Psychological Debriefing and the Workplace: Defining a Concept, Controversies and Guidelines for Intervention

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Critical incident stress debriefing (CISD), a specific form of psychological debriefing, has gathered widespread acceptance and implementation in the few short years since it was first proposed (Mitchell, 1983). However, there has been recent doubt cast on this practice and confusion regarding the terminology used. This article explores the claims frequently made by proponents regarding its use, counterclaims of ineffectiveness by its detractors, and general consensus regarding its specific use and the use of more generic psychological debriefing. We conclude that the recently introduced critical incident stress management (CISM) and its proposed progenitor, CISD, are currently poorly defined and relatively distinct in the treatment-outcome literature and should be treated similarly. Current expert consensus and meta-analytic reviews suggest that CISD is possibly noxious, generic psychological debriefing is probably inert, and that more emphasis should be placed on screening for, and providing, early intervention to those who go on to develop pathological reactions. A set of generic guidelines for the minimisation and management of workplace traumatic stress responses is also proposed.

During times of organisational upheaval and personal and interpersonal crisis, organisations frequently access the services of psychologists to help mitigate the long-term consequences of these occurrences. Indeed, the provision of "debriefing" services to organisations is now a multimillion dollar industry. For example, after the tragedy of the World Trade Center terrorist attacks in New York (2001) newspaper articles reported that thousands of "debriefers" attended the area, advocating and offering debriefing services (Kadet, 2002). This also involved many of the organisations associated with the World Trade Center being contacted and offered such debriefing services. The primary aims of this article are to evaluate the need for "psychological debriefing"; to define the terms currently being used and to determine whether such an intervention is useful or can, in fact, be counterproductive.

Our secondary goal is to extrapolate from what we do know from the literature and provide some general guidelines for organisations and psychologists, based on our current state of knowledge.

Psychological debriefing has been recently placed under the scientific microscope (van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002), and it has been argued that good intentions and the passion to help following a trauma may carry with it paradoxical effects, particularly if the tools being used to aid are cursorily understood, dogmatically applied and the peer-reviewed research literature left untouched (Gist & Devilly, 2002). Yet debriefing is widely and routinely practised and appears to be increasingly turned to as a first resort when disasters strike. Following harrowing experiences psychological debriefing providers frequently advise organisations to utilise their services, asserting a number of claims about the effectiveness of debriefing. The rationale typically includes the following:

- Debriefing will be seen as a gesture of support by the employer, concerned with the psychological welfare of their employees.
- Psychological debriefing will help mitigate long-term poor functioning, which otherwise is "likely" to occur and is a "foreseeable" consequence of the event.
- This will, therefore, also protect the organisation from litigation for not fulfilling their workplace, health and safety obligations.
- And, lastly, with employees less likely to suffer long-term psychological consequences following the debriefing, the workforce will be healthier — and a healthy workforce is a more productive workforce.

With these claims in mind, it is fitting that we present working definition of our terms. Frequently, and particularly in applied contexts, terms are being used without operational definitions and are often used interchangeably. This makes inspecting the evidence behind the claims a murky and very difficult task.

Definitions
"Psychological debriefing" is a generic term that has been suitably equated with "emotional first-aid" following trauma. To our knowledge the term was first referenced in the Australian literature by Raphael (1984) who noted that some psychological debriefing programs "usually involved the rapid mobilisation of skilled staff to interview and work with the victims to assist them with the psychological response to the disaster and its aftermath, frequently in direct

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outreach to the disaster sites and the victims' homes." (p. 303). More recently, in a meta-analytic review of psychological debriefing (PD), Rose, Westley, and Bisson (2001) defined PD as "any brief psychological intervention that involves some reworking/reliving/recollection of the trauma and subsequent emotional reactions". However, for the sake of being comprehensive, yet not at the price of specificity, Devilly, Gist, and Cotton (2002) describe PD as:

... the generic term for immediate interventions following trauma (usually within 3 days) that seek to relieve stress with the hope of mitigating or preventing long term pathology ... and that ... PD relies predominantly on ventilation/catharsis, normalisation of distress, and psycho-education regarding presumed symptoms (p. 4).

