IN-DEPTH REVIEW

Post-trauma support in the workplace: the current status and practice of critical incident stress management (CISM) and psychological debriefing (PD) within organizations in the UK

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Abstract

Employers’ duties of care under both common and statute law include the need to take reasonable care of the health and safety of the workforce. This includes both the moral and legal duties to consider the psychological needs of personnel following exposure to traumatic events related to the workplace. While this has been recognized within many high-risk occupations such the police, fire and rescue services and the military, there is also evidence that post-trauma support in the workplace is increasingly commonly provided not only among health and social services agencies, but within many private sector organizations. Over the past decade, however, there has been considerable controversy over the provision of early psychological support to personnel in the form of critical incident stress management (CISM) processes. In particular, one aspect of CISM, the use of psychological debriefing (PD) has come under scrutiny and criticism as two studies indicated that PD was ineffective and had the potential to do harm. Inevitably, this has provoked much uncertainty and confusion among some organizations as what should be the most appropriate support. It has also led to misconceptions and misunderstandings as to the aims and purpose of PD, together with inaccuracies of terminology, for example describing PD as ‘counselling’. Despite the controversy, both CISM and PD continue to be provided on a widespread basis, often utilizing a framework of voluntary peer group support. This paper intends to (i) present a review of the current status of CISM practices, including the use of PD within various organizations in the UK and (ii) provide a clear framework and understanding of the main issues and to clarify conceptual misunderstandings. The history, principles and background of the use of post-trauma support in the workplace, charting trends over the past two decades, previous research, problems with the evidence base and current thinking and practice in the field are reviewed. The relevance and implications of the National Institute for Clinical Excellence Guidelines on the Assessment and Management of Post Traumatic Stress Disorder, which make recommendations for early interventions for post-traumatic stress disorder are discussed. Reference is made to the use of CISM and PD within both statutory and voluntary organizations in an international context.

Key words

Peer group; post-traumatic stress; psychological debriefing; workplace support.

Introduction

Critical incident stress management (CISM) was originally conceived and devised in the early 1980s for the emergency medical services personnel in the US [1]. It has further developed and refined [2,3] over the past two decades and has since been clearly articulated in a comprehensive review [4]. CISM refers to a comprehensive, systematic and integrated multi-component crisis intervention package that enables individuals and groups to receive assessment of need, practical support and follow-up following exposure to traumatic events in the workplace. In addition, it facilitates the early detection and treatment of post-trauma reactions and other psychological sequelae. The basic conceptual framework was drawn from crisis intervention theories, a significant influencing factor was work developed by Lindemann following support offered to victims of the Coconut Grove nightclub fire in Boston, Massachusetts in 1944 [5]. This work was further developed and broadened by Caplan [6], from
loss and grief to that of more broadly defined potentially stressful or traumatic events. CISM in its current form was designed to be used with groups of emergency personnel exposed to potentially traumatic experiences through the course of their work. CISM programmes comprise many elements, including pre-crisis education, assessment, defusing, critical incident stress debriefing (CISD) and specialist follow-up for ongoing psychological support if necessary [1–4].

The controversy arose because attention was focused upon one component of CISM, that of CISD. This one aspect of the CISM process became the focus of attention for research because it was erroneously perceived that this particular aspect of the model would (i) prevent the development of post-traumatic stress disorder (PTSD) per se and (ii) was a stand alone process. For the purposes of this paper and for the sake of clarity, the term psychological debriefing (PD) will be used rather than CISD, as it has been widely described as such in the literature and was also used as the working title of the British Psychological Society’s Professional Practice Board Working Party [7]. The term PD was adopted by Dyregrov [8], a Norwegian psychologist who had also been using an almost identical structure since 1989 and always maintained that it is in essence the same as CISD. Since then the terms (especially in Europe) have become interchangeable and mean the same thing. The main difference (apart from the names of some of the phases) is that Dyregrov [8] places more emphasis on process than does Mitchell [1]. The latter has also been developed within a European context and therefore reflects a different tradition for groups and structure than in the US. The other difference is the use of the word ‘psychological’, which may in some organizational and cultural contexts have negative connotations.

PD represents a structured form of group crisis intervention and a discussion and review of the traumatic event or critical incident. The most common current model of PD is facilitated through a series of seven phases (see Figure 1). Dyregrov defined PD as:

“...A group meeting arranged for the purpose of integrating profound personal experiences both on the cognitive, emotional and group level, and thus preventing the development of adverse reactions”. Dyregrov [1989, p. 25].

