

# *Journal of* **Employee Assistance**

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## **The Evolution of Psychological First Aid**

by

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*Evidence-based practice guidance underscores the value of prompt and practical workplace response to critical incidents, but increasingly there is compelling evidence that traditional approaches must be reconsidered.*

Evidence-based practice has become increasingly important in all aspects of medical care, including behavioral health. Interventions designed to address psychological trauma, especially preventative interventions of the type typically used in workplaces, have received particular scrutiny as the mobilization of mental health resources in response to disasters and terrorist incidents has gained strong momentum.

There is a clear consensus that the mental health impacts of such incidents can be significant and warrant systematic response efforts, but some widely practiced and promoted approaches—most specifically, debriefing and related techniques—have proven, in a growing range of controlled studies, to be ineffective in preventing post-traumatic stress disorder (PTSD) or depression, and a few well-controlled studies have reported adverse outcomes from using these approaches with some traumatized persons (see, for example, Rose et al. 2004 or van Emmerik et al. 2002, for detailed meta-analyses of relevant studies; see also McNally, Bryant, and Ehlers 2003 for an exhaustive review of the issues and arguments). The weight of the evidence has become overwhelming, as bodies ranging from the World Health Organization (2005) to the British National Institute for Clinical Excellence (2005) have issued guidelines that expressly contraindicate exclusive over-reliance upon the continued use of interventions styled after debriefing.

This does not, even remotely, preclude EAP assistance to client organizations following workplace events. Current evidence and best practice emphasize strongly the importance of practical, palliative assistance in the crisis phase and of competent, efficient, and efficacious early screening of those exposed, even where traditional counseling or debriefing services may not be needed or desired (cf. Rubin et al. 2005). The importance of evidence-based treatment for those whose exposure will result in clinically significant impairment over time is also widely accepted (Litz et al. 2002).

But it is the perception of support and responsiveness, regardless of the particular intervention offered, that likely plays the most central role in the reports of help that employees and employers consistently indicate they receive from their involvement in critical incident response interventions (Deville and Cotton 2003; McNally, Bryant, and

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Ehlers 2003). Organizational recovery is further facilitated when leadership is positioned, equipped, and supported as competent and compassionate. When this occurs, the organization and its workers experience the desired business and personal objectives of regaining work-life equilibrium. Workers return to a high level of productivity more frequently and more quickly.

The onus that emerging research findings and practice guidelines place upon our profession is not to abandon our efforts but to relinquish our ties to the familiar and the convenient while diligently pursuing the integration of evidence-based best practices into our programs. We can no longer count on a single system to cover all our needs, get the training we need from a single conference, or remain current just by reading trade magazines or proprietary publications. We must instead find ways to keep abreast of the entire breadth and depth of research that affects our practice and profession.

## **Reshaping Our Repertoire**

Our most difficult hurdle may arise in repositioning our understanding of what we want to do and what we regard as success. We must revisit who we serve as clients—in most crisis planning and response projects, our clients are organizations rather than individuals. Our customary clinical goals may, therefore, be less pertinent, especially during immediate crisis response.

We need to explore with our organizational clients what they seek as a result of our work on their behalf, helping them define clear outcomes so we can select the most pertinent approaches and clearly calibrate their impact. We need to embrace a more focused and perhaps more circumspect collaborative role in the organization's overall crisis preparedness and response efforts, realizing that our influence in human resources matters has grown and expanded. And we need to learn to act as partners with other "players" and realize that we have much to learn about how they operate in order to be valued as guests in their particular settings.

Acquiring the ever-evolving cache of trauma response skills and expertise that best practice demands requires a great deal of time, attention, and specialization. Responsible organizations and the EAPs that serve them increasingly are looking to established specialty partnerships, both to maximize their capacity to respond immediately with the latest in evidence-based practice and to ensure that their planning, response, and follow-through always reflect the best current information and techniques.

Psychological first aid (PFA), the approach currently advocated by most authoritative guidelines, is more a concept than a particular technique. Effective PFA practice requires not only developing competence in a range of evidence-informed exercises and interventions but, even more, nurturing a professional capacity to assess situations, select and tailor appropriate approaches, facilitate partnerships, and promote resilience (Young 2006). Screening efforts must employ well-tested and validated instruments and lead to competent assessment and treatment for those in need (cf. Rona, Hyams, and Wessely 2005).

