1998). *The Impact of Critical Incidents and the Value of Critical Incident Stress Debriefing.* Hobart, Tasmania, Australia: The Tasmanian Emergency Services Critical Incident Stress Management Program

Key points and findings:

- Various traumatic events impacting emergency personnel between 1988 and 1998
- One of the traumatic events was the murder of 32 tourists at a historical site in 1996
- Evaluations were based on follow-up surveys provided immediately after a CISM service and returned within 10 days
- 586 personnel participated in the study
- The individual CISM services were rated as at least moderately valuable by 96% of the respondents
- CISD was rated at moderately valuable by 90% of the personnel. 67% found it very valuable
- 55.6% of the respondents felt that the CISD had brought them relief from or lessening of symptoms

48) Rime, B. (1995). Mental rumination, social sharing, and the recovery from emotional exposure. In J.W. Pennebaker (Ed.). *Emotion, Disclosure and Health,* (pp.271-291). Washington DC: American Psychological Association.

Key points and findings:

- Natural social situations are not likely to offer people opportunities to verbalize in depth and at length the feelings experienced during an emotional episode.
- "It may thus be that what people evidence as social sharing behaviours in everyday life would rather be uncompleted attempts at processing episode-related emotional information. One can probably conclude that in the field of emotion, there is ample place for professional intervention." (p.287).
- Structured follow-up sessions, such as debriefing meetings, may be one necessary professional intervention to help to process critical events.

49) Robinson, R.C. and Mitchell, J.T. (1993) Evaluation of psychological debriefings. *Journal of Traumatic Stress*, 6(3), 367-382.

Key points and findings:

- 288 emergency workers
- 31 "Mitchell Model" CISD between 1987 and 1989 in Melbourne, Australia
- Evaluation forms distributed within two weeks of the CISD
- 96% of emergency services personnel and 77% of welfare or hospital staff stated that they had experienced symptom reduction which they attributed to the CISD.
- No one reported experiencing harm from the CISD
- The greater the impact of an event on the personnel, the greater the benefit of the CISD

50) Robinson, R.C. (1994). *Follow-up study of health and stress in ambulance services, Victoria, Australia.* Part I. Melbourne, Australia: Victorian Ambulance Crisis Counseling Unit.

Key points and findings:

- 823 ambulance personnel
- 45% had incidents which cause them to experience significant distress.
- 64% of the 823 were aware of CISM services.
- Of those, 71% felt that CISM services including CISD services very important, 26% felt that the services were quite important and only 3% felt that the services were not important
- When only the CISD were evaluated, 37% of personnel found them to be very helpful, 45% found them to be moderately helpful and 18% found them unhelpful.
- 21% of those who went through a CISD had considerably lower symptoms, another 51% said the symptoms lowered a little. 28% of the personnel in the CISD said they had no symptom reduction.
- 48 % of the personnel said the symptom reduction was long lasting, 10% said the symptom reduction lasted up to a few weeks, 14% said the symptom reduction lasted up to a few days. 28% said they did not perceive any benefits of the CISD.

51) Rogers, O.W. (1992) *An examination of Critical Incident Stress Debriefing for Emergency Services Providers: A quasi experimental field study*. Ann Arbor, MI: UMI Dissertation Services.

Key points and findings:

- Doctoral dissertation
- Quasi experimental design
- Data suggest that there may be a powerful symptom mitigation effect from the use of CISD
- The effect may not be evident until several weeks after the CISD
- In the immediate 36 hour period the CISD effect appears minimal but becomes more evident over time.
- 72% of emergency personnel who were given CISD reported lower symptoms after the CISD
- Feelings of control of one's reactions increased after CISD
- Reported small "…significant increases in resolution in persons who participated in the debriefing process, when controlling for other presumed influencing variables" (p.71)
- "…the resolution of stress as measured by the Critical Incident Resolution Scale…Mean scores for the participant sample are 1.06 times grater than the nonparticipant sample" (p.77).

52) Shalev, A.Y. (2000). Stress management and debriefing: historical concepts and present patterns. In B. Raphael and J.P. Wilson (Eds.), *Psychological debriefing: Theory, Practice and Evidence* (pp.17-31. Cambridge, UK: Cambridge University Press.

Key points and findings:

- "Debriefing has been accepted as a standard to meet obligations by many of the institutions that expose their members to stressful events, and this should not be overlooked. So far no viable alternative has been shown to fare better" (p.18)

53) Stallard, P. and Law, F. (1993). Screening and Psychological debriefing of adolescent survivors of life threatening events. *British Journal of Psychiatry.*163, 660-665.

Key points and findings:

- Psychological debriefing was used in part to screen for teenagers in need of additional assistance
- Psychological debriefing was followed by a positive effect for the participants.

