CISM: A Rational Perspective

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It has always surprised me that we emergency services folk are quick to embrace a concept or practice simply because someone with authority tells us it is proper. Such was the case with Critical Incident Stress Management (CISM), introduced to the EMS community in a 1983 issue of the Journal of Emergency Medical Services.

Following that, it was widely adopted and practiced throughout the emergency services community. But the problem with CISM was that it was just an idea—a concept—that was never adequately tested before it was adopted lock, stock, and barrel by the emergency services community. And, despite mounting scientific evidence that CISM is ineffective and potentially harmful, it is still widely practiced.

My daughter is a college freshman. She recently pointed out a paragraph about this that was in her freshman psychology textbook:

“For example, in the aftermath of natural and human-made disasters, from earthquakes to terrorist attacks, disaster therapists often arrive on the scene to treat survivors for symptoms of trauma. Survivors are pressured, or even required, to attend one or more trauma-therapy sessions. The therapists’ intentions are obviously well-meaning. But consider what the research shows about a popular intervention program called Critical Incident Stress Debriefing (CISD). Its practitioners ‘debrief’ people after a trauma, telling them what symptoms to expect and often encouraging them to vent their emotions.

Yet independent assessments of CISD find that most people benefit just as much by simply talking with friends and other survivors. Sometimes the CISD intervention slows recovery by preventing victims from drawing on their own well-springs of resilience. And sometimes the intervention actually harms people because of the scientifically unsupported techniques the therapists use, such as having survivors keep ventilating their emotions without also learning good methods of coping.”

Following the attack on the World Trade Center and the Pentagon in 2001, an article appeared in the Wall Street Journal’s magazine Smart Money. That article “Good Grief!” clearly detailed the problems with grief counseling and specifically addressed the problems with the CISM. It is clear that mainstream psychology and even the general public are aware of the problems associated with the CISM. Why has EMS not dropped this practice?

The CISM Debate

Proponents of CISM often cite “numerous studies” that reportedly support the effectiveness of CISM. But you should closely look at these articles before simply accepting them as valid. Most are from trade magazines, obscure mental health journals, nonpublished graduate school dissertations or from papers written by those who have a financial interest in CISM. In fact, many of these “numerous studies” are published in the International Journal of Emergency Mental Health, which is owned and edited by the founders of CISM and affiliated with the International Critical Incident Stress Foundation.

Because CISM was launched without any significant scientific evidence to support its practice, mainstream psychological and psychiatric researchers have subsequently studied the practice. Their findings might surprise you. Not only did they find that CISM was ineffective in mitigating the stress associated with emergency services, it actually made some people feel worse. These findings have been robust in numerous subsequent studies. When you look at the studies that are critical of CISM, you will find that they are published in the most prestigious scientific journals in the world.

Two of the better studies were meta-analyses of other published studies of CISM and psychological debriefing. Meta-analyses of randomized, controlled trials, when properly conducted, represent the highest level of scientific validity. That is, the more valid the study, the closer it is to the truth. A well-conducted meta-analysis allows for a more objective appraisal of the evidence, thus leading to resolution of uncertainty and disagreement. In addition, it may reduce the probability of false negative results and thus prevent undue delays in the introduction of effective treatments into clinical practice.

The first meta-analysis evaluated seven studies that specifically evaluated single-session debriefings performed within one month after a traumatic event. Five of the studies specifically evaluated CISM, and three evaluated non-CISM interventions (historical group debriefing, a 30-minute counseling session, and education). Six of the studies reviewed utilized nonintervention controls. The researchers reported that non-CISM interventions and no intervention were found to have improved symptoms of posttraumatic stress disorder (PTSD), but CISM did not improve symptoms and may have retarded natural resolution for some. Stated another way, persons who received no intervention and those who received non-CISM interventions, actually fared better than those who received CISM interventions.

They found that CISD did not improve natural recovery with respect to other trauma-related disorders. The second meta-analysis evaluated 11 studies where single-session psychological debriefings were provided within one month after a traumatic event. They found CISM did not reduce psychological distress nor prevent the onset of PTSD. They concluded that there was no current evidence that CISM is a useful treatment for the prevention of PTSD. Proponents of CISM attempted two meta-analyses of studies they felt supported CISM, but these were extremely flawed and highly criti-
cized by mainstream psychologists.

In fact, researchers from the Department of Psychiatry at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, criticized these two meta-analyses stating, "Reports cited in a meta-analysis by Everly, Boyle, and Lating; and Everly and Boyle, are not representative outcome studies."19

Several other studies have questioned the validity of CISM. The Federal Emergency Management Agency commissioned a three-year study on the effectiveness of CISD as an early intervention for traumatic stress in firefighters.10,11 Thorough assessments were made of 660 firefighters exposed to a critical event—including some firefighters involved in the Oklahoma City bombing response. Of these, 264 had attended one or more CISM sessions. Standard objective psychological measures found a weak inverse relationship with negative affectivity and a weak positive correlation with positive world assumptions. That is, participants actually felt worse after the sessions, but overall had a better image of the world and their place in it. No relationship was found between debriefing and PTSD.

In the Netherlands, researchers studied 243 traumatized police officers who were assigned to a debriefing group or to one of two control groups. Pretests and post-tests were administered. No differences in psychological morbidity were found between the groups at pretest, at 24 hours, or at six months post-trauma. At one week post-trauma, they found that debriefed subjects exhibited significantly more PTSD symptoms than nondebriefed subjects.12

These findings were consistent with an earlier study of debriefing for police officers, conducted by these same researchers,13 where comparison of 46 debriefed and 59 nondebriefed officers found no differences at eight months post-exposure, but significantly more disaster-related hyperarousal symptoms at 18 months post-event in the group that received debriefing.

