CRITICAL INCIDENT MANAGEMENT

White Paper

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# TABLE OF CONTENTS

**Introduction** ................................................................................................................ 4
  Key Terms ...........................................................................................................................5

**Traditional Interventions** ............................................................................................ 6
  Critical Incident Stress Debriefings (CISD) ........................................................................6
  Research findings ............................................................................................................7
  Specific Problems with CISD .............................................................................................8
    Phase 1 - Process Introductions ......................................................................................8
    Phase 2 – Facts Phase ....................................................................................................8
    Phase 3 – Thoughts .......................................................................................................8
    Phase 4 – Reactions .......................................................................................................9
    Phase 5 – Symptoms .......................................................................................................9
    Phase 6 – Teaching Phase ..............................................................................................9
    Phase 7 - Referrals ........................................................................................................9

**Other Intervention Models and Evidence** ................................................................. 10
  Psychological First Aid .....................................................................................................10
  Royal Mail Group Study .................................................................................................11
  Psychoeducation .............................................................................................................12

**Where to from here** .................................................................................................... 14
  Practitioner's Perspective ...............................................................................................14
  Organisational Perspective .............................................................................................14

**Conclusion** .................................................................................................................. 16

**References & Further Reading** ..................................................................................... 17
Introduction

Workplace critical incidents by their nature occur rarely but, when they do, it is important to support the affected staff in such a way that their health and wellbeing are not put at greater risk. Employers have obligations under OHS legislation to provide a work environment that is free of risk to the psychological health of their employees, and of course managers want to do the ‘right’ thing and support their employees and provide assistance. So what do they do? “Debrief” is usually the first answer that comes to mind, and workplace policies are likely to dictate such a response, so they promptly organise a debrief – but many other questions then arise: How should it be delivered - one-on-one or as a group? Should it be voluntary or compulsory? Should the affected staff be allowed to go home and then return to attend the debrief? When should it take place? Who should facilitate it?

Organisational policies are often silent on these important procedural questions and managers are left to make quick decisions while they themselves may also be affected by such incidents. There is now an urgent need to update critical incident policies in line with the latest research, to enable managers to take efficient and appropriate action at those difficult times, and mitigate the risks.

Most people expect that debriefing is meant to reduce distress among staff and more importantly prevent the development of psychiatric disorders such as Post Traumatic Stress Disorder (PTSD), however, debrief outcomes and their effectiveness depend on how it is delivered. Traditionally, debriefing services were based on Mitchell’s (1983) Critical Incident Stress Debriefing Model (CISD), the most common debriefing model in Australia1.

Evidence is mounting that although this form of debriefing is intended to reduce the negative effect of traumatic events it has little or no effect on preventing stress related symptoms or PTSD and may in fact exacerbate these negative symptoms.

Though the calls to abandon this form of debriefing have grown stronger in recent years, the area of critical incident management is complex and care must be taken not to “throw the baby out with the bathwater”. Hence, we need to take a closer look and examine the latest thinking and current practices surrounding crisis intervention management, and examine alternative interventions.

This paper first defines key terms; then examines in greater depth what is currently known about traditional interventions and other alternative intervention models. It concludes with suggestions for organisations as to how we align current evidence with practice.

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Key Terms

The terms surrounding critical incidents can sometimes cause confusion. This section defines those most commonly used.

Disasters: refer to events which cause or threaten death within an identifiable and somewhat defined community. These can incorporate ‘natural disasters’ such as floods, bushfires, cyclones, tsunamis, earthquakes, and ‘man made disasters’ such as industrial accidents, shootings, robberies/hold-ups, major crashes and hostage taking. The impact of disasters can be at a societal, environmental and/or personal level.

Critical Incidents/Traumatic events: conceptually both of these terms are the same and are sometimes used interchangeably. Specifically they refer to powerful and upsetting incidents that intrude into daily life. According to the Australian Psychological Society (APS) critical incidents are usually defined as experiences which are life threatening, or where there is a significant threat to one’s physical or psychological well being. It is noteworthy that the same critical incident whilst causing severe distress in some individuals may have little impact on other individuals. An individual’s mental and physical health, level of available support at the time of the event, as well as previous experience and coping skills may be related to their ability to deal with (or not) a critical incident.