54) Talbot, A. (1990). The importance of parallel process in debriefing crisis counselors. *Journal of Traumatic Stress*, 3, 265-278.

Key points and findings;

- It is important to take care of the providers of services after debriefing
- Suggest steps to provide debriefing of the debriefers to help them stay healthy

55) Talbot, A., Manton, M., and Dunn, P.J. (1992). Debriefing the debriefers: An intervention strategy to assist psychologists after a crisis. *Journal of traumatic Stress,* 5, 4-62.

Key points and findings:

- Outlines a format for caring for the helpers who may have encountered vicarious stress reactions.
- Warns that a failure to care for the team members may result in personal pain or even a loss of well trained psychological debriefers.

56) Tehrani, N. (1995). An integrated response to trauma in three post office businesses. *Work and Stress*, 19, 380-393.

Key points and findings:

- Sickness and absence levels in employees held captive in armed raids fell by 50% after the introduction of a multi-component trauma package
- Psychological debriefing was among the interventions utilized.

57) Tehrani, N. (1998). Debriefing a safe way to defuse emotion. *The Therapist,* 5, 24-29.

Key points and findings:

- After psychological debriefings positive effects were found in the participants
- Cautions against using debriefing with those who are healing from physical wounds since physical healing takes precedence over emotional healing.
- Symptoms reduced and people were able to return to work more comfortably after group psychological debriefing

58) Turnbull, G. (1997). Hostage retrieval. *Journal of the Royal Society of Medicine,* 90, 478-483

Key points and findings:

- Describes what he calls "support" or "secondary debriefings" for debriefers involved in debriefings of prisoners-of –war and hostages to manage the "ripple effect" of emotional contamination experienced in such arduous work.
- Participants found psychological debriefing helpful in managing their reactions to having been a hostage.

59) Ursano, R.J., Fullerton, C.S., Vance, K. and Wang, L. (2000). Debriefing: its role in the spectrum of prevention and acute management of psychological trauma. In Rraphael and J.P. Wilson (Eds.). ***Psychological Debriefing: Theory, Practice and Evidence (pp. 32-42). Cambridge, UK: Cambridge University Press.***

Key points and findings:

- "Debriefing, like sleep medication or pain medication, may have little or no impact on standard health measures but still is an important intervention to limit pain, discomfort and disability" (p. 40).

60) Watchorn, J.H. (2000). Role of debriefing in the prevention of PTSD. Invited paper presented to the Inaugural Conference on Stress, Trauma and Coping in the Emergency Services and Allied Professions. Melbourne, Australia.

Key points and findings:

- The CISD model of debriefing can be an effective clinical tool for reducing psychological distress, reducing alcohol use, and preventing PTSD
- Those who did not actively disclose during debriefings, especially those who had experienced high levels of peri-traumatic dissociation, had experienced a greater concentration of problems over time than those who disclosed.

61) Watchorn, J.H. (2001). ***Surviving Port Arhur: The role of dissociation in the impact of and its implications for the process of recovery.*** **Hobart, Tasmania, Australia: University of Tasmania.**

Key points and findings:

- 96 emergency services personnel involved in response to the Port Arthur massacre in which a lone gunman killed 32 visitors in a historic area of Tasmania, Australia.
- Experiencing dissociative symptoms at the time of the incident was predictive of long term psychological and physiological distress.
- Those who experienced dissociation at the event but disclosed their related thoughts and feelings at the group debriefings showed significantly less long-term psychological distress.

- CISD appears to provide an opportunity for the necessary psychological processing to commence and assist emergency services personnel in managing what might otherwise develop into PTSD.
- Baseline data were established
- Follow-up assessments were made at 8 months and 20 months

62) Wee, D.F., Mills, D.M. and Koelher, G. (1999). The effects of Critical Incident Stress Debriefing on emergency medical services personnel following the Los Angeles civil disturbance. *International Journal of Emergency Mental Health,* 1, 33-38.

Key points and findings:

- 65 emergency medical personnel were studied after exposure to urban riots in Los Angeles
- 42 given CISD within 1 to 14 days after riot
- 23 no-CISD
- Frederick Reaction Index (self-report symptoms of PTSD)
- Assessed 3 months after the CISD
- Those who received the CISD had significantly less symptoms of PTSD than those without the CISD.