This is to be contrasted with the proprietary based term critical incident stress debriefing (and, more recently, critical incident stress management). This is a specific variety of PD, frequently utilised with groups, and developed by Mitchell (1983) as a structured approach with seven aspects. These steps include:

1. the introductory phase (where the rules, process and goals are outlined)
2. the fact phase (serial clarification of what the participants saw, did, heard etc.)
3. the thoughts phase (what the participants' first thoughts were/are following the event)
4. the reaction phase (exploration of individuals emotional reactions)
5. the symptoms phase (global assessment of physical or psychological symptoms).
6. the teaching/information phase (educating the participants about possible, common, or even "likely" stress responses)
7. the re-entry phase (referral information provided for future follow-up).

Moreover, and with evidence against the use of CISM becoming more and more convincing, Everly and Mitchell (1999) proposed that CISM had been superseded by Critical Incident Stress Management (CISM) and these authors have since offered two reviews of CISM (Everly, Flannery, & Mitchell, 2000; Everly, Flannery, & Eyler, 2002). But what is CISM and does it significantly and operationally differ from CISM?

A review of the CISM literature offered by Everly et al. (2000) described it as "a new generation of intervention technologies" (p. 23) and, in keeping with a 7-step formula, offered the following definition:

CISM represents seven core integrated elements: (a) pre-crisis preparation (both individual and organisational); (b) large scale desensitisation procedures for use after mass disasters; (c) individual acute crisis counselling; (d) brief small group discussions, called defusings, designed to assist in acute symptom reduction; (e) longer small group discussions, called Critical Incident Stress Debriefing (CISM), designed to assist in achieving a sense of psychological closure post-crisis and to facilitate the referral process; (f) family crisis intervention techniques; and (g) follow-up procedures, and/or referral for psychological assessment or treatment (p. 24).

It would seem, therefore, that by 2000 CISM had been somewhat redefined and incorporated into a larger and more encompassing approach, although it should be stressed that there is no empirical support for any of the newly proposed steps. However, of interest in the review is that in support of CISM, studies which used only CISM were cited. It, therefore, begs the question of whether CISM and CISM are distinguishable.

In fact, in supporting the use of CISM, one of the studies Everly et al. (2000) cite is an Australian report (Leenan-Conley, 1990). This study details a management-wide intervention for dealing with trauma following violent bank hold-ups in the Commonwealth Banking Corporation. However, the term CISM is never referred to in this study, the procedure appears to differ significantly from that outlined by Everly et al. (2000), and outcome was assessed by comparing compensation costs and absenteeism in the year following the introduction of the intervention to the previous year's costs (i.e., not a randomised trial and open to untold influence from many other organisational and non-specific changes that may have occurred, e.g., improved security, improved health plans, fewer hold-ups, change in seasonal illnesses, changes in absenteeism practices).

By 2002 Everly et al. describe CISM as "an integrated multicomponent crisis intervention system" (p. 171, Everly et al., 2002). It is unclear exactly how to interpret this, but the authors claim that CISM "was designed to be only one component of a comprehensive multicomponent crisis intervention program referred to as Critical Incident Stress Management" (p. 174) and then cite Everly and Mitchell (1999) in support of this. It is difficult to see how this can be the case since the term CISM did not even enter the debriefing lexicon until the mid-1990s and CISM was advocated as a method for mitigating the effects of trauma back in the early 1980s (Mitchell, 1983).

The review by Everly et al. (2002) of CISM also needs further analysis. Firstly, the authors claimed that "CISM was never designed to be implemented as a single intervention outside of the multicomponent CISM program" (p. 174) and provide a 1999 reference to support this. As alluded to above, there appears to be an element of historical revisionism characterising this account, which is further weakened through citing such recent references. Notwithstanding, there are three further factors which are of even greater concern.

First, no operational definition of the facets integral to CISM, and necessary or sufficient to qualify as CISM, were incorporated into the review. Rather, studies were included which were "purporting to specifically assess interventions consistent with the CISM formulation" (p. 177). Second, of the eight studies that met this criteria, there were studies by the directors of the International Critical Incident Stress Foundation (ICISF) who are also the originators of CISM/M. This is important because meta-analyses typically draw on a range of studies delivering conclusions that are less likely to be disproportionately weighted by methodological weaknesses and/or researcher allegiance. Out of the two studies by other authors, one (Busuttil et al., 1995) had incorporated PD within a group therapy program aimed at treating posttraumatic stress disorder (PTSD) and no explicit mention of CISM is made, and the other (Richards, 1999) was a presentation at an ICISF conference and, therefore, not easily accessible for review.