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*Note:* Treatment approaches with a strong evidence base generally are variants of cognitive behavior therapy (CBT) and require specific skills that many EA professionals may not possess (cf. Gist 2002; NICE 2005). Longer-term consultative and facilitative assistance to organizations, both in planning and in response, also require specific knowledge and skill sets that practitioners in this specialty must acquire if they are to obtain and maintain competence.

There is no organization or vendor that “owns” these models or the training related to them, nor would one expect or desire one to emerge. These approaches have no proprietary advocacy groups arguing that any one branded technique be treated as sacrosanct. There are, however, organized efforts to make evidence-based information, skills, and materials widely available to practitioners so they can develop the capacity to implement best-practice approaches. Our objective as EA professionals should be to reshape our repertoire as new information becomes available and adopt techniques and approaches that show solid empirical evidence of their efficacy in achieving the goals our clients seek.

Last year, the National Child Traumatic Stress Network (NCTSN) and the Substance Abuse and Mental Health Services Administration (SAMHSA) convened a panel of early-intervention experts to compile and evaluate a manual for evidence-informed PFA (Brymer et al. 2005). The manual is available online, along with samples of handouts, exercises, and training materials, at <http://www.ncptsd.va.gov/pfa/PFA.html>. Another resource, the Trauma Screening Questionnaire (Brewin et al. 2003), provides a well validated, easily administered and scored, 10-item screen for post-traumatic stress disorder that can be conducted within three weeks of exposure to identify those in need of further evaluation. The questionnaire can be combined with brief screening instruments for depression such as the WHO-5 (Henkel et al. 2002) to yield a screening protocol easily employed in primary care settings, assistance centers, or even through self administration (see Brewin 2005 for a more complete overview of PTSD screening instruments; see Bech et al. 2003 for information on the application of WHO-5 for a more general evaluation of recent well-being).

Trauma-focused cognitive behavior therapy (TF-CBT) is the most widely endorsed approach for early and effective treatment of PTSD; CBT is also among the best-researched and most widely endorsed treatments for depression (see, for example, NICE 2005). A short cycle (5 to 12 sessions) of TF-CBT, begun about 5 to 6 weeks after exposure—about the time that the Trauma Screening Questionnaire becomes effective—has been shown empirically to be effective in the early treatment of PTSD.

But despite widespread acceptance of its efficacy, TF-CBT has not been widely practiced by EA professionals. This may simply reflect the fact that TF-CBT training can be both costly and intensive. The National Crime Victims Research and Treatment Center at the Medical University of South Carolina has developed, with the support of NCTSN and SAMHSA, a pilot of an online “crash course” in TF-CBT training (available at <http://tfcbt.musc.edu>). While not intended to be

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a substitute for complete training (and especially not for supervised clinical practice in this relatively complex intervention set), it gives the journeyman provider a solid overview of the nature and application of this intervention. Evidence-informed approaches for ongoing support of those affected by disaster, terrorism, and other crisis events are also being catalogued (examples can be found in Ritchie et al. 2006).

## **Moving Beyond the Familiar**

Taken together, these components provide a staged model for evidence-based best practices in workplace crisis response (see Figure 1). While all require learning new techniques and intervention approaches, none represent “branded” or proprietary intervention products.

Competent practice in contemporary trauma response demands that we move beyond our familiar training and become well grounded in these and other practices in this increasingly complex area of specialization. Indeed, addressing the needs of contemporary EAP clients for services that integrate human resource factors into the full range of corporate contingency planning, risk management, and business continuity and recovery measures will require conversance and capabilities that fall increasingly outside the training most EA professionals bring to their positions.

Both EAPs and their specialty partners must embrace these new demands if we are to serve our clients effectively. There is much we must learn, and many ideas and interventions must ultimately change, but the reward comes in our expanded capability to provide extended services with greatly broadened impact.

Most importantly, however, by embracing the demands of evidence-based crisis response, we contribute to the advancement of our profession and our practice. If we choose instead to cling to the familiar, we risk standing static while advancing

information and expectations lead our clients to look elsewhere for new approaches to meet their