63) Western Management Consultants. (1996). *The Medical Services Branch CISM Evaluation Report.* Edmonton Alberta: WMC

Key points and findings:

- Data were collected, analyzed and reviewed by an independent evaluation organization, Western Management Consultants
- Of 582 nurses working in British Columbia, Alberta , Manitoba and Ontario 236 (41%) responded to the survey.
- 65% of the nurses had at least one critical incident per year in the workplace.
- Death of a child 37% of nurses
- Attempted or actual physical assault 28%
- Break-in at nursing facilities 25%
- Verbal threats / Assaults 52%
- Suicide attempt or completed suicide of a patient 44%
- CISM was instituted by the employer (Federal Government of Canada) as a means of reducing critical incident-related stress and discord.
- 82% of the nurses who had used CISM services reported that the services met or exceeded their expectations.
- 89% of the nurses in the overall sample indicated that they were satisfied with CISM services

- 99% of nurses indicated that the CISM program had helped them to reduce the number of sick days taken on the job. A review of three years of sick time utilization confirmed this finding to be true.
- "Survey data suggest MSB CISM significantly reduced turnover among field nurses" (p.53).
- As many as 24% of the nurses who experienced a critical incident contemplated leaving their jobs, but did not after A CISM intervention. Estimates are that a single nurse replacement would cost CN $38,000.
- Financial evaluations revealed a $7.09 benefit-to-cost ratio. That may be interpreted as a 700% return on the investment of the Canadian Government.
- "It is evident that the quality of the existing program is exceptional. The MSB program is a state-of-the-art program that should be emulated by other employers, and sets a standard by which alternatives should be judged." (Western Management Consultants, 1996, p. iv).

64) Wollman, D. (1993) Critical Incident Stress Debriefing and crisis groups: A review of the literature. *Group,* 17, 70-83.

Key points and findings:

- Critical incident are specific, unexpected, often potentially life threatening, time limited events which may involve loss, threat or some turning point in life.
- Crisis intervention approaches focus on primary prevention through early intervention to avoid maladaptive problem solving and to restore a person to an adaptive level of independent functioning.
- CISD is only one type of support group

65) Yule, W. and Udwin, O. (1991). Screening child survivors for post-traumatic stress disorders: Experiences from the "Jupiter" sinking. *British Journal of Clinical Psychology*. 30, 131-138.

Key points and findings:

- Debriefing is followed by positive effect for the participants.
- When properly applied psychological debriefings can be very helpful to children

Additional Articles and Books in Support of Crisis Intervention and CISM

Artiss, K. (1963). Human behavior under stress: From combat to social psychiatry. *Military Medicine,* 128, 1011-1015.

Key points and findings:

- Soldiers in combat
- Use of a crisis intervention program
- *Proximity* of intervention to the operational zone, *immediacy* of intervention and positive outcome *expectancy* were associated with a higher rate of return to military service during combat.
- 5% return before crisis intervention program was instituted
- 70-80% return to combat once a crisis intervention program was in place.

Bordow, S. & Porritt, D. (1979). An experimental evaluation of crisis intervention. *Social Science and Medicine*, 13, 251-256.

Key points and findings:

- One crisis intervention tactic was better than none
- Combined crisis intervention tactics were most helpful

Breznitz, S. (1980). Stress in Israel. In H. Selye (Ed.) *Guide to Stress Research.* New York: Van Nostrand Reinhold Company.

Key points and findings:

- *600 soldiers evacuated from the front lines*
- *Peer support of fellow soldiers*
- *Only 60 (10%) required further care*
- *None required long term care.*
- *Overall incidence of psychiatric disturbance in Israeli combat forces dropped 60%*

Friedman, R., Framer, M. and Shearer, D. (1988). Early response to post-traumatic stress. *EAP Digest,* September-October, 45-49.

Key points and findings:

- Early detection and early intervention with PTSD or post trauma syndromes led to lower costs
- Early intervention led also to more favorable prognosis
- 100 traumatized people received were diagnosed and treated within six months of the trauma
- 100 traumatized people were diagnosed and treated after six months and up to 36 months after the traumatic experience.
- Average cost of recovery with the earlier intervention was $8,300
- Average cost of recovery with the later intervention personnel was $46,000
- The earlier cases returned to work about 12 weeks after the traumatic event

- The later cases required up to 46 weeks to achieve recovery
- 13% of those treated early sued their employers
- 94% of those who were treated late sued their employers

Lindy, J. (1985). The trauma membrane and other clinical concepts derived from psychotherapeutic work with survivors of natural disasters. *Psychiatric Annals,* 15, 153-160

Key points and findings:

- *"Trauma Membrane Theory"*
- Survivors of disasters and other traumatic events surround themselves with a protective "membrane" which insulates them from demands in their environment.
- As time passes, the "membrane" grows maladaptively thicker and less permeable. They are thus effectively isolated from virtually all external relationships be they friends, family or work associates.
- Early psychological intervention may represent a means of providing support and security without the necessity of constructing an impermeable barrier.

Lopez-Ibor, J., President, World Psychiatric Association (2002). Psychopathology of disasters. Plenary address to XII World Psychiatric Congress. *Medscape Psychiatry and Mental Health, 2 (2),* August 2002.

