How do I help them through this?

Critical Incident Stress Management (CISM) for Educators Supporting Trainees After a Traumatic Event

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Causes of Stress?
Types of Incident?
UK doctors at greater risk of stress, burnout, & mental health problems than general population

This risk is increasing, not decreasing

GPs in particular, trainees even more so

Doctors now facing burnout symptoms early on in career

Presenteeism very high - doctors likely to work whilst sick

“The risk of suicide, especially among GPs, psychiatrists and trainees, and among women, is high compared to the general population.”

“Adequate opportunities to recover from the job mentally as well as physically are vital to ensure health and optimum job performance.”

(See Kinman & Teoh Report 2018)
• PTSD rates in gen population: 1.5 - 3%
• PTSD rates for staff in inpatient mental health facilities: 10 - 25% (US research but comparable to UK)
• PTSD symptoms: at least 60%
• Stress – NHS Occ Health - “majority of our work is seeing staff with mental health problems”.
• Sickness & retention are impacted by incidents
• Team cohesion is impacted by incidents
• Mustn’t forget conflict & bullying (and very challenging patients) as ‘critical incidents’
Taking This Deeper... Causal Variables

Variables that increase risk of mental health problems in doctors

The occupation itself

The state of the organisation you are working in

The type of individual you are

Conflict between work & personal life and lack of work-life balance are key risk factors
Most common causes:

1. High perceived workload
2. Growing intensity and complexity of the work
3. Rapid change within healthcare
4. Low control & support
5. Personal experiences of bullying & harassment
Critical Incident Stress Management – What is it?

• “A systematic, multi-pronged approach to managing stress after traumatic events in the workplace”

• Not just ‘debriefing’ - includes immediate support meeting (‘defusing’), follow up, & preventative measures

• Came from emergency services, military, aid agencies

• Aims to reduce potential for long term stress, maintain group cohesion, promote support, improve retention

• Not a magic solution! Part of a ‘culture’ of support within the organisation:  
  - Trainer / Mentor / Supervisor
  - Reflective practice opportunities
  - Intelligent appraisal system
  - Effective HR
  - Supportive management
Postal Service:

Support on the day
+
Debriefing later on
=
Reduced symptoms & sickness absence
Critical Incident Stress Management (CISM)

Four Parts:

1. Defusing / ‘Immediate Support Meeting’
2. Debriefing / ‘Subsequent Support Meeting’
3. Follow up care
4. Preventative measures
   eg ‘Culture of support’ within organisation
   Attention to staff well-being literature
   Building resilience in staff
PART 1: Immediate Post-Incident Response
Immediate Post-Incident Response: ‘Defusing’

- 15-30 mins, on day of event, before staff go home
- Taken by most senior leader present
- Structure: Introduction, Exploration, Information, Motivation
- Significant trauma may be dealt with directly - phone personal contacts, take home / GP / A&E
- Symptom leaflets can assist this decision
- Leaders involved may need own support meeting.
Immediate Post-Incident Response: ‘Defusing’

- Reduce immediate potential for psychological harm
- Prevent misinterpretation of what has happened
- Prevent rumours from spreading
- Explain what response will follow - eg investigation
- Affirm value of staff involved
- Evaluate immediate reactions & normalize if appropriate
- Begin to assess whether debriefing is necessary
- Re-establish social network of staff group & prevent feelings of isolation
- Encourage mutual support from this point on
The Structure of a ‘Defusing’

1. Introduction

- Introduce anyone not known to the team
- Explain purpose of meeting
- Emphasise what it’s not! (ie investigation, critique, debriefing)
- Groundrules if necessary (esp confidentiality)
The Aim of a Defusing Meeting

The Structure of a ‘Defusing’

2. Exploration

• Summarise what has happened
• Ask how staff are feeling (motivates mutual support)
• *Not* detailed run through of traumatic event
The Structure of a ‘Defusing’

3. Information

- Reassure staff / normalise stress reactions
- Warn (gently) that development of stress symptoms is normal in these circumstances
- Recommend coping strategies / hand out
- Explain process that is likely to happen:
  - eg SUI investigation, police investigation, coroner, debriefing
The Aim of a Defusing Meeting