Third, the authors of this review included into the same analysis studies using different domains of outcome measurement. Some of the studies were termed "Assault Staff Action Programs" and the outcome measure was the number of times staff (psychiatric hospital staff or community care staff) were assaulted following the intervention compared to before the intervention. Other studies utilised diagnostic interviews/psychometric assessment of distress levels of workers with PTSD and traumatic reactions. As mentioned, some of the studies were aimed at treating trauma reactions (and sometimes many months following the trauma; Busuttil et al., 1995; Mitchell, Schiller, Eyler, & Everly, 1999) and others were aimed at mitigating further distress or number of
assaults (Flannery, Hanson, Penk, Flannery, & Gallagher, 1995; Flannery et al., 1998; Flannery, Penk, & Corrigan, 1999; Flannery, Anderson, Marks, & Uzoma, 2000). Such a fundamental methodological flaw undermines the validity of any conclusions based on the meta-analysis of this group of studies.

For now, we can only conclude that CISD may or may not be one component of CISM, or CISD may be equivalent to CISM, and CISD may or may not have a definite procedure. Until the necessary and sufficient conditions for what counts as CISD and/or CISM are clarified CISM must be regarded as an unfalsifiable intervention system, and the two terms should for now be treated synonymously.

More broadly, it is important to differentiate debriefing from early intervention. Devilly (2002) suggested that early intervention “is the provision of what could be called ‘restorative treatment’ to individuals who request psychological help following crime/tragedy and have a clinically significant presentation” (p. 4). The notion here is that whilst the individuals report pathological functioning (2 days to 4 weeks following the event), the goal of early intervention is to prevent long-term, psychological and functional impairment. Interventions at this level are goal orientated, explicit and evidence-based. Such an example would be interventions for Acute Stress Disorder (ASD). Untreated, about 30% of individuals with ASD go on to develop PTSD by 6 months, and 75% maintain this presentation up to 2 years later (Bryant & Harvey, 2000). However, cognitive-behavioural treatments (CBT) based upon exposure principles have demonstrated efficacy to the point where only 8% at post-treatment (17% at 6 months) meet the criteria for PTSD, which is contrasted to supportive counselling strategies which show that 83% at post-treatment (67% at 6 months) meet criteria for PTSD (Foá, Hearst-Iseda, & Perry, 1995; Bryant, Harvey, Dang, Sackville, & Basten, 1998; Bryant, Sackville, Dang, Moulds, & Guthrie, 1999). Likewise, CBT treatment for PTSD has shown exceptional efficacy with between 80 to 90% of those treated no longer meeting criteria at post-treatment and maintaining this presentation to 3 months and even 12 months follow-up (e.g., Devilly & Spence, 1999; Foà et al., 1999; Foà, Rothbaum, Rigs, & Murdoch, 1991).

Current research in this paradigm is now focussing on improving the attrition rates during treatment and factors associated with treatment tolerance (see Devilly & Foà, 2001, and Tarrier, 2001, for a discussion of measurement issues relating to this and Foà, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002, for a discussion of predictors of attrition during exposure therapy).

It should be clear that the basis of the distinction between CISD and early intervention goals appears to be that while the former aims to mitigate short and long-term negative reactions through preventative intervention immediately following an event, the latter aims to actively treat pathology with the goal of restoring the individual to pre-trauma functioning.

Consensus: Mitigation of Long-term Poor Functioning?

At the beginning of this article we outlined some arguments frequently posited by those promoting the use of PD. Perhaps the most important of these from a psychologist’s perspective is the promise that psychological debriefing will help mitigate poor long-term functioning, which otherwise may occur, or even worse is “likely” to occur, and is a “foreseeable” consequence of the event.

Turning to the second half of this statement first, while it can be convincingly argued that there is the possibility of poor long-term functioning following a trauma, this is not equivalent to claiming that it is likely and foreseeable. In the Australian National Morbidity Study, Creamer, Burgess, and McParlane (2001) found an estimated 12-month, PTSD prevalence rate of 1.3% in the community, with 64.6% of males and 49.5% of females having ever experienced at least one traumatic event. However, of those who had experienced any trauma, 1.9% of men and 2.9% of women met criteria for PTSD over the previous 12 months. Notwithstanding specific categories of trauma, such as rape, which evidences a 12-month PTSD prevalence rate of 9.2% in women (Creamer et al., 2001), lifetime prevalence rates of PTSD for the whole community is estimated at 7.8% (10.4% for women, 5.0% for men; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Hence, in the light of this epidemiological evidence, it is spurious to assert that PTSD is likely and foreseeable following exposure to a specific stressful event.

