

A Primer on Critical Incident Stress Management (CISM)

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As crises and disasters become epidemic, the need for effective crisis response capabilities becomes obvious. Crisis intervention programs are recommended and even mandated in a wide variety of community and occupational settings (Everly and Mitchell, 1997). Critical Incident Stress Management (CISM) represents a powerful, yet cost-effective approach to crisis response (Everly, Flannery, & Mitchell, in press; Flannery, 1998; Everly & Mitchell, 1997) which unfortunately is often misrepresented and misunderstood.

What is CISM? CISM is a comprehensive, integrative, multicomponent crisis intervention system. CISM is considered comprehensive because it consists of multiple crisis intervention components, which functionally span the entire temporal spectrum of a crisis. CISM interventions range from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. CISM is also considered comprehensive in that it consists of interventions which may be applied to individuals, small functional groups, large groups, families, organizations, and even communities. The 7 core components of CISM are defined below.

1. Pre-crisis preparation. This includes stress management education, stress resistance, and crisis mitigation training for both individuals and organizations.
2. Disaster or large-scale incident, as well as, school and community support programs including demobilizations, informational briefings, "town meetings" and staff advisement
3. Defusing. This is a 3-phase, structured small group discussion provided within hours of a crisis for purposes of assessment, triaging, and acute symptom mitigation.
4. Critical Incident Stress Debriefing (CISD) refers to the "Mitchell model" (Mitchell and Everly, 1996) 7-phase, structured group discussion, usually provided 1 to 10 days post crisis, and designed to mitigate acute symptoms, assess the need for follow-up, and if possible provide a sense of post-crisis psychological closure.
5. One-on-one crisis intervention/counseling or psychological support throughout the full range of the crisis spectrum.
6. Family crisis intervention, as well as, organizational consultation.
7. Follow-up and referral mechanisms for assessment and treatment, if neces

As one would never attempt to play a round of golf with only one golf club, one would not attempt the complex task of intervention within a crisis or disaster with only one crisis

intervention technology.

As crisis intervention, generically, and CISM, specifically, represent a subspecialty within behavioral health, one should not attempt application without adequate and specific training. CISM is not psychotherapy, nor a substitute for psychotherapy. CISM is a form of psychological "first aid."

As noted earlier, CISM represents an integrated multicomponent crisis intervention system. This systems approach underscores the importance of using multiple interventions combined in such a manner as to yield maximum impact to achieve the goal of crisis stabilization and symptom mitigation. Although in evidence since 1983 (Mitchell, 1983), this concept is commonly misunderstood as evidenced by a recent article by Snelgrove (1998) who argues that the CISD group intervention should not be a stand alone intervention. This point has, frankly, never been in contention. The CISD intervention has always been conceived of as one component within a larger functional intervention framework. Admittedly, some of the confusion surrounding this point was engendered by virtue of the fact that in the earlier expositions, the term CISD was used to denote the generic and overarching umbrella program/ system, while the term "formal CISD" was used to denote the specific 7-phase group discussion process. The term CISM was later used to replace the generic CISD and serve as the overarching umbrella program/ system, as noted in Table 1 (see Everly and Mitchell, 1997).

The effectiveness of CISM programs has been empirically validated through thoughtful qualitative analyses, as well as through controlled investigations, and even meta-analyses (Everly, Boyle, & Lating, in press; Flannery, 1998; Everly & Mitchell, 1997; Everly & Boyle, 1997; Mitchell & Everly, in press; Everly, Flannery, & Mitchell, in press; Dyregrov, 1997), unfortunately, this is a fact often overlooked (e.g. see Snelgrove, 1998).

Similarly, there is a misconception that evidence exists to suggest that CISD/ CISM has proven harmful to its recipients (e.g. see Snelgrove, 1998), this is a misrepresentation of the extant data. There is no extant evidence to argue that the "Mitchell model" CISD, or the CISM system, has proven harmful! The investigations that are frequently cited to suggest such an adverse effect simply did not use the CISD or CISM system as prescribed, a fact that is too often ignored (e.g. see Snelgrove, 1998).

In sum, no one CISM intervention is designed to stand alone, not even the widely used CISD. Efforts to implement and evaluate CISM must be programmatic, not unidimensional (Mitchell & Everly, in press). While the CISM approach to crisis intervention is continuing to evolve, as should any worthwhile endeavor, current investigations have clearly demonstrated its value as a tool to reduce human suffering. Future research should focus upon ways in which the CISM process can be made even more effective to those in crisis.

While the roots of CISM can be found in the emergency services professions dating back to the late 1970s, CISM is now becoming a "standard of care" in many schools, communities, and organizations well outside the field of emergency services (Everly & Mitchell, 1997).

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