The Structure of a ‘Defusing’

4. Motivation

- Remind them of their value
- Ask how they would like to be supported
- Emphasise taking care of self - esp rest, family & friends
- Encourage mutual support, not isolation
- Ask who is not present who might need support & plan it
- Offer to be available for 1:1 meeting afterwards
- Ask to meet with anyone who looks like they are not coping
- Take questions
The Aim of a Defusing Meeting

The Structure of a ‘Defusing’

Remember:

- This is a *support meeting* before it is anything else.
- It is very likely you will have to say “I don’t know” to a lot of questions.
- Keep a fairly tight reign over the meeting: don’t allow too much speculation / complex discussion.
- But it needs to be an *interactive* meeting - you are listening to them & assessing their needs.
- A team that feels fully supported is a team that is effective and present with the patients!
Possible Scenarios That Might Warrant ‘Defusing’?
Defusing in Action: A GP Scenario

Well-known patient ‘Susan’ became very angry in waiting room, refused to see a doctor and stormed out. She is now in A&E after a serious incident of self-harm in a local shop.

Surgery received distressing phonecall from her during incident.

Police are involved, members of public witnessed the incident and were told which surgery she had attended, and local media have heard about it.

The working day is coming to an end. A Defusing Meeting is called…
Part 2: Subsequent Support Meeting

DEBRIEFING
‘Debriefing’ – The Basics…

- Different to Procedural / Operational debriefing
- Reflective meeting to assist personal adjustment and/or team cohesion after critical incident
- 2-14 days after serious event. Literature varies on timing (eg 24-72 hrs is more for ambulance crews)
- Takes on average 2 hrs. Follow-up normally offered
- Conducted by professional(s) with experience of PTSD, working with teams if necessary, ideally trained in debriefing
- Sensitivity needed & some knowledge of research (eg not everyone benefits from retelling events)
The Aim of a Debriefing

• Draw people together – sense of safety & containment
• Establish [shared] picture of what happened
• Assist expression of thoughts & feelings
• Limit feelings of self-blame / isolation
• Integrate the experience into life as a whole
• Normalise stress reactions
• Discuss coping mechanisms
• [Increase supportiveness within group]
• Help to bring sense of closure
• Pick up on more serious difficulties
• Feed back to management any concerns
The Steps of a Debrief

Based on well established models by Mitchell (1988) & Dyregrov (1989)

Cognitive Level

Intro
Facts
Immediate Reactions (thoughts/feelings)
Later Reactions / Symptoms
Normalisation
Coping / Support
Feedback / Further Help

Emotional Level
The Evidence for Debriefing: Why all the Controversy?
NICE Guidelines & Cochrane Review don’t appear to recommend debriefing:

“For individuals who have experienced a traumatic event the systematic provision to that individual alone of brief, single-session interventions (often referred to as debriefing) that focus on the traumatic incident should not be routine practice when delivering services.” (NICE Guidelines for PTSD)

BUT: this is for *individual* debriefing to *treat* trauma

AND: based on poor studies. Eg Too short, too soon, untrained debriefers, wrong purpose

The true picture deserves more careful consideration…”
Surveys consistently report debriefing to be subjectively helpful if done properly (eg Mitchell & Everly, 1997).

Cochrane & NICE ignore qualitative studies.

Of the 11 RCTs in Cochrane (Rose, Bisson & Wessely, 2003) & 4 in 2006 update, ALL involved 1-off sessions for individuals.

4 indicated positive outcome, 9 no effect, 2 negative. Conclusion was: no effect. No attempt to break this down.

NICE comments based on same studies.

Dept of Health (2001) evidence-based practice guidelines: concerns about quality of these studies. ‘Many of the published studies showing negative results for critical incident debriefing do not assure the quality of the intervention’ (p.24).

Cochrane authors: quality of studies ‘was generally poor’
What Does the British Psychological Society Say?

Document: ‘Psychological Debriefing’ (May 2002)
BPS Professional Practice Board Working Party

• “There can be little doubt that rapid assistance and support following a traumatic incident can be beneficial in a variety of ways.” (p 34)

• “However, it is also undeniable that the wrong type of intervention, or intervention by the wrong person, may be damaging. It is the organisation’s responsibility to monitor its response in the aftermath of incidents to ensure that it is beneficial to its staff.”