Key points and findings:

- Crisis intervention should be as immediate as possible
- Integrated
- Assessment and triage are important
- Provide adequate information designed to minimize rumors
- Pre-incident training is important
- Sensitivity to situational and cultural needs
- "an important intervention is verbal – debriefing, discussions, social support. individually and group if possible"
- Role of mental health professional is to integrate and organize social / behavioral / individual / systems.

NIMH. (2002). Mental Health and Mass Violence: Evidence-based early psychological intervention for victims /survivors of Mass violence. A workshop to reach consensus on best practices." Washington, DC: NIMH

The10 Key points and findings:

- **1)** The report supports *early intervention*, that is, interventions which take place within 4 weeks of the traumatic exposure.
- **2)** *Expect normal recovery for most people*
- **3)** *Mental health services should be integrated* within the overall disaster response plan
- **4)** *Intervention should be as needed and voluntary*
- **5)** *Meet the basic needs first* (survival, safety, food, shelter, physical / psychological health, triage and communications)
- **6)** *Include the key elements of early intervention*:
  a) Pre-incident preparation (Caplan, 1964)
  b) Psychological first aid
  c) Needs assessment and monitoring
  d) Outreach and information dissemination (Caplan, 1964)
  e) Technical assistance and training
  f) Fostering resiliency and natural recovery mechanisms (offer group and family intervention)
  g) Triage, provide for emergency psychiatric hospitalization
  h) Referrals for further assessment for possible psychotherapy
- **7)** *It is essential that intervention should be sensitive to diversity.* Services should be provided on as needed basis. Services should be tailored to the unique culture of the recipient population (e.g. ethnic, racial, occupation, geographic, etc.)
- **8)** *There is limited research on mass disasters*.
  a) Therefore generalizations are often based on other research.
  b) Cognitive behavioral approaches show promise
  c) Single 1:1 recitals of events (debriefing) without follow-up does not reduce risk and it may be counterproductive
  d) Clinical research needs to be conducted
  e) Standard taxonomy and nomenclature is needed
  f) Policies should be based on defensible empiricism
- **9***)* *Providers of early interventions*:
  a) Mental Health Clinicians
  b) Clergy
  c) School personnel
  d) Community volunteers
  e) Medical personnel
  f) Emergency responders
  g) Should operate within a sanctioned system (e.g. ICS)
  h) Specialized training programs recommended
- **10)** *Post incident follow-up*
  a) Precise time tables for intervention unavailable
  b) Many survivors experience distress
  c) Most symptoms will remit
  d) Survivors without symptoms after 2 months will generally not require therapy follow-up

e) However, follow-up should be offered to those at high risk: Acute Stress Disorder, Bereaved, pre-existing psychiatric disorders, resultant medical / surgical patients, high intensity / chronic exposure and those who request it.

Salmon, T.S. (1919). War neuroses and their lesson. *New York Medical Journal,* 108, 993-994.

Key points and findings:

- Early psychological intervention is important
- "…Nothing could be more striking than the comparison between cases treated near the front and those treated far behind the lines…As soon as treatment near the front became possible, symptoms disappeared with the slightest amount of treatment." (p. 994).
- Rapid intervention was better than letting nature takes its course.
- 40% return to combat by letting nature takes its course 60-65% return to combat with early intervention

Solomon, Z. and Benbenishty, R. (1986). The role of proximity, immediacy and expectancy in frontline treatment of combat stress reactions among Israelis in the Lebanon War. *American Journal of Psychiatry,* 143f, 613-617.

Key points and findings:

- Several hundred Israeli soldiers
- Naturalistic randomization
- *Proximity* of intervention to the operational zone, *immediacy* of intervention and positive outcome *expectancy* were associated with a higher rate of return to military service during combat.
- Expectancy was most powerful of the three crisis intervention principles
- Return to service was substantially improved with the program
- PTSD symptoms were lessened.

Swanson, W.C. and Carbon, J.B. (1989). Crisis intervention: Theory and Technique. In Task Force Report of the American Psychiatric Association. *Treatments of Psychiatric Disorders*. Washington, DC: APA press.

Key points and findings:

- When writing for the American Psychiatric Association Task Force Report on Treatment of Psychiatric Disorders, state, "Crisis intervention is a proven approach to helping in the pain of an emotional crisis." (p.2520).
- Crisis intervention (rapid and acute psychological intervention following critical incidents and traumatic events) has demonstrated itself to be an effective means of reducing psychological morbidity.

Other Reviews and Articles and Items of Interest

Bucci, W. (1995). The power of the narrative: A multiple code account. In J. W. Pennebaker (Ed.). *Emotion, Disclosure and Health* (pp.93-122). Washington, DC: American Psychological Association.

Bunn, T. and Clark, A. (1979). Crisis intervention. *British Journal of Psychiatry*, 52, 191-195

Caplan, G. (1961). *An approach to Community Mental Health*. New York: Grune and Stratton

Caplan, G. (1964). *Principles of Preventive Psychiatry.* New York: Basic Books.