Crisis response: when faced with a perceived challenge or threat, a crisis response is an acute response (physical or mental) when an individual’s ability to cope effectively is overwhelmed in the face of a perceived challenge or threat. When stress responses are insufficient or inappropriate there is the potential for trauma to develop.

Trauma: caused by a deeply disturbing experience, trauma refers to an emotional wound or shock that creates substantial, lasting damage to one’s psychological development often leading to neurosis.

Acute Stress Disorder (ASD): occurs when a person is exposed to a traumatic event that involved actual or threatened death or serious injury or threat to self or others and their response involved intense fear, helplessness or horror. Though many of the symptoms of ASD are similar to PTSD (recurrent intrusive thoughts or images, recurrent distressing dreams, flashbacks, psychological distress and physical agitation when exposed to reminders of the event), ASD differs fundamentally in that it lasts a minimum of 2 days and maximum of 4 weeks and occurs within 4 weeks of a traumatic event.

Post Traumatic Stress Disorder (PTSD): Symptoms include (but are not limited to) recurrent intrusive thoughts or images, distressing dreams, flashbacks to the event, avoiding thoughts or feelings associated with the event, diminished interest in significant activities, feeling detached or estranged from others and restricted range of emotions. For a diagnosis of PTSD these symptoms must be present for at least 1 to 3 months consecutively.

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2 Psychological Services in Disasters: Australian Emergency Management Institute and Australasian Society for Traumatic Stress Studies
Traditional Interventions

Critical Incident Stress Debriefings (CISD)

One of the most widespread and best known models of crisis intervention is Critical Incident Stress Debriefings (CISD). A seven phase model, designed by Mitchell in the early eighties specifically as an intervention tool, CISD is usually implemented in a single session, between 24-72 hours post impact. The stages include:

1. Process introductions – rules, processes and goals are outlined
2. The ‘facts’ phase and event reconstruction (group and 1:1)
3. The ‘thoughts’ phase and cognitive reappraisal-survivors asked to articulate their first thoughts as the impact and magnitude of the traumatic event first came to their awareness
4. The ‘reactions’ phase and cathartic ventilation – survivors articulate their recollection of what was the worst part of the experience
5. The ‘symptoms’ phase and attribution-global assessment of physical or psychological symptoms
6. The ‘teaching’ phase and psycho-education – educating survivors about possible, common or even ‘likely’ stress responses
7. The ‘re-entry’ phase and appropriate referral information provided for future follow-up.

The rationale behind Mitchell's model is that it was generally thought that a brief intervention during the early crisis state can produce a large amount of change in a short period of time compared with the slower, smaller gains likely to be made in therapy during non-crisis states, especially if the person has adopted dysfunctional strategies to resolve the crisis. CISD is reportedly the most common model of debriefing used in Australia, and there have been a host of other interventions which share a similar structure to that pioneered by Mitchell. Worldwide there are more than 350 organised CISD teams used in settings such as banks, government education and welfare departments, schools, community groups, and the military. Evidence is emerging that this one-size-fits-all intervention for all who are exposed to a traumatic event is not only impractical, but for most affected ‘victims’ unnecessary, or for others, too early and intrusive or too little. Additionally, current research into CISD has highlighted that debriefing is not as simple a measure as sometimes presented and it is extremely important that it be done by mental health professionals from a background of expertise as opposed to individuals who are simply trained as ‘debriefers’ or ‘peer debriefers’ under the Mitchell model of certification or those who offer debriefing services based on their previous experience with disaster.

The evidence seems to be suggesting that there is considerable risk involved in pushing those exposed to a traumatic event too hard or fast to confront their experience. Indeed pushing too hard...
for trauma details runs the risk of leading to overwhelming emotions and feeling of vulnerability and loss of control. Further findings suggest that secondary traumatisation may occur if a practitioner insists those affected recount their role before they are ready or able to emotionally process the event.