PD typically takes 1.5–3.0 h to facilitate and is usually held 72 h–14 days post-incident. The aim of PD is also to provide education about normal and pathological reactions to traumatic events, indicate resources for further help and support if necessary and to begin to facilitate the process of coming to terms with the traumatic incident. Most importantly, it was designed to facilitate early help seeking. It also aims to facilitate normal recovery, resilience and personal growth. PD was never intended as a ‘stand alone’ intervention or as a substitute for psychotherapy.

It is important to note that PD is not counselling or psychotherapy and was never intended as a ‘psychological treatment’. PD as reviewed by the Cochrane Reviews [9] has been consistently and misleadingly viewed as a form of counselling or psychotherapy. PD is based on crisis intervention theory and is psycho-educational in purpose, rather than concerned with the re-configuration of personality or altering personal defences as is the case with counselling and psychotherapy.

This is an extremely important distinction, because not only has it influenced and driven the research methodology thus far, with the inevitable problematic outcomes, but also leads consistently to the process being described in the academic press and media as a psychological treatment or ‘counselling’. Inevitably, and equally importantly, this also influences the thinking behind the development of policy in terms of support mechanisms within the context of health and safety and occupational health and welfare provision. Therefore, the whole principle and ethos behind CISM has become negatively influenced and driven by the focus on one aspect of a programme, for reasons which have never been clearly understood.

The research

In 1994, an editorial was published in the British Journal of Psychiatry which reviewed some existing studies on PD [10]. The conclusion was that more research was needed}

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Figure 1. The seven stage model of Psychological Debriefing.
as there were a number of significant methodological shortcomings in the studies undertaken. These were highlighted as follows: the studies were not prospective; sample sizes were small; there was an absence of control groups; victims were exposed to varying degrees of trauma; other confounding variables were ignored; low response rates; a sampling bias was present; there was a lack of uniformity of PD; there were timing variances and finally, questionnaire versus interview results [10]. Of particular note here is the issue of lack of uniformity. This is of particular significance as it is a key element of the research and has been cited by the National Institute for Health and Excellence (NICE) clinical guidelines [11] and will be addressed in more detail below. Two randomised controlled trials (RCTs) were subsequently published. Both studies were carried out with primary victims of trauma, i.e. burn trauma victims [12] and injured road traffic accident survivors [13]. Both studies demonstrated negative effects among the intervention groups. The Cochrane report on PD [9] has been interpreted as providing evidence that PD could have negative effects on people and this resulted in many organizations and professionals abolishing PD as an organizational response. However, there are a number of reasons why this conclusion should be approached cautiously.

First, the studies reviewed by Cochrane [9] consisted only of RCTs of single sessions with individuals who were primary victims of trauma, as described above. Second, there were a number of methodological shortcomings in the two most cited studies [11,12]. In the study on burn trauma [11], the authors acknowledged that the vagaries of randomization meant that all the subjects with the highest levels of subjective life threat, previous psychological morbidity and previous psychological treatment, all factors predictive of poor psychological outcome, were in the intervention group. In addition, the authors described PD as involving ‘intense imaginal exposure to a traumatic incident’ [11, p. 80]. Imaginal exposure is a psychological treatment technique, which is often used with trauma survivors as part of a comprehensive psychological treatment package. It is a technique that involves the patient reliving the traumatic experience as if it were occurring again, describing their experience in the first person and in the present tense. It is a demanding and anxiety provoking procedure, which is only conducted after careful assessment and consent of the patient within the confines of an established therapeutic relationship. PD, as described above, does not entail imaginal exposure.

The study involving road accident victims [13] was also not without limitations. The authors in a later volume describing the study in detail acknowledged that.

‘After the first ten subjects, the interventions were undertaken instead by the research assistant. The intervention therefore immediately followed the screening interview, with which it became merged to some degree, and interviewer “blindness” was inevitably compromised’ [14, p. 167]. Furthermore, the two studies just mentioned failed to achieve equivalent group membership at pre-test (debriefed groups had more severe injuries in both studies). These differences may well have influenced post-intervention outcomes. Moreover, the deterioration in the psychopathology of the debriefed group in the road accident study, although statistically significant, was so slight as to be clinically irrelevant [13]. Therefore, the two most quoted studies that cast doubts on the efficacy of debriefing are methodologically flawed and thus cannot be seen as representative of research in this field.

Thirdly, the Cochrane Review [9], which was also used as the criteria for inclusion in the NICE guidelines [11], acknowledged that there was a lack of or inappropriate training for those facilitating PD as it is defined above. There are no detailed descriptions of training described in any of the RCTs reviewed through the Cochrane process.