Caplan, G. (1969). Opportunities for school psychologists in the primary prevention of mental health disorders in children, In A. Bindman and A. Spiegel (Eds.) *Perspectives in Community Mental Health* (pp.420-436). Chicago: Aldine.

Dyregrov, A., Thyholdt, R. and Mitchell, J.T. (1992). Rescue workers emotional reactions following a disaster. In Engleman, S. R. (Ed.) *Confronting life- threatening illness.* New York: Irvington Publishers, Inc.

Dalgeish, T., Joseph, S., Thrasher, S., Tranah, T., & Yule, W. (1996) Crisis support following the Herald of Free Enterprise disaster. *Journal of Traumatic Stress*, 9, 833-845.

Deahl, M. (2000). Psychological debriefing: controversy and challenge. Australian and *New Zealand Journal of Psychiatry*, 34, 929-939.

Decker, J. & Stubblebine, J (1972). Crisis intervention and prevention of psychiatric disability: A follow-up. *American Journal of Psychiatry*, 129, 725-729.

Department of Health (2001). Treatment Choice in Psychological Therapies and Counseling. London: Crown.

Dyregrov, A., Solomon, R.M., Bassoe, C.F. (2000). Mental mobilization in critical incident stress situations. *International Journal of Emergency Mental Health*, 2, 73-81

Dyregrov, A. (2001). Early Intervention – a family perspective. *Advances in Mind-Body Medicine,* 17, 9-17

Everly, G.S., Flannery, R. and Mitchell, J.T. (2000). Critical Incident Stress Management (CISM): A review of the literature. *Aggression and Violent Behavior: A Review Journal,* 5, 23-40.

Everly, G.S. and Mitchell, J.T. (1998) CISD revisited: A primer on Critical Incident Stress Management. *ATSS Trauma Lines,* Fall, 1, 3.

Everly, G. S., Jr. and Mitchell, J.T. (1999). *Critical Incident Stress Management (CISM): A new era and standard of care in crisis intervention, second edition.* Ellicott City, MD: Chevron Publishing Corporation.

Flannery, R.B., Jr. (2001). Assaulted Staff Action Program (ASAP): Ten years of empirical support for Critical Incident Stress Management (CISM). *International Journal of Emergency Mental Health*, 3, 5-10.

Farberow, N.L. and Shneidman, E. (Eds.) (1965). *The Cry for Help.* New York: McGraw Hill.

Farberow, N.L., Frederick, C.J. (1978).Disaster relief workers burnout syndrome. *Field Manual for Human Service Workers in Major Disasters.* Washington, DC: US Government Printing Office.

Figley, C.R. (1995) (Ed.), *Compassion Fatigue.* New York: Brunner Mazel.

Geiger, B. (2001). Counseling poor, abused, and neglected children in a fair society. *Directions in Clinical Psychology,* 13, 39-51.

Gore, A. (1997). *White House Commission Report on Aviation Safety and Security*. Washington, DC: The White House.

Hassling, P. (2000). Disaster management and the Gothenburg fire of 1998: when first responders are blamed. *International Journal of Emergency Mental Health,* 2, 267-273.

Kardiner A. and Spiegel, H. (1947). *War, Stress, and Neurotic Illness*. New York: Hoeber.

Krupnick, J.L. (2001). Interpersonal psychotherapy for PTSD following interpersonal trauma. *Directions in Clinical Psychology,* 13, 75-90.

Langsley, D., Machotka, P., & Flomenhaft, K. (1971). Avoiding mental health admission: A follow-up. *American Journal of Psychiatry*, 127, 1391-1394.

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Crisis Intervention is Not Psychotherapy

Mental health professionals with appropriate training are capable of providing crisis intervention. In fact, the first session or two of many therapy relationships often utilize crisis intervention tactics. There are certainly therapeutic elements in crisis intervention, but crisis intervention is not psychotherapy. Crisis intervention is a form of psychological "first aid". It is suggested that as medical first aid is to surgery, crisis intervention is to psychotherapy. Crisis intervention is supportive not curative. The main differences between crisis intervention and psychotherapy are outlined below.