Further, the Cochrane Review (a highly respected international not-for-profit organisation providing systematic reviews of all relevant randomized controlled trials of health care) goes so far as to say that the compulsory debriefing of victims of traumatic events should cease. This call for a cessation of the practice of CISD has been echoed by the Australian Psychological Society (APS), British Psychological Society, American Psychological Society, World Health Organisation and NATO. However it would appear that many organisations and practitioners are unwilling to give up this program because in general satisfaction with the procedure among clients (i.e. those exposed to a traumatic event as well as other employees and management) has been strong despite high levels of satisfaction not necessarily reflected in positive outcomes. Its acceptability appears to be based more on the satisfaction expressed by debriefed parties who appreciated the gesture, rather than on measured outcomes.6

**Research findings**

Research has highlighted a number of possible negative impacts of debriefing which lead to paradoxical inhibition of recovery and provide compelling evidence as to why the practice should be abandoned. For example, several meta-analyses of the literature on CISD have shown that it has no effect on preventing stress related symptoms following a traumatic event especially PTSD. Some studies found even worsening of stress-related symptoms in those receiving CISD. For example in one study, at the 4-month period post incident, levels of anxiety and somatization (converting anxiety into physical symptoms) had declined more in the non treatment group, while levels of hostility and psychiatric symptoms had actually risen in the treatment group. Another study conducted in road accident victims who received early debriefing (within 24-48 hours of the accident) indicated debriefing may have been disadvantageous. This study found strong indications of paradoxical outcomes for debriefed patients and concluded that debriefing was of no benefit and may have made patients worse and deemed CISD inappropriate for trauma. A study involving 123 adult burn trauma victims by Bisson et al cited in Bledsoe, found 16 (26%) of the group who received debriefing had PTSD at 13mth follow-up, while only 4 (9%) of the control group had PTSD.

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Specific Problems with CISD

Given the prevalence of CISD in Australia it is worth taking a closer look at the seven phase model and highlighting where the criticisms have been levied. Questionable claims, dubious marketing practices and misrepresentation of the empirical standing of the technique have been recurrent issues regarding CISD and its proponents. The issues presented below have been identified as the most serious.

Phase 1 - Process Introductions

Though process introductions appear relatively benign, it has been suggested that in light of recent evidence linking individuals who received debriefing more likely to develop PTSD, failure to disclose these risks and the paradoxical inhibition of recovery raises issues around fully informed consent.10

Phase 2 – Facts Phase

Most debriefing protocols encourage specific reporting of what one saw and heard during the event, moving from there to articulation of what one was thinking and feeling – often specifically inquiring as to the worst moments and most intense emotions encountered.

Critics argue that in this phase, in one-on-one there is a real danger that recalling the facts may modify the eye witness memory of the event and intensify already disturbing reactions by reconnecting the individual with the sources of discomfort well before the individual has had sufficient time to process and distance him/herself from the traumatic event.

For group debriefing this phase creates a shared picture of the event that may further compound these issues by exposing individuals struggling to keep their own emotions in check to additional potentially even more vivid and arousing construction of the event and its images. Research has found that only positive reappraisal and distancing to be coping strategies predictive of successful adaptation. Therefore encouraging or insisting on reconstruction is likely to run counter to what well might support ultimate resolution11.

Phase 3 – Thoughts

Here participants are asked to articulate their first thoughts as the impact and magnitude of the traumatic event first came into their awareness.

The criticism here is that people may not have originally been fully aware of the level of danger to which they were exposed. This post event process could lead to priming their memory in a way that could increase subjective estimation of threat (e.g. “I thought the gun was fake!”).

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Such reassessment of a situation has been considered central in the source of a fear response and evidences suggests that increased subjective deliberation of danger correlates with pathologic outcomes. It has been suggested that this might be exacerbated in vulnerable individuals as these thoughts are again paired with the arousal sensations as the process moves into the feeling or reaction phase.