• “Evidence as to the efficacy of debriefing is inconclusive because of the difficulties in carrying out controlled studies in organisations and debate about whether such studies are appropriate anyway.” (p 35)
Debriefing:
How do I prepare?
Things to Think About…

When The Call Comes Through…

What are they actually asking for?

• defusing?
• ‘make it better’ / take away someone’s trauma
• tidy up a mess in the system?
• conflict resolution?

How should you respond?

• make it clear what you can provide
• explain optimal timing
• don’t immediately agree to everything asked
• discuss with someone knowledgeable
• conduct mental ‘risk assessment’ if necessary, to make sure debriefing is appropriate & you are the person to do it
• don’t necessarily take on responsibility for organising it
You’ve Agreed to Do it. What Now?

Things to Request of the Organising Manager

- Room is booked - quiet, private, minimal interruptions (including from on-call phones etc)
- Time is set aside (2 hrs)
- All relevant parties are invited if debriefing a group, including...
  - key people who may not be working that day
  - all staff present during incident / who know patient well
  - other figures involved in case. Eg support worker, if appropriate
  - consider giving option to anyone off sick to attend
  - not always good to have managers/leaders present
  - attendance should be voluntary but worth encouraging people to attend if they feel able, as their presence will be a support to others and make strengthening of group more likely
**Things to Think About…**

You’ve Agreed to Do it. What Now?

To Prepare Yourself

- inform your line manager if they don’t already know
- you need to set 3 hrs aside ideally
- meet with anyone necessary beforehand to find out status of investigation, possibility of coroner’s court, any conflict within group, etc.
- get your leaflets and debriefer’s document ready
- have a think about the dynamics you may face: blame, conflict, shame, guilt, etc.
Possible Scenarios That Might Warrant ‘Debriefing’?
A GP Debriefing Scenario

At the start of last week you came into work to hear that a newly acquired patient ‘Peter’ had committed suicide at home a few hours after a consultation with one of the trainees in your practice. He is thought to have taken a combination of medications that he had been hoarding and he could not be resuscitated when the ambulance arrived.

A few days before his death he had visited the practice twice in a highly agitated state and left several staff members feeling very shaken. The practice is busy and understaffed and they were not given the chance to talk about it at the time.

It is now 12 days since the incident and you are leading a debriefing for all practice staff who had come into contact with Peter, plus an additional doctor and nurse who had been at the practice when news came through of his death. One of the receptionists is off sick. She has been invited but has not come to the meeting.
PART 3: Follow Up of Group or Individuals

Follow Up Care
Organisational Resilience Building
Stress can be your friend...

Yerkes-Dodson Correlation

Too Low  Optimum  Too High

Level of Arousal

Level of Performance

‘Flow’

Adapted from Yerkes & Dodson (1908)
Factors influencing quality of the workplace in the UK:

1. Leaders who support employees and see where they fit into the bigger organisational picture
2. Effective line managers who respect, develop and reward their staff
3. Consultation that values the voices of the employees and listens to their views
4. Concerns and relationships based on trust and shared values.
Money is a motivator at work - if you don't pay people enough they won't be motivated. However, if you pay people enough so that they're not thinking about money then for most people the issue goes away and they start thinking about the work.

Once you have done that, there are three main factors that the science suggests lead to better performance: Autonomy, Mastery, and Purpose

Other things associated with a happier working life

- Feeling valued and cared for
- Not feeling overloaded
- Job stimulation and enjoyment
Personal Factors
Maslow’s Hierarchy of Needs

- **Physiological Needs**: Air, food, water, shelter, clothing, sleep
- **Safety and Security Needs**: Health, employment, property, family, stability
- **Love and Belongingness Needs**: Friendship, family, intimacy, connections
- **Self-Esteem Needs**: Confidence, achievements, respect of others, connections, need for individuality
- **Self-Actualisation**: Morality, creativity, spontaneity, acceptance. Experience purpose, meaning and inner potential
THE PILLARS OF WELLBEING

- Positive Emotions
  - feeling good

- Engagement
  - finding flow

- Relationships
  - authentic connections

- Achievement
  - a sense of accomplishment

- Meaning
  - purposeful existence
Figure 2.3: Wellbeing is a dynamic process that can be fed by virtuous circles of feedback between its component parts.