Psychotherapy	**Crisis Intervention**
Context:	
Reparation, reconstruction, growth	Prevention, acute mitigation Restoration to adaptive function
Strategic foci:	
Conscious and unconscious sources of pathology	Conscious processes and environmental stressors / factors
Location:	
Safe, secure environment	Close proximity to stressor Anywhere needed
Purpose:	
Personal growth and development	Emotional "first aid" to reduce distress and assist the person in crisis to return to a state of adaptive functioning

Temporal focus:

Present and past	Here and now

Providers:

Mental health professionals	A trained, outgoing person who cares for people and has a desire to help those in a state of crisis Paraprofessionals Mental health professionals Clergy

Provider Role:

Guiding, collaborative, consultative	Active, directive

Timing:

Typically within weeks to months or years after the development of a problem that interferes with normal life pursuits Delayed, distant from stressor	During a critical incident and in the immediate aftermath of an exposure to the event Immediate, close temporal relationship to stressor Generally within hours to 4 weeks

Duration:

8-12 sessions for short term Months to years of weekly sessions for as long as needed for long term	3 to 5 contacts some of which are only minutes in length maximum contacts usually 8

Goals:

Symptom reduction, reduction of impairment, correction of pathological states, personal growth, personal reconstruction

Stabilization, reduce impairment, return to function or move to next of care

Research Items and Issues For Consideration:

NOTE: Below is a list of some of the most well known resources in the fields of research design and methodology. Some highlights are included to assist the reader in understanding some of the issues that must be understood if a person is going to fully comprehend the arguments *for or against* CISD and CISM. It is recommended that the reader review the highlights here for an overview of some of the issues. Further information on research design and methods is available in the references listed in this section.

Blum, T. and Roman, P. (1995). Cost effectiveness and preventive implications of employee assistance programs. Washington, DC: US Department of Health and Human Services.

Key points and findings:

- EAP are important components of a comprehensive work site program
- Their effectiveness has been consistently documented
- EAP organizations use an integrated multi-component intervention program
- Mostly based on non-randomized trials

Campbell, D.T. and Stanley, J.C. (1963*) Experimental and Quasi-experimental Designs for Research.* Chicago: Rand McNally.

Key points and findings:

- Provides detailed descriptions of research designs and methodologies.
- A landmark text in research

Cook, T.D., Campbell, D.T. (1979). *Quasi-Experimentation: Design and Analysis Issues for Field Settings.* Boston, MA: Houghton Mifflin Company.

Key points and findings:

- Common textbook in university based research methods courses

Consumer Reports (1995, November). Mental health: Does therapy work? 734-739.

Key points and findings:

- All psychotherapies work
- All psychotherapies fail
- It all depends on the training, skill and personality of the provider
- Success in any therapy also depends on non-specific factors.

Cronbach, L.J., Ambron, S. Dornbusch, S., Hess, R., Hornick, R., Phillips, D., Walker, D and Weiner, S. (1980). ***Toward Reform of Program Evaluation.*** **San Francisco: Jossey-Bass.**

Key points and findings:

- Non equivalent comparison groups serve as reasonable substitutes for randomized trials.

Deahl, M., Srinivasan, M., Jones, N., Neblett, C., & Jolly, A. (2001). Evaluating psychological debriefing: are we measuring the right outcomes? ***Journal of Traumatic Stress*****, 14, 527-528**

Key points and findings:

- Some researchers may be choosing the wrong dependent variables.
- They choose psychotherapy dependent variables instead of crisis intervention variables.
- Results are suspect when that occurs.

Goldfried, M. and Wolfe, B.. (1998). Toward a more clinically valid approach to therapy research. ***Journal of Consulting and Clinical Psychology*** **66, 143-150.**

Key points and findings:

- The clinical validity of research has been compromised by the medicalization of outcome research and the use of a fixed number of intervention sessions and the use of Randomized Controlled Trials without regard to appropriateness.

Institute Of Medicine (1990) ***Broadening the base of treatment for alcohol problems*****. Washington, DC: National Academy Press.**

Key points and findings:

- The Randomized Controlled Trial (RCT) does not guarantee that the outcome obtained will generalize to the real world

- Quasi Experimental designs offer a sound alternative for studying the effects of an intervention.

Mullen, B. (1989). *Advanced BASIC meta-Analysis.* Hilldale, NJ: Earlbaum.

Key points and findings:

- Details combinatorial statistical procedures
- Meta-analysis represents a procedure wherein the researcher aggregates the data generated from similar dependent variables (measures of stress symptoms) compiled from research studies which purport to use the ***same*** independent variable (e.g. group CISD)
- Mullen strongly emphasizes the extreme importance of making sure that the independent variable (what you are doing to the subjects in a study) is the **same** thing or the analysis will be invalid.
- The goal of reducing the chance of systematic error derived from set, setting, and selection biases is reduced in that the likelihood that several independent researchers using independent samples drawn from varying populations all perpetuated the same systematic experimental error is extremely unlikely.
- If you are not measuring the ***same*** procedure no legitimate conclusions can be drawn from the research.

North, C.S. and Pfefferbaum, B. (2002). Research on the mental Health Effects of Terrorism. *JAMA*, 288 (5), 633-636.