Further, PTSD is not the only, or even the most likely pathological outcome from experiencing traumatic events. Studies have demonstrated that a history of trauma is in itself a risk factor for depression (Zlotnick, Warshaw, Shea, & Keller, 1997) with one study (Lopez, Piffaut, & Seguin, 1992) reporting that 71% of raped women suffered from major depression whilst 37.5% developed chronic PTSD that lasted from 1 to 3 years. Given that proponents of CISD have claimed that it aims to mitigate long-term distress, one needs to also investigate whether it has demonstrated potency in domains other than PTSD.

As part of the Cochrane Collaboration, Rose et al. (2001) conducted a meta-analytic review of the psychological debriefing literature. Their inclusion criteria were that the studies utilised psychological debriefing (which employed normalisation and ventilation), was administered as a single session within one month of the trauma, and relied upon a randomised design. This elicited only eight studies in all, two of which had uninterpretable statistics (Bunn & Clarke, 1979; Bordrow & Porritt, 1979).

Unfortunately, the randomisation requirement, though scientifically rigorous and laudable, also meant that no group-based interventions were included in the review. This is problematic because group-based debriefing is the usual method of delivery for this type of intervention. Nevertheless, of the six studies that were interpretable, all either found no benefit of PD or — and worryingly — that PD increased the likelihood of developing PTSD compared to no intervention. Rose et al. (2001) concluded that compulsory debriefings should cease immediately and that resources would be better utilised by focusing on those individuals who develop recognised disorders.

The thrust of this sentiment is shared in a recent meta-analysis by van Emmerik et al. (2002). These authors likewise conducted a literature search to find studies which had used debriefing within 1 month following a trauma, and where symptoms were assessed pre- and post-debriefing using psychometrically acceptable assessment instruments. Seven studies met their criteria, five of which used CISD as one intervention, six used no-intervention control conditions, and three used conditions of other PD interventions (i.e., “30 minute counselling”, “education”, and “historical group debriefing”). The results suggested that while people have a disposition to improve over time when they received no intervention (on both measures of PTSD and other trauma related domains), if they received non-CISD based interventions this made no significant difference to the outcome. However, those who received CISD did not improve over time on either PTSD symptoms or on other symptom dimensions. In summary, these authors found that
while some generic PD made no significant difference to long-term outcome, CISD would seem to hinder recovery.

These findings and conclusion contrast drastically with the review of CISD/CISM by Everly et al. (2000) and a statistical meta-analysis by Everly and Boyle (1997). The meta-analytic review stated that it only included studies that explicitly used CISD and group debriefings. They concluded that CISD achieved a treatment effect size of Cohen’s d = 0.86 (i.e., a large, positive effect). However, when one looks at the studies included it is interesting to note that not one of them was included in either of the reviews outlined above (Rose et al., 2001; van Emmerik et al., 2002). It should also be stressed that none of the studies used a randomised, controlled design and some of the studies were unavailable for inspection. Furthermore, of those that were available, Devilly et al. (2002) were unable to equate the reported effect size in Everly and Boyle (1997) with the original data presented in two of the available three articles. Additionally, if CISD was never designed to be used as a stand-alone intervention, but rather as one aspect of a “multicomponent CISM program” (Everly et al., 2002), then it is puzzling why a meta-analysis of CISD was performed and acts as the bedrock to base claims for CISD/M effectiveness.

For now, one can only conclude that there has never been a randomly controlled trial of group CISD/M and, therefore, its effectiveness has not been demonstrated. On the other hand, a consensus of randomised controlled trials suggests that individual debriefings using the CISD/M system are noxious, and that generic PD has little or no prophylactic effect.

One anomaly characterising PD, though, is the replicated finding that people typically report high satisfaction ratings following involvement in PD (e.g., Matthews, 1998; Robinson & Mitchell, 1993). However, it has been argued that while this is one outcome domain, it is not necessarily the best upon which to make decisions regarding treatment implementation (Devilly, 2002). Additionally, Hart and Cotton (2003) have suggested an alternative explanation in terms of the possible impact of PD not on employee distress levels but on employee positive affective responses. In other words, PD may be more of a “moral maintenance” intervention qua gesture of employer support, rather than a clinical intervention influencing distress and clinical symptomatology. This line of enquiry is promising and warrants further investigation.

Of further interest are the findings that those who are offered PD yet decline to be involved are the most likely to be unaffected by the event in the long-term (Matthews, 1998), and those who are most distressed by the event are the very same people who are most likely to be adversely affected by debriefing (Mayou, Ehlers, & Hobbs, 2000). Such results do not make good bed-fellows with enforced practice following employee exposure to a major stressor.

Protection From Litigation.

As mentioned above, an argument is frequently made for PD that reminds organisations that they have obligations under workplace health and safety commitments to provide for their staff when traumatic incidents occur in the workplace. Putting aside possible issues related to ‘terminology slippage’ and the definition of what could count as a traumatic event — which has been and is still an issue of great debate (e.g., see Bryant, 1996, and Dobson & Marshall, 1998) — the basis of this claim needs to be scrutinised. Perhaps the most famous case in Australia is that of Howell v the State Rail Authority of New South Wales (1997; S6/1997). On 4th December 1992 a female suicided by jumping in front of a train, the result of which was that some 42 different body parts lay on the track and surrounding area. A rail worker (Mr Howell) was called from a nearby station to secure the scene while emergency service workers were called for and during this time he witnessed the horrific outcome of the suicide. A psychologist, contracted by the rail authority to follow-up on their worker, telephoned Mr Howell at home later that night and asked whether he would like to speak about how the event had affected him. Mr Howell reported that he did not wish to do so and the psychologist arranged to follow-up again a few days later. On the second contact Mr Howell again refused help and the psychologist submitted a report and remit for payment to the rail authority. In a case which came to a close in 1997, Mr Howell sued the rail authority for breach of duty, having developed PTSD as a result of the incident. Mr Howell was first awarded $514,000 ($130,000 damages for non-economic loss, $115,000 for past economic loss, $200,000 for future economic loss, $15,000 for inconvenience, $16,000 in past medical expenses, $18,000 for future medical costs, and $20,000 relating to topping-up received workers compensation). However, after various presentations and appeals, this sum was eventually increased to $750,000.

Naturally, such a hefty award has made many employers anxious to mitigate the effects of trauma that occur in the workplace. Indeed, a cursory search of Australian websites quickly demonstrates how this case is currently being used as a reason why debriefing should always be advocated, particularly by the providers of Employee Assistance Programs. Furthermore, in answer to Bledsoe (2002) who warns of possible liability for providing debriefing, the ICSF recently used this decision as further evidence for the use of CISD (Robinson, 2002). However, this decision needs to be inspected more closely.

First, it was implicitly accepted by the trial judge that debriefing would have improved the status of Mr Howell and acted as a mitigating force in long-term pathology. In light of hindsight and the more recent evidence, as cited above, such a decision would now seem ill-advised. Secondly, the rail authority handbook stipulated that Critical Incident Stress Debriefing (note that CISD was used and not generic PD) be provided in such cases within 48 hours. The fact that this was not followed meant heavily on the decision that the authority had breached their duty and acted negligently. Naturally, such practices need to be amended. Finally, keeping with the first point above. Thirdly, the trial judge decided that the psychologist either knew or should have known that “by 12.30 p.m. on Saturday 5th December 1992 ... that the plaintiff was showing signs of Post-traumatic Stress Disorder”. This is indeed a bold claim and in direct contradiction to research evidence and our current method of classification. Acute Stress Disorder (outlined above), as a method of early detection for PTSD, is sensitive but not specific as it currently stands (Harvey & Bryant, 1998) and even then cannot be diagnosed until at least 2 days following the event. However, and of further interest to psychologists, was the judge’s explicitly declared low opinion of the psychologist. The judge decided that this psychologist was negligent in not conducting a face-to-face interview with Mr Howell and had:

... seriously suggested in an initial report to the Railways that he had, in fact, had interviews, which would infer that he had conducted face to face interviews with the plaintiff at least on 7 December and 9 December ... and (therefore) that there had been a misreporting by the psychologist as too what he had done.
It is thought that such a disparaged view of a psychologist may have tempered the final decision and detracted from the substantive point of whether the debriefing would have actually helped or not.

In an appeal that challenged this implicit assumption of debriefing as effective, the awarded sum was actually further increased to $750,000. However, it appears that this was mainly because it was testified by a prominent psychiatrist who had ASD been diagnosed, then early intervention could have been instituted based upon CBT procedures, which would increase the likelihood of recovery. This is a different argument to looking at debriefing effectiveness and appropriateness. Furthermore, this argument appears to be utilising information that was not available to either the organisation or the psychological community in 1992.

In fact, in light of the available evidence it is, in our opinion, more likely that at some point in the future a company may be litigated against where they compel employees to attend CISD rather than omit to provide it. This opinion is being taken more seriously in the literature (e.g., Bledsoe, 2002; in press) and one can only sympathise with organisations who must feel that they are trapped between a rock and a very hard place. Irrespective of vulnerability to litigation and support to traumatic stress panels have warned against such well-intentioned care and, for example, after the World Trade Centre Terrorist attacks on 11 September 2001, a letter signed by 14 eminent psychologists from around the world appeared in the New York Times and the American Psychiatric Association's newsletter, The Monitor. (Herbert et al., 2001) warning of the dangers of “debriefers'” flocking to the area. In fact, this practice of armies of debriefers descending upon war-torn or devastated parts of the world has received the moniker, somewhat cynically, of “Trauma Tourism” (Gist & Lubin, 1999).

**A Healthy Workforce Is a Productive Workforce**

A review of the organisational behaviour and work psychology literature suggests that limited progress has been made in linking workplace-oriented clinical interventions to organisational performance outcomes (Hart & Cooper, 2001; Wright & Cropanzano, 2000). However, there are indications that increasing employee positive affective responses contributes towards increasing discretionary performance (Borman & Motowildo, 1993), as well as reducing absenteeism (George, 1989, 1996) and workers compensation costs (Hart & Coton, 2003).

Accordingly, a healthy workforce may well be a more productive workforce, but the most reliable method of avoiding a sick workforce after a traumatic event is still open to debate. Nevertheless, given our current state of knowledge, it is possible to delineate some general guidelines to be used in organisational practice.

**General Guidelines**

Below we have outlined a very brief summary of suggested intervention principles:

**Organisational policy.** An organisation's critical incident management policy should be regularly updated and be consistent with developments in the research literature. To facilitate this an organisation might contract a recognised expert in this field to review their policy documentation.

**Facilitate access to immediate practical and social support.** It is not possible to specify all the kinds of practical support that are viable in all situations. For example, following mass trauma events, such as bushfires and floods, governments provide facilities such as access to information, places of safety, bedding, food and sanitation. Organisations after events, such as a workplace fatality, may provide such facilities as help with funeral arrangements, transport for work colleagues, and general changes in workplace conditions that may facilitate a sense that the employer cares about their plight. This may include making available a “veteran” in their area of work who has a wealth of experience and is willing to talk to those who witnessed the event or are concerned regarding how to cope. This use of a respected veteran that workers know and trust is discussed in greater detail by Bledsoe (in press) and Devilly et al. (2002). Contact from the exposed individuals' immediate manager to express concern and support is also helpful, as is the availability of contact with peers. The type of social support referred to here is the (non-clinical) everyday expression of care and listening to the individual's concerns.

**Offer access to Employee Assistance Services for those who request it.** In Australia organisations have a non-delegable duty of care in relation to workplace health. Providing access to appropriately qualified mental health service providers, for face-to-face emotional support and follow-up, also provides an important gesture of employer support. Additionally, accessing employee assistance programs provides an opportunity to screen for individuals who may go on to develop post-trauma reactions. The provision of “comfort” may also appease general and non-diagnosable distress. However, at this point it should not be regarded as a clinical intervention, but more as a socially supportive intervention and an opportunity to screen for individuals who may require more substantive support and treatment.

**Provide factual information and normalise reactions (not “symptoms”).** Without doubt, most frequently the first need of victims of crime or surviving members of a trauma (or related family and friends) is the need for information. This information can include the need to know who has been hurt, how far investigative processes have progressed, which documentation should be completed and when, and how to access facilities. At a national level this need is frequently met by the use of well-informed telephone help-line, and at an organisational level this can be accomplished by regular, frequent and official meetings with all those involved.