- **Good feelings**
  - day-to-day and overall
  - e.g. happiness, joy, affection, satisfaction

- **Good psychological functioning, need-satisfaction & engagement**
  - e.g. being autonomous, competent, safe and secure, connected to others

- **External conditions**
  - e.g. work, home, family, physical health

- **Psychological resources**
  - e.g. optimism, self-esteem, resilience

*Based on a figure in nef (2008)*.
Work-Life Balance
THE END

EXTRA SLIDES FOLLOW…
Critical Incident Stress Management

If You Think Someone’s Not Coping…  A Brief Assessment Interview

1. Ask how they are (eg “I’ve noticed you look a bit tired – is everything ok?)
2. Help them talk about what is going on
3. See if they can identify a cause (eg traumatic incident, recent changes, workload, etc)
4. Ask about symptoms (eg “how else is this affecting you?)
   Could use leaflet on ‘Recognising Symptoms’
5. Normalise symptoms (if confident). Explain stress is not a weakness
6. Ask about history (eg “have you had this kind of reaction before?)
7. Check support network / home situation
8. Consider risk (but not necessarily with direct questions)
9. Ask how you can help
10. Make a plan together (ideas coming up)
11. Finish on supportive note
If You Think Someone’s Not Coping…  Making a Plan

1. Suggest contacting trainer/supervisor. Help find them a mentor if necessary.
2. Set up regular support meetings with them or provide temporary support person to meet with.
3. Complete a Stress Assessment measure together.
4. Discuss coping strategies for dealing with stress – see separate leaflet on ‘Coping After a Stressful Incident’ for ideas.
5. Offer to meet again and review how they are doing.
If You Think Someone’s Not Coping…  If they have symptoms of trauma

1. Offer PTSD leaflet (eg from MIND, Royal College of Psychiatry).
2. Consider different types of leave that may be appropriate.
3. Suggest visiting GP to discuss options / see if should be off work.
5. Suggest contacting Employee Assistance Programme – usually free counselling sessions are available with independent counsellor. Eg 6 sessions per yr, spread out as you like. You could offer to ring number for them.
6. Sensitively ask about risk. Eg how well/badly are they coping, any disturbing thoughts, over-use of sleeping tablets / alcohol, safety while driving, etc.
7. Ring friend / family member to come & pick them up if really not coping.
8. Drive them home / to GP / to A&E yourself if immediate concerns.
Things to Remember…

1. Overall aim is supportive not investigative.

2. Remember your basic listening & motivating skills: open questions, reflecting back, summarising, supporting, validating, praising, encouraging.

3. Don’t reach a conclusion too quickly. Form your opinion through listening to them, not making a quick judgement. These situations can be very complicated.

Points to add?
How Are You Going to do This Safely?

1. Safety of Debriefees
2. Safety of Debriefee

1. Safety of Debriefees

- Comfortable, quiet room, with no interruptions
- Tissues available
- Boundaries & Groundrules (discuss later)
- Authority figures not normally present
1. Safety of Debriefees (cont)

Three Main concerns in reviews critical of ‘small group debriefing’:

1. Traumatic story-telling may traumatize other participants (Watson et al, 2003; Stokes, 2002)
2. Probing into affective domain with those who experience numbing & avoidance may trigger re-traumatization (North, 2003; Stokes, 2002)
3. Inappropriate timing for hyper-aroused individuals (NIMH, 2002)

Therefore…
1. Safety of Debriefees (cont)

- Voluntary participation reduces risk
- Minimise potential for traumatisation from ‘new’ information - usually ok as we have homogenous groups, but be careful if non-homogenous (e.g. non-professional present)
- Take extra care when ‘heightened arousal’ present - avoid too much depth in retelling or probing too much into symptoms. Education can be done in roundabout way.
- “Maintain an educational and story-telling format” (not a ‘trauma therapy’ format) (Shalev, et al., 2003)
- Debriefing is contraindicated if basic safety needs not met (Ritchie 2002)
1. Safety of Debriefees (cont)

- Training for Debriefers (Crisis Intervention is improved by increased training - Stapleton, 2007)
- Keep up to date with research to ensure best practice
- Evaluate debriefings carefully to assess effectiveness
- Group supervision to share lessons learned
Things to Think About…

How Are You Going to do This Safely?