Key points or findings:

- "Most questionnaires do not distinguish new symptoms associated with the event from endemic symptoms such as sleeplessness that affect many people at one time or another." (p.634)
- "Acknowledgement of symptoms does not necessarily indicate psychopathology. Most individuals directly involved in catastrophic events do not develop diagnosable psychiatric illness, but the majority report experiences such as sleep disturbance, loss of concentration, or feeling emotionally upset afterward." (p.634)
- "The emotional distress that falls clearly below the diagnostic threshold for PTSD (subdiagnostic distress) that is prevalent among individuals exposed to catastrophic events deserves different mental health interventions from the customary psychiatric treatment for the minority who develop a diagnosable disorder." (p. 634)

Olsen, O., Middleton, P., Ezzo, J., Gotzsche, P.C., Hadhazy, V., Herxheimer, A., Klwijnen, J., and McIntosh, H. (2001). Quality Of Cochrane reviews: Assessment of sample form 1998. *British Medical Journal.* 323: 829-832

Key points and findings:

- Assessment of the quality of Cochrane reviews
- Ten methodologists independently examined the quality of a sample of Cochrane Reviews published in 1998. (Coincidently, the first Cochrane report on debriefings came out in 1998.) Random assignment of the reviews was made to the evaluators.
- Two reviewers on each report. If one picked up on a problem the report was more thoroughly evaluated.
- 53 studies were reviewed.
- Major overlapping problems were identified in 15 of the reviews (29%)
- The major problem for 9 of the studies (17%) was that the evidence did not fully support the conclusions drawn
- In 12 (23%) of the reviews the conduct of the review or the reporting of the findings was unsatisfactory.
- Stylistic problems were identified in 12 (23%) of the reviews
- The problematic conclusions all gave too favorable a picture of the experimental intervention
- Users of the Cochrane reviews "should interpret the reviews cautiously…." (p.830).
- "Errors occur, and potential biases may emerge…[and] some Cochrane reviews have need of correction and improvement." (p.830).

Petticrew, M. (2001). Systematic reviews from astronomy to zoology: Myths and misconceptions. *British Medical Journal,* 322, 98-101.

Key points and findings:

- "There is a misconception that systematic reviews can only include RCT"

Seligman, M. (1995). The effectiveness of psychotherapy. *American Psychologist*, 29, (12), 965-974.

Key points and findings:

- "I no longer believe that efficacy studies are the only, or even the best, way of finding out what treatments actually work in the field. I have come to believe that the 'effectiveness' study of how patients fare under the actual conditions…in the field, can yield… 'empirical validation'." (1995, p. 966)
- "Random assignment…may turn out to be worse than useless for the investigation of the actual treatment of mental illness in the field" (1995, p. 974).

Seligman, M. (1996). Science as an ally of practice. *American Psychologist*, 51, 1072-1079.

Key points and findings:

- Argues cogently for the power of nonrandomized experimental and even survey research designs.
- Seligman believes that efficacy studies are simply the wrong method for field research because they omit too many of the crucial elements that characterize what is actually done in the field; for example, the level of competence of the interventionist, the real-time self correcting nature of the intervention, the complexity of the intervention and the nature of the precipitating stressors.
- Keep in mind that randomized designs do not eliminate selection or assignment error. They simply serve to diminish the likelihood of systematic error.
- Alternatives to randomized studies include measurement of the potential sources of systematic error, the use of large sample sizes drawn from diverse constituencies and properly designed meta-analytic approaches.
- Large scale, self report survey research has a low likelihood of possessing systematic error.
- Self report survey data may contribute in a meaningful manner to the issue of effectiveness of an intervention.
- "…efficacy studies are not necessary, sufficient or privileged over effectiveness studies in deciding whether treatment works." (p.1077)

Speer, D. and Newman, F.. (1996). Mental Health Services outcome evaluation. *Clinical Psychology , Science and Practice,* 3, 105-129

Key points and findings:

- Non equivalent comparison group designs offer promise as reasonable proxies for randomized studies

Conclusion:

A thorough review of the literature confirms a number of points. First, there is a great deal of confusion in the world about just what a debriefing actually is. As G. Engel states, rational discourse is predicated upon consistent terminology. T.S. Elliot also said that "words decay with imprecision". So our first big problem is that everyone talks about "debriefing" and means something different. This is going to be a monumental problem to overcome and no viable solution has appeared to date.

Next, there is much support for the concept of a comprehensive, systematic and multi-tactic approach for early intervention. The history on this goes back to the early 1900's. The most recent report by NIMH (2002) clearly supports a comprehensive systematic and multi-component to early intervention. Few seem to doubt the importance of appropriate early intervention. There are numerous positive outcome studies to

support well orchestrated early intervention programs. Please review the articles in the section entitled "Articles and Books in Support of Early Intervention" in this summary.