Fourthly, all the studies chosen for review by Cochrane and the NICE guidelines that conclude that PD is of no value in preventing PTSD have little to do with PD as conducted within a range of high-risk occupational settings, e.g. as used by the emergency services, but instead use subjects who were medically ill or suffering from obstetric complications. Symptomatology of PTSD was generally employed as the main outcome measure, and none of the studies assessed the impact of the intervention on other symptoms of trauma, e.g. substance misuse or effects on occupational or social functioning. Those studies that have measured a broad range of outcomes and which were conducted with groups have demonstrated a positive debriefing effect [15–18].

For these reasons, the conclusion to the Cochrane report must be approached cautiously as many of the studies included in the review were not concerned with CISM or PD procedures as they are technically defined by workers in that field.

It is also often suggested that PD is of little benefit for those suffering from PTSD, which is of course true, as it was never intended for PTSD sufferers, given that it is intended as a crisis intervention strategy used within the first 2 weeks following exposure to an incident. PTSD can only be diagnosed 1 month after exposure to the traumatic event.

**Current models and use of PD within organizations in the UK**

The current evidence suggests that many organizations in the UK and abroad continue to utilize CISM and PD as part of that process. London’s Metropolitan Police and many other police forces in the UK utilized a PD in a model adapted from Mitchell and known as the three stage model, comprising of facts (equates to the
introduction and facts phase of PD); feelings (equates to thoughts and reactions phase of PD) and future (equates to normalization, future planning/cop ing and disengagement phases of PD) [19]. While this model has been in use for a number of years, the current trend is to re-train many peer support teams in PD using Dyregrov’s approach [8,20,21]. In view of the past controversy and the NICE guidelines, there has been a shift for some organizations to develop a new CISM model. An example is critical incident processing [22], which contains all the elements recommended by Everly and Mitchell [4] and thus CISM by another name. The same can be said of trauma risk management (TRiM), a model favoured by the British Royal Marines [23,24]. TRiM has been described as a post-traumatic management strategy based upon peer group assessment for hierarchical organizations [24]. It was developed for the military and also contains all the CISM elements as described by Everly and Mitchell [4]. In addition, it also makes use of the Three Stage Model of PD. On close inspection, models which purport to be offering different solutions to post- trauma support are all seen to be practising CISM and PD under new acronyms. While TRiM can be seen to be very effective in a military context, it remains to be seen whether it is transferable to other contexts and settings, even though some UK police forces have adopted the model. The authors argue that the focus on risk assessment avoids excessive exploration of emotions or enforced catharsis, which they claim is the case with PD. They also suggest that this is in keeping with the conclusions of the Cochrane review that suggests that the exploration of emotions may in part be responsible for the worsening of symptoms [24]. Enforced catharsis was never the aim of PD, as those who have been trained and are experienced in the model as devised by Mitchell and Dyregrov would know that this was not the intended aim of the structure and process. The evidence suggests that worsening of symptoms and reactions may be due to the inappropriateness of the application of the model and the lack of training in PD which may account for the negative outcomes. That is, it is akin to assessing a surgical technique as having a poor outcome, but only researching its effectiveness after it has been used in inappropriate circumstances, with the wrong instruments, untrained practitioners and with the wrong patients.

Another criticism aimed at PD is that it is compulsory in many organizations [25]. This is inaccurate, particularly in public sector organizations in the UK. The vast majority of organizations (if not all) within the public sector that offer PD within the context of a CISM programme, do so on a voluntary basis. This includes fire and rescue services, health and social care providers and the police. CISM services are offered in-house by Occupational Health and Welfare Departments and provided by teams of trained peer supporters. In many instances this is a combination of welfare and operational personnel. The same may not apply to the private sector, which utilizes the services of Employee Assistance Providers (EAPs) for counselling and post-trauma support needs. EAPs also offer PD and other related services, but these services can be more difficult to quality control in real terms within an organizational context and setting where CISM programmes work most effectively.

In 2002, the British Psychological Society’s (BPS) Professional Practice Board Working Party [7] produced their report on PD. An important part of the brief was to look at the existing research. The most widely publicized studies were found to be seriously flawed and lead to the Working Party’s call for the development of new research methods suited to the complex situations where PD was employed. Another conclusion was that if PD was to be successful, it had to be undertaken by competent practitioners within an appropriate context and setting, with adequate supervision and support. The BPS also viewed the provision of PD as a community support and cohesion strategy rather than a treatment intervention to prevent PTSD [7].