2. Safety of Debriefee

- Supervision
- Training
- Personal ‘risk assessment’ - is it right for you to take this on?
- Be aware of ‘vicarious trauma’
- Debrief in pairs
- Grounded value system helps / thought-through view of suffering
- Good personal support network
- Don’t do too much of this
- Know when to have a break from debriefing
What is likely to be going on within the group?

1. Internally within individuals:
   - Huge range - some may be fine, some traumatised
   - some may feel guilty, others secretly blaming colleagues

2. Interpersonally between individuals:
   - Huge range: from enhanced closeness to outright blame & conflict

3. Systemically between the group and other parties:
   - eg managers, senior managers, other agencies (eg police)

All this will be in the room with you!
Unpacking the ‘Debriefing’ Research Further

**Negative Outcome 1**
- Mayou, Ehlers & Hobbs, 2000
- RTA victims admitted to hospital
- Debriefed within 24 hrs of accident

**Negative Outcome 2**
- Bisson at al, 1997
- Burns victims
- Sooner debriefing = worse outcome

Obvious issues in both above:
- Sessions too soon, too short (under 1 hr, some 20 mins), victims probably still in pain, limited structure, inexperienced debriefers
- Eg Mayou et al: debriefing was “relatively short and had limited internal structure. It contrasted in significant ways with the models of psychological debriefing described by Mitchell & Dyregrov’

Less obvious issues - Groups not properly randomised:
- In both studies: Debriefed group more severe injuries
- In burns study: Debriefed group twice as much previous trauma
- Effects may be due to severity of injury & distress not debriefing
The one RCT that used an experienced debriefer with a session of 1-2 hrs found a positive outcome

Separate review by Arendt & Elklit (2001):

• 6 studies where debriefing lasted 1 hr or less all found no or negative effect
• 5 studies where debriefing lasted 1 hr + all found positive effect
‘My organisation offered a 45 minute debriefing appointment. I was conscious of the time limit right from the start. It made me feel “unrelaxed” and all I could think of was “how can I fit in all I’d like to tell someone?” I came out of it feeling like it was open heart surgery without time to be stitched back up, and I was left to pick up the pieces afterwards.’

‘I was then very fortunate to be offered another debriefing through my church, and this was the complete opposite. From the beginning I felt that I could talk over the things that really mattered to me. To not have any time constraint helped, and conveyed to me that this person put a priority on this time as well. We talked for more than three hours.’

‘If I was in the same situation again, I’d prefer to not have a debriefing at all than to be debriefed in 45 minutes – it just is not possible.’
Why is it not helpful if done too soon?

- Insisting on immediate debriefing may reinforce feelings of helplessness (Everstine & Everstine, 1993)
- Forcing re-telling of trauma details on same day may encode it more vividly into memory & impede recovery
- Participants may be in shock, pain, dissociating, avoidant, highly aroused - unlikely to be able to make use of even good debriefing
In the RTA Study:

‘Regrettably, the experienced clinical nurse specialists and social workers who were recruited initially to undertake the interventions, found that their primary clinical responsibilities in the emergency psychiatric service prevented their reaching many of the study patients before they were discharged. After the first ten subjects, the interventions were undertaken instead by the research assistant’ (Hobbs & Adshead, 1997, p. 166-167).

In the Burns Victim Study:

Debriefers received only half a day’s training (Parkinson, 2001). Many were nurses who were also changing their dressings etc.

Research suggests debriefing tends to be beneficial only when led by a trained, experienced debriefer (Arendt & Elklit, 2001).

This has been emphasised from the beginning. Eg Dyregrov (1999) and Mitchell & Everly (1993)
‘She was well-meaning but obviously had no idea of what I was talking about. She kept squirming and saying ‘ooh, that sounds awful’. She said ‘I don’t know why you want to go back to that job anyway’! She couldn’t help me at all, as she didn’t understand the sort of job I do.’