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lance in British Columbia in which five people died, Canadian researchers evaluated the effectiveness of CISM provided for paramedics, physicians, and nurses.14 They found that CISM did not appear to affect the severity of stress symptoms. They also found that those who had preexisting stress management routines appeared to have less severe symptoms at six months post incident.

Several studies have demonstrated an actual worsening of stress symptoms in people who received debriefing. In one study, the levels of anxiety and somatization at four months post accident had declined more in the nondebriefed group, while levels of hostility and psychiatric symptoms had actually risen in the debriefed group.15 In the same study group, three years post accident, patients in the debriefed group had marginally more severe psychiatric symptoms, more severe pain, had recovered less well, reported more impaired functioning, and had greater financial problems as a result of the accident.16 At 13 months following their injuries, burn patients who had received debriefing actually

had worse anxiety, depression, and PTSD symptoms compared to the nondebriefed control group.17

An early Norwegian study evaluated 115 firefighters involved in a major hotel fire that 47 percent described as the "worst experience they ever had." Of these firefighters, 39 underwent formal debriefing. The results showed no significant difference between the group that was debriefed and the group that simply talked to their colleagues. They found that, in spite of an extreme stress situation, the frequency of disturbing stress reactions following the event were low.

Because the research is starting to clearly show that CISM and similar interventions are harmful, numerous organizations are dropping or forbidding the practice. The National Institute of Mental Health, in conjunction with the U.S. Department of Health and Human Services, the U.S. Department of Defense, U.S. Department of Veterans Affairs, the U.S. Department of Justice, and the American Red Cross, held a workshop to reach consensus on best practices in evidenced-based early psychological intervention for victims or survivors of mass violence.

In its report, following an exhaustive review of the world literature on the subject, that panel specifically did not recommend CISM or psychological debriefing as an early intervention practice.19

In a recent document on mental health in emergencies, the World Health Organization stated, "Because of the possible negative effects, it is not advised to organize forms of single-session psychological debriefing that pushes persons to share their personal experiences beyond what they would normally share."20

Following a systematic evidence-based review, backed by an expert consensus panel, the British Health Service listed routine debriefing as a contraindicated procedure. They concluded, "Review of the best-designed studies suggests that routine 'debriefing' (a single session intervention soon after the traumatic event) is not help-
ful in preventing posttraumatic disorders."21

The North Atlantic Treaty Organization Russia Advanced Research Workshop on Social and Psychological Consequences of Chemical, Biological, and Radiological Terrorism, which convened to discuss the social and psychological implications of terrorism, similarly concluded, "There is still no consensus on the role, if any, of very acute interventions. CISD debriefing can no longer be recommended." 22

The New South Wales (Australia) Health Department did not recommend CISD in its guidelines for the 2000 Olympic Games in Sydney, Australia. They concluded that, "There is no evidence that it [CISD] prevents PTSD or other psychological morbidity and it may make some people worse."23

The Australasian Critical Incident Stress Association, in their "Guidelines for Good Practice for Emergency Responder Groups," stated, "...experience and systematic investigations have revealed a marked discrepancy between outcomes once presumed to be achievable (Mitchell, 1983; Mitchell and Everly, 1995) and those that can be reliably delivered (Rose and Bisson, 1998)." 24

What Should We Be Doing?

So, if CISD is bad, what should we be doing? There are actually three types of clearly defined EMS stresses:

- **Daily Stresses**
  In the overall scheme of things, most EMS stress is not related to critical incidents and disasters, but related to such things as pay, working conditions, dealing with the public, administrative matters, and the other hassles of day-to-day living. All emergency services personnel should develop personal stress management strategies to help deal with these. This includes developing a personal support system, which may include coworkers, family, clergy, and others with whom you can talk and express your feelings for signs and symptoms of abnormal response to the stress and, if detected, refer them accordingly to competent mental health personnel who use accepted mental health techniques in treatment.

- **Large Incidents and Disasters**
  Most emergency services personnel will never encounter a disaster situation. However, all must be ready in case such a catastrophe occurs. The stress of large-scale disasters can be mitigated by a well-coordinated and organized response. Use of the Incident Command System serves to appropriately direct responding personnel. It also rotates personnel through rehabilitation and surveillance stations to monitor their physical and mental health. Those who are showing signs of stress or fatigue should be removed from duty—at least temporarily. Here, too, there is a role for competent mental health personnel. They should be readily available to provide what experts call "psychological first aid." This entails:
  - Listening;
  - Conveying compassion;
  - Assessing needs;
  - Ensuring that basic physical needs are met;
  - Not forcing personnel to talk;
  - Providing or mobilizing company from family or significant others;
  - Encouraging, but not forcing, social support; and
  - Protecting from additional harm.

In addition, information and education may be provided to help understand trauma, what to expect, and where to get help if needed. "Psychological first aid" is not a packaged or proprietary intervention technique, but instead is an attempt to provide practical palliative care and contact while respecting the wishes of those who may not be ready to discuss what happened or to deal with a possible onslaught of emotional responses in the early days following exposure. The recommendations add the caveat that competent mental health personnel be available within two months following a critical incident to screen and assist anyone who may be developing stress-related symptoms or PTSD.

Conclusions

There are a limited number of quality scientific studies related to CISM and CISD. However, the better studies raise serious doubts about the effectiveness of CISM, and some studies
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seem to indicate that CISM and CISD may actually be harmful. This should be ample reason to reconsider the practice. Additional randomized controlled trials are needed to more fully determine the effectiveness of these practices. The absence of demonstrated effectiveness and the demonstrated potential for iatrogenic injury requires that CISM and CISD be utilized with extreme caution, if at all, in emergency services.

References