PD and the NICE Guidelines for PTSD

In March 2005, NICE produced Guidelines on the Management of Post Traumatic Stress Disorder in Primary and Secondary care [11]. The guidelines include a chapter on early interventions for PTSD and include recommendations about the use of PD. Much of the evidence cited in the guidelines is drawn from the Cochrane review and therefore cites the same studies as described above. Within the clinical summary, entitled ‘Treatment for all’, it states that ‘no trial of Critical Incident Stress Debriefing as originally conceived by Mitchell and colleagues (i.e. as a group intervention for teams of emergency workers, military personnel or others who are used to working together) or Critical Incident Stress Management (i.e. a multi-component programme of debriefing, follow-up and case management) met our methodological inclusion criteria. As a consequence we have a lack of evidence of practice in these situations’ [7, p. 84, para 7.5]. Nevertheless, there is a wealth of literature supporting the use of PD in these settings [15–18]. However, as none of these are randomized control trials they did not merit inclusion in any of the literature reviews. The Cochrane Review explicitly excluded 19 studies because of ‘methodological shortcomings’, principally concerning problems of randomization. These included many RCTs of group debriefing in naturalistic settings, for which PD was intended. RCTs appear to have become the dominant paradigm of treatment outcome studies to the virtual exclusion of naturalistic, observational studies or case series (evidence levels ii–v).

The Guidelines state that they do not recommend systematic brief single-session interventions focused on...
a traumatic incident. This is again based on the RCTs on PD with negative outcomes which have all focused on individuals who have been primary victims, but the Guidelines offer little practical guidance to many occupational health and welfare departments who may have to see individuals affected by potentially traumatic events within the workplace. The reality is that if individuals are seen after the incident, it is not compulsory, but a mutually consensual arrangement. It is never brief or for a single session, as follow-up is always offered.

Finally, the clinical practice recommendations with the Guidelines indicate that

... we do recommend the good practice of providing general practical and social support and guidance to anyone following a traumatic incident. Acknowledgement of the psychological impact of traumatic incidents should be part of healthcare and social service workers’ responses to incidents. Support and guidance are likely to cover reassurance about immediate distress, information about the likely course of symptoms, and practical and emotional support in the first month after the incident [11, p. 84].

Most significantly, there is nothing in the Guidelines to suggest what should be done in order to fulfil that recommendation or address these issues. Therefore, what is clear is that many organizations are continuing to offer both individual and group support for personnel involved in potentially traumatic events in the workplace through a CISM programme as it is clear this meets the requirements suggested as exemplified by the recommendation described above. These organizations continue to provide PD as part of that programme. Those organizations who have scrutinized the recommendations of the NICE Guidelines thoroughly and are aware of the history, developments and controversy surrounding PD, realize and understand that they are operating within the scope of guidelines and are thus mindful of fulfilling their duty of care to personnel who work in challenging and difficult environments.

Discussion

This paper has attempted to review the current status of CISM programmes and one component of CISM, that of PD. In a review of the existing evidence, it has been demonstrated that the studies have considerable methodological shortcomings, particularly utilizing PD, and crisis intervention techniques designed for groups of emergency service personnel with primary victims of burn trauma and accidental injury. Other methodological shortcomings include a lack of appropriate training for those facilitating the PD, a factor recognized and acknowledged by the NICE Guidelines for PTSD [11], and viewing PD as a form of treatment or counselling.

The research has also relied upon RCTs. In attempting to satisfy the rigorous methodological criteria demanded of level I evidence, many RCTs become detached from clinical reality, losing validity and rendering the findings clinically meaningless. Level I RCTs are not the sine qua non of evidence-based medicine. PD challenges the hegemony of RCTs, lending credibility to observational studies and more qualitative-orientated research. Deahl et al. [26] have suggested that future trials of debriefing should employ a wider range of outcome measures than hitherto and assess social and occupational function, personality, substance misuse and other psychopathology as well as the symptoms of PTSD. In addition, whether or not PD reduces longer term morbidity, several studies report that individuals find it helpful at the time, but this is another outcome that has not been properly investigated.

Many major international humanitarian aid agencies, such as the International Federation of Red Cross and Red Crescent Societies and the United Nations High Commissioner for Refugees, utilize PD as part of their CISM programmes [27], along with many other law enforcement agencies and emergency service providers in Europe, Scandinavia, the US and Australia. The fact that other organizations such as the Royal Marines have adopted and adapted the model to suit their needs is evidence that it has utility in the context of post-trauma support in the workplace. Calls for the cessation of PD in the emergency services and similar contexts and settings have been demonstrated to be premature. It has an important psycho-educational role and facilitates identification of individuals experiencing acute stress reactions (who are at greater risk of developing longer term disorders) [28]. PD was never meant to be a stand alone intervention but was always intended to be part of a comprehensive stress management package that enables individuals and groups to receive assessment of individual and group needs, practical support, follow-up which would facilitate the early detection and prompt treatment of psychological conditions such as PTSD. Abandoning CISM and components such as PD sends out a dangerous message that doing nothing for individuals and groups following traumatic events is acceptable, leaving employers neglecting an important duty of care [29].

Conflicts of interest

None declared.

References