CISM has been successfully utilized for twenty eight years by a wide range of organizations in 28 countries around the world. Each of these organizations had their mental health professionals review the program prior to its initiation and each organization made independent decisions to utilize the program. They have found CISM to be helpful to their personnel and they support the continuation of the program.

CISM has positive effects when it is applied by trained personnel as it was designed. It is a comprehensive, systematic and multi-tactic approach to managing traumatic stress within organizations. It is not psychotherapy nor is it a substitute for psychotherapy. It is crisis intervention. It has elements of the program that need to be in place prior to the occurrence of a traumatic event. CISM then has elements that need to be in place during a traumatic event. Finally, CISM has elements that are applied after a traumatic event. There are six **core competencies** that are necessary **for an effective CISM program.** They are:

a) **Assessment skills** which include an assessment of the situation as well as an assessment of the severity of the impact of impact of the event on the personnel. Assessment skills also include knowing whether or not the symptoms of distress are benign or malignant. That is, it is important that one know whether or not those symptoms are normal under the circumstances or if they are significant enough to refer someone for additional mental health care.
b) **Strategic planning skills.** What is most important in CISM is knowing who does or does not need intervention and to determine what tactics, if any, should be applied to which people, at what time and by whom.
c) **Skills to aid individuals** in need of assistance.
d) **Large group intervention skills**.
e) Small group intervention skills.
f) Follow-up and referral skills.

Numerous studies cited above indicate that CISD has been used successfully and employed with a variety of populations in several countries around the world. It has its greatest potential for positive outcomes, however, when it has been applied within the context of the comprehensive, systematic and multi-tactic program in which it was developed.

As in any human endeavor, CISD can fail if certain conditions are present. The **factors which are most likely to set the stage for a <u>failure</u>** in applying the tactic are:

a) Untrained and unskilled providers
b) Failure to adhere to standards of care (e.g. applying to individuals instead of groups for which it was developed)
c) Applications to inappropriate populations (e.g. individual primary victims)

d) Applications in inappropriate circumstances (in emergency rooms with people in pain and sometimes medicated)
e) Attempts to use the debriefing to do things it was never designed to do (e.g. treat depression or psychiatric disorders)
f) Stand alone applications outside of the CISM system
g) Unrealistic expectations about what CISD can actually achieve

Here is what makes CISD successful:

a) Well trained, experienced and skilled providers
b) Adherence to established standards of practice.
c) Applications to homogenous groups, who have had roughly the same exposure to a traumatic event and under circumstances in which the traumatic event is at least under control if not fully completed,
d) Applications in appropriate circumstances
e) Realistic goals to achieve with the CISD
f) Application of the CISD within the context of the comprehensive and multi-tactic package called CISM.

It is important that we shift the focus away from a tactic to a strategy. CISM is the strategy, CISD is merely a tactic. It is a tactic which has to be applied to appropriate groups and only when it is necessary and under the right circumstances. It should only be applied by properly trained personnel. The negative outcome CISD research to date is seriously flawed and unrealistic. It represents misunderstandings of the nature of crisis intervention and confuses crisis intervention with therapy. The current negative research and the inflammatory negative media regarding early intervention in general is proof that the basic goals of crisis intervention, CISM and CISD have not been understood. Elizabeth Capewell (2002) from the Centre for Crisis Management and Education in the United Kingdom says it quite well.

> "The effect of debriefing on people cannot be tested and measured as if it were a pill. However, a study of the research shows that it often is. The impact is only judged in terms of measurable symptoms and whether these are reduced as a result of one brief 'debriefing' session i.e., debriefing is being viewed as a treatment of an individual's symptoms – a purpose for which it was not designed. A further study of the research shows that the 'debriefing' being given deviates a long way from the original criteria for its use and its protocol. The research often tests 'debriefing' on direct victims of trauma.

> These victims may be physically injured and medicated. They may be debriefed within hours of arriving in hospital soon after their traumatic incident. Rather than a carefully assessed group session individuals are subjected to an intense 1:1 session of detailed recall of their incident, catharsis and education conducted by people with very little training in debriefing (in one case, medical students). Such research cannot be said to be testing Mitchell's CISD model but rather the debriefing method designed by the researcher for inappropriate people in situations unsuitable for CISD." [Elizabeth Capewell, (2002). Reclaiming Process in Crisis Intervention: A review of Critical Incident Stress Debriefing (CISD).]

It is recommended that interested parties actually read the original articles described in this summary before making decisions to implement or remove CISM services for their organizations. If a decision to implement is made, then only specially trained teams of mental health professionals, clergy members and peer support personnel should be chosen. They should receive training in the six core crisis intervention competencies described above. Decisions to apply any CISM services should be made carefully and all applications should be in concert with the current standards of practice within the CISM field. Such decisions should not be taken lightly. At stake is the most precious resource any organization could have – its people. Their welfare should never be taken lightly!