**Phase 4 – Reactions**

Participants are asked to articulate their emotional responses to the event, often through queries such as “What was the worst part of the experience for you?”

Moving from facts to thoughts to reactions could potentially move survivors back to a state close to terror, helplessness and confusion when the priority should be for them to distance themselves from the traumatic event. Despite the fact that the goal of CISD is to normalise the situation, this condition of subjective arousal may in fact exacerbate and reinforce distress rather than mitigate and reduce it. Critics argue that individuals run the risk of becoming sensitised to the stimuli involved, at a time when desensitization is paramount to resolution.

**Phase 5 – Symptoms**

The very label of symptoms may prime people to consider these discomfitures as if pathological symptoms. Labelling the event as traumatic may dispose some vulnerable individuals to interpret the inescapable disequilibrium of disruptive life events as pathological anxiety becoming in effect a self-fulfilling prophecy of despair, (eg: “I didn’t know I was sick until you told me so”). Preliminary evidence suggests that providing trauma patients with psycho-education appears to have a paradoxical effect on depression and PTSD ‘caseness’. Further it has been noted in the British Medical Journal that when people are emotionally aroused they are more open to suggestion rendering them particularly vulnerable. Current thinking centres on emphasising adaptation rather than maladaptation. This is discussed in more detail below.

**Phase 6 – Teaching Phase**

Debriefers tend to attempt to accomplish this by distributing list of problems which participants are told they may expect to experience and then provide suggestions, often simplistic at best, regarding coping strategies and approaches.

CISD approaches frequently prescribe utilisation of peer debriefers who themselves have had exposure to traumatic events. However the danger here is that those whose prior exposure to traumatic events has left them with unresolved issues for which vicarious rumination may be sought might well relish opportunities to enter settings where such reprocessing can be offered as if a therapeutic contribution to others.

**Phase 7 - Referrals**

No formal studies referring to this phase were found.

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Other Intervention Models and Evidence

Psychological First Aid

Although the concept of psychological first aid (PFA) for individuals who have experienced traumatic events has been around in the critical incident management arena for many years, interest in operationalising this concept has been relatively recent, spurred on in part by recent disasters in the US and beyond.\(^{13}\) In collaboration with the National Child Traumatic Stress Network and the National Centre for Posttraumatic Stress Disorder, the Psychological First Aid Field Operations Guide was developed and has subsequently been adopted by the Australian Centre for Posttraumatic Mental Health and APS. PFA represents an evidence-informed modular approach for assisting children, adolescents, adults and families in reducing initial distress following a disaster and in fostering both short and long-term adaptive functioning. Intervention strategies of PFA are grouped conceptually into eight modules described as core actions with each action containing a variety of specific recommendations for working with survivors. The rationale for each core action rests on theory and research on stress, coping and adaptation in the aftermath of disaster or catastrophic events. Based on five basic principles that have received broad empirical support for facilitating positive adaptation following trauma, these core actions are outlined below\(^{14}\).

1. Promote a sense of safety – evidence has shown that victims who can maintain or re-establish a relative sense of safety have considerably lower risk of developing PTSD in the months following exposure than those who do not. Further evidence indicates that people who are likely to develop subsequent disorders are more likely to exaggerate future risk.
2. Promote calming – although initial arousal and numbing may be adaptive, prolonged states of heightened emotional responding may lead to agitation, depression and somatic problems. Evidence suggests that implementing treatments for calming (e.g. breathing exercises, yoga, imagery and music etc) are key to attaining anxiety management.
3. Promote sense of self-and collective efficacy – evidence suggests that having a specific sense that one can cope with trauma related events has been found to be beneficial. As such people must feel that they have the skills to overcome threat and solve their problems.
4. Promote connectedness – social support and sustained attachments have been consistently found to beneficial in combating stress and trauma.
5. Promote hope – those individuals who remain optimistic are likely to have more favourable outcomes after experiencing trauma because they maintain a reasonable degree of hope for their future.