‘The background, training and personal qualities of the leaders are extremely important variables in making successful debriefings.’ (Dyregrov, 1997, p.593).

‘Cultural competence / credibility’ - includes experience of trauma, expertise / information re symptoms & course, ability to answer questions, ability to cope with traumatic material, understanding of participant’s job (eg Watts 2000; Orner 2003; Alexander & Wells 1991) Participants are more likely to talk to a trained colleague than random mental health professional (Lovell 1999)
Interesting Research on Group Debriefing

Boscarino, et al, IJEMH, 2005

Post 9/11 New York crisis intervention (n = 1681) associated with reduced risk (at 1 and 2 yrs on) for:

- binge drinking (d=.74)
- alcohol dependence (.92)
- PTSD symptoms (.56)
- major depression (.81)
- anxiety disorder (.98)
- global impairment (.66)
- compared with comparable individuals who did not receive this intervention
Boscarino (2006). Medical Care, 44, 454-462

Evaluation of crisis interventions after World Trade Center disaster (n=1121)

• Brief post disaster CISM interventions show positive outcome up to 2 yrs post disaster
• Reduced depression, alcohol abuse, PTSD severity, anxiety
Flannery’s ASAP (1999)

- Assaulted Staff Action Program (ASAP) was originally designed to reduce stress associated with assaults on staff
- Unexpected Outcome: Consistent reduction in assaults
- 15 years of data
**Research on Group Debriefing**

- “There is now emerging evidence that prompt delivery of brief, acute phase services in the first weeks after an event can lead to sustained reduction in morbidity years later, reducing the burden of secondary functional impairment, presumed daily average life years lost, and costs to both the individual and the public”

What Else Does the British Psychological Society Say?

Document: ‘Psychological Debriefing’ (May 2002)
Professional Practice Board Working Party

- Lists ways in which debriefing can be damaging if approached wrongly
- Stresses that debriefers must be competent “in terms of experience, knowledge, awareness, and sensitivity to the organisational dynamics.”
- Stresses “duty of the organisation to ensure that safeguards are built into the systems to protect vulnerable employees” (eg highly traumatised, history of trauma, blamed by others, responsible for event, broken law).
- Offers examples of things to consider in pre-debriefing risk assessment
- Offers comments on venue, group size, participant choice, etc
- Gives requirements that interventions must attempt to satisfy (p 34)
- Stresses importance of multi-faceted approach to stress management
- Acknowledges variety of approaches to CISM which seem sensible & comprehensive but which avoid use of term ‘debriefing’
Other Literature

• **Robinson (2008)**. Good appraisal of debriefing debate, limitations and possibilities for CISM.
• **Hawker et al (2010)**. Well designed research demonstrates effectiveness – limitations in research design, and findings over generalised.
• **Tuckey and Scott (2013)**. RCT with Australian emergency services – lower alc. use and improved well being (QOL) – but no reduction in stress or trauma response.
CISM Usually Fits Well With Local & National Priorities…

Employee Support & Well Being Policy

eg “This NHS Trust is committed to ensuring that employees can effectively manage their stress to minimise the impact on their health within the workplace.”

Prevention & Management of Stress at Work Policy

“This Trust places a high value on the physical and mental health of its staff and is committed to putting into place all reasonable measures that encourage and protect Trust staff from the effects of work-related stress.”

Health & Safety Executive often highlights need to address sources of workplace stress

NICE: “Acknowledgement of the psychological impact of traumatic incidents should be part of healthcare and social service workers’ responses to incidents” (PTSD guidelines)
Where Has it Come From?

- Armed forces
- Emergency services
- Aid agencies - disaster response units
- Not dreamt up by amateurs!
- Begun to happen in NHS Trusts - need for effective framework for staff support
- Being formalised into successful programs e.g. Flannery’s Assulted Staff Action Program
- Hampshire Partnership’s CISM service won award
- Broadmoor doing it for years
- Happening informally in many places for a long time (formally in many forensic services)
- Introduction often driven by nursing managers
Hampshire Partnership NHS Trust’s CISM Service won a prize in the Celebrating Success Healthcare awards. The service has helped many hundreds of staff in the Trust.