Some authors recommend educating the client at various points about reactions to stressors (e.g., Litz, Gray, Bryant, & Adler, 2002) and others suggest that psycho-education regarding possible reactions should be done as a matter of course (e.g., Mitchell, 1983). However, we have argued elsewhere (Deville et al., 2002) that this may in fact be counterproductive and may actually prime participating individuals to develop the very problems we wish them to avoid. However, educating people about possible reactions is very different to normalising problems that they report to be already experiencing. The latter is the more appropriate focus in post-incident follow-up. In the past, however, such intervention has been mandatory and did not take into account individual coping styles and reflect the wishes of the individuals involved. We suggest that this form of intervention can be conducted in either a group meeting or on an individual basis. The point, however, is that the delivery not be compulsory.

**Terminology slippage.** Frequently the types of “critical events” that psychologists are brought in to provide services for are not of a “traumatic” nature. “Debriefing” following, for example, workplace bullying or in reaction to a member of a team being dismissed, has become increasingly frequent and the terminology used during these interventions
are often inappropriate. It is our view that the available evidence suggests that in these cases the responsible course is to recommend referral to a specialist in organisational psychology and, frequently, an expert in organisational change or mediation.

**Promote proactive problem-solving.** Proactivity increases a sense of mastery over situations and increases a sense of self-efficacy. It is suggested that employees be encouraged to devise coping strategies that make sense to their specific situation. No specific coping strategies should be mandated (apart from discouraging counter-productive coping strategies such as increased alcohol consumption).

**Monitor staff to identify at-risk individuals.** Following the provision of "comfort" and the facilitation of immediate needs being met, a follow-up for individuals of between 4 days and 2 weeks subsequent to the incident would offer the appropriate window of opportunity to screen for symptoms of depression, excessive arousal, avoidance behaviours, intrusive phenomena and dissociation.

Monitoring can be conducted collaboratively between employee assistance providers, managers and Human Resource professionals. The psychologist or EAP provider can consult with workplace personnel, to support them in identifying possible at-risk individuals, who can then be specifically followed up.

**Provide access to early intervention for individuals who report enduring distress.** Access to early intervention psychological treatment has been shown to mitigate long-term pathology. More specifically, these interventions are specific and structured, and rely on cognitive-behavioural strategies, and predominantly on exposure treatment. These interventions should not be confused with more generic supportive counselling which has no demonstrated impact on the course of post-traumatic incident recovery. Moreover, the effective delivery of these interventions requires specialised clinical training. Given the wide range of training and skill levels characterising employee assistance professionals, it is important for an organisation to ensure that any contracted Employee Assistance Providers possess the relevant specialist skills in this area. We note that in our own profession, a wide range of interventions are currently advocated, and not all of these are evidenced-based. Reliance on anecdotal reports or personal commitment to support the application of an intervention is inappropriate. Given that we know that early intervention cognitive-behavioural based interventions have demonstrated effectiveness, we suggest that we are now entering a time where serious ethical concerns may arise in circumstances where exposed individuals are initially offered other types of interventions.

**Ensure appropriate organisational liaison and feedback occurs.** This may also require that the psychologist feedback to the organisation ideas, concepts and remedies suggested by the employees. However, caution should be taken during this process to ensure that the psychologist does not actively collude with any dissatisfaction with the organisation that may be expressed by the workers, but rather acts as a facilitative conduit between the organisational floor and management. It is important that service providers avoid confounding post incident distress with any pre-existing industrial discontent. In effect, the service provider should carefully balance "dual-client" considerations and not become an advocate for the individual, and should carefully differentiate incident related concerns from other industrial preoccupations.

The above guidelines should not be seen as prescriptive but rather suggestive of approaches that may act as a template to be adapted to the specific needs of the organisation and event.

**Conclusion**

What we hope to have highlighted in this paper is that claims of CISD/M being able to mitigate long-term pathology are not proven and this intervention system may, in fact, result in paradoxical outcomes. Specifically, this appears to be the case for individual CISD. To our knowledge there are currently no randomised group debriefing studies in existence and hence the efficacy of such approaches is unproven. We also conclude that CISD and CISM, as terms currently used in the research literature, have not been sufficiently differentiated to be used independently. Further, it is our opinion that research and practice in this area of psychological debriefing (or "psychological first-aid"), if not in its embryonic stage, has yet to reach adolescence.

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