Psychological first aid trains first responders and care providers to be sensitive to competing needs and the systems in place to address them in disaster sites. Specifically the eight core actions include:

1. Contact and engagement
2. Safety & concern
3. Information gathering
4. Practical assistance
5. Connection with social support
6. Information on coping
7. Linkage with collaborative services
8. Appendices and handouts

Currently PFA is intended to represent the approach most consistently supported by research and practice, and evaluation research is ongoing in an effort to establish empirical evidence. How applicable PFA is within a smaller scale organisational context is still largely unknown. Interestingly however, critical incident management interventions have been implemented within an organisational context and this is the next focus of attention.

**Royal Mail Group Study**

In an effort to establish a framework that provides safe and effective trauma management practices within an organisational context the Royal Mail Group (RMG) in the UK conducted a longitudinal study over a thirteen month period to provide evidence of an alternate intervention that did not involve intense re-exposure to traumatic events. RMG is one of the largest employer groups in the UK and typically deals with a wide array of potentially traumatic incidents. These range from robberies, attempted robberies, armed robberies, hostage taking situations, dog attacks, physical assaults, and accidents, falls and road traffic accidents through to incidents more specific to the nature of the individual job. Evolving over ten years, its trauma management program incorporates three phases:

1. Practical support on the day of the incident in the form of crisis management
2. A SPoT (support post trauma) protocol, designed to ensure managers provide appropriate practical, emotional and social support.
3. Further ongoing 1:1 support from the professional trauma counselling service.

RMG’s approach was relatively simple yet structured and readily transferable to many different work settings. Their findings concluded that employees who attended SPoT meetings reported significantly higher scores than non attendees on three important aspects of post trauma management:

1. **Reassurance** that the symptoms they might be experiencing were normal
2. Knowledge about sources of [further information](#) about traumatic reactions
3. Knowledge about where in the Royal Mail to access [further information](#)

Further, those who attended those meetings were far more positive in their views of RMG and the role of support in enabling them to get back to normal. It is of interest to note that SPoT is a voluntary meeting with a trained manager. Additionally, absence from work was found to be significantly correlated with perceived organisational support, with those who felt supported immediately post trauma also having lower absence 12 months later.
This study concluded that the SPoT interventions were safe to use in organisational settings. Its use was not associated with increased symptoms and the process was found to have positive organisational benefits. Findings suggest that the way an individual perceives the organisational support they receive is more important than any specific intervention (assuming of course the particular intervention is appropriate and safe). Both support on the day of the incident and attendance at a SPoT meeting were important constituents of perceived organisation support post trauma. “Good support” i.e. the factors immediately post trauma that were associated with reduced symptom levels – was found to be an empathic response from the line manager and prompt practical support in dealing with the situation and getting back to normal. Further ‘good’ support was also found to be in relation to the educational aspects of meeting i.e. information about where to go to obtain further support within the organisation, identification of symptoms individuals might have been experiencing since the incident and information about the normal reactions to trauma and coping-mechanisms.

SPoT meetings differ from other crisis intervention models in several fundamental ways: Firstly, they are delivered by trained managers (in-house) whereas CISD is generally delivered by Health Care Professionals. Secondly, intense re-exposure of feelings is not part of the SPoT program. Thirdly, managers are trained to identify individual cases requiring counselling input, whilst CISD is generally a ‘one-off’ session. Lastly managers in a SPoT meeting are trained to provide reassurance to the affected individual that they complied with organisational procedures (if relevant) whereas CISD debriefers do not comment on organisational procedures.

In conclusion, the key elements of a good organisational response emanating from this research were:

- Immediacy of response from manager
- A personal touch
- Practical help, being directive
- Follow-up in the days and indeed weeks following an incident.

Psychoeducation

Another organisational intervention is psychoeducation. Psychoeducation refers to the provision of information about the nature of stress, post traumatic and other symptoms, and what to do about them. It can be delivered before possible exposure to stressful situations as part of what is sometimes called “fear training” or “pre-briefing” or after exposure to a traumatic event. Psychoeducation can be delivered in one of several ways including briefings, informational pamphlets or via the internet. The assumptions underlying psycho education are that if people are given information about what symptoms they might experience following a trauma they may find these symptoms less disturbing. Generally information provided to victims of traumatic events that their emotional reactions are ‘normal’ reactions to abnormal events and that the majority of people will experience similar

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symptoms and recover over time. It is also believed that provision of psychoeducation assists individuals in providing them with information on where to get help should they feel the need for professional assistance with their symptoms.

On the other hand, some critics argue providing trauma survivors with lists of possible symptoms expected following a traumatic event potentially leads to the expectation of maladaptation and pathology. Recent research indicates that psychoeducation which incorporates constructive information that proactively encourages the expectation of resilience and if necessary help seeking is far more beneficial than merely providing lists of expected potential symptoms or hazards following trauma. Other critics argue governments, agencies and mental health professionals favour psychoeducation not only because of its cost effectiveness, but also because it portrays the image that they have actually done something about the situation/trauma yet have paid scant regard to its efficacy.

Evidence suggests however that psychoeducation that enhances those mechanisms associated with adaptation and resilience and minimises those that may contribute pathologising and dysfunction appears to be a way forward for practitioners in the field. These include normalising the perception of transient stress reactions, reducing the expectancy of pathology, maintaining safety, integrating corrective information that enhances adaptation, reducing the stigma of stress reactions, encouraging social support, and if necessary subsequent help seeking. An important caveat is that these components need to be delivered in a framework that expects recovery and is appropriate to the targeted agency. Furthermore, if a psychoeducational program is to be effective, it must be delivered in a manner that is sensitive to the target audience. Interesting evidence about the efficacy of psychoeducation has recently emerged. The “Battlemind” program specifically initiated for US troops in Iraq, intentionally provides education to troops about stress reactions in a manner that frames it in an adaptive manner, strategically does not medicalize the responses, and heightens expectancy of both resilience and functioning and so far this program is obtaining positive results. However other studies have failed to show any influence either positive or negative on stress reactions in those who received stress briefing or psycho education. Nonetheless, the evidence that psychoeducation should be dismissed altogether is not sufficient and more rigorous research is required.


Where to from here

Practitioner’s Perspective

Individuals cope with trauma in varying ways and with varying degrees of success but perhaps the most consistent finding in disaster or critical incident research is that the vast majority of individuals recover from a traumatic experience without experiencing significant psychopathology. Practitioners have a duty of care to their clients and their first priority is to do no harm, thus any critical incident intervention strategy proposed for a given situation must be situation and incident specific. There is clear and compelling evidence that employing traditional CISD to respond to critical incidents has paradoxical effects on the very recipients it is intended to help. At best it would seem to be a band aid solution to a multi layered and faceted situation. Psychological debriefing and particularly CISD has been proffered as a prophylactic approach and relegated to the pseudo or junk sciences. Of serious concern to practitioners given the recent mounting evidence against psychological debriefing and its inefficacy, practitioners and organisations alike are being warned that they could conceivably be sued for providing a service that has been demonstrated to increase risk to recipients. This has already been the case in the US and UK.

Certainly clear guidelines around administering PFA are available; however it would seem that PFA works well when dealing with large scale disasters. For those working on smaller scale crisis responses there appears to be a dearth in the research as to what kind of framework would be appropriate. It is clear that a ‘one size fits all’ approach is inappropriate and solutions/assistance should be tailored to specific situations, nonetheless guidelines around how best to respond and assist those experiencing trauma following an incident would be helpful.

Organisational Perspective

Recent evidence around psychological debriefing similarly provides a conundrum for organisations. Wanting and needing to do the right thing for employees immediately following a critical incident is of clear importance. Recent research has suggested that there is quite a lot organisations can do or put in place to prepare for disaster and appropriately respond if it occurs. For example, having detailed response plans, instilling a sense of mastery and resilience amongst its employees or implementing programs such as those outlined in the RMG study above.

This paper has highlighted just how important an organisation’s response to traumatic events is; demonstrating that the way an organisation responds when employees are exposed to traumatic events can have an impact on subsequent symptom levels and unplanned absences.

The latest findings have been slowly changing professionals’ approaches and clinical practice, which now must be matched by employers’ awareness, policy and practice. This includes changing their expectations of debrief providers to match established best practice. Rather than leaving the management of their employees’ post-trauma support in the hands of a provider it is incumbent on employers to adopt an informed and proactive response. In the first instance it is the employers who must ensure their employees are appropriately assisted after a critical incident, and thereby fulfil their duty of care. The evidence presented in this paper suggests that this will reduce the risk of prolonged absences, compensation claims and other litigation.

Moving forward it is imperative that employers review their existing critical incident management policy directions and ensure they reflect the latest guidelines. It is suggested that these policies need to encompass at least the following principles:

- Practical support provided on the day of the incident
- Good support is demonstrated by the organisation to the employee through:
  - Empathic, personal and immediate response from the line manager
  - Ongoing practical and emotional support to deal with the situation and to get back to normal for a period of days and weeks after the incident
  - Follow up support meetings to ensure the communication is complete, required information is provided, reactions are monitored and any issues are addressed, for some months after the incident
  - Provision of information regarding where to get further support in the organisation
  - Provision of information about the normal reactions to trauma and coping mechanisms
  - Access to professional counselling services when needed
- Monitoring of symptoms and reactions systematically, either through the involvement of professional support or through the support meetings to identify at-risk individuals
- Referral for appropriate treatment once the symptoms are identified to persist for 3-4 weeks after the incident, such as expressions of extreme feelings of shame, guilt or anger, abuse of alcohol/drugs, sleep difficulties or other reactions which interfere with normal work/life activities or relationships.

Each case needs to take into account the individual differences and preferences for people to cope. Those who are in people support roles need to increase their awareness in this area and gain access to up-to-date information and resources.

Of course, rewriting policy statements and documents to reflect the above principles will not, in itself, produce any changes if work practices do not change. In support of such policy implementation employers need to:

- Increase line managers’ awareness of their role in demonstrating organisational support
- Increase awareness of managers and other support role personnel of the normal post trauma symptoms and those associates with ASD and PTSD
- Ensure resources are available to provide educational material and practical information to employees following a traumatic event
- Develop a relationship with the providers of professional services to ensure they can respond immediately when needed and in a format aligned with the organisational process
- Assure themselves that their providers of debrief services adhere to the latest guidelines issued by the Australian Centre for Posttraumatic Mental Health or the UK National Institute for Health and Clinical Excellence.

**Conclusion**

Disasters both man made and natural have been with us since time immemorial. However it would seem that there has been a significant increase in the frequency and prevalence of traumatic inducing events throughout the world or perhaps it is our ability to access information on, and images of, these events in ‘real time’ through both the power of the internet and mass media. That said many believe\(^{21}\) the dynamic environment of today’s businesses is such that it is no longer a question of ‘if’ a business will face a traumatic event: it is, rather a question of ‘when’, ‘what type’ and ‘how prepared’ the organisation is to deal with it. Recent high profile world disasters and the ways in which they have been handled has enabled researchers to gather evidence around critical incident management and what has worked and what has not worked so well and what needs to be done better in the future. Slowly a body of evidence is emerging that the way critical incidents have been handled in the past have been ineffective and indeed may even have paradoxical effects when it comes to the treatment of individuals following a critical incident.

Clearly there is much work to be done; educating practitioners, organisations and recipients of trauma services that perhaps traditional approaches to responding to disaster and critical incidents may cause more harm than good is a good first step and both a necessary and urgent requirement. The immediate next step is to adjust our organisation’s policies, processes and training to ensure we respond effectively to critical incidents when they occur, providing appropriate support while minimising risk.

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References & Further Reading


Psychological Services in Disasters: Australian Emergency Management Institute and Australasian Society for Traumatic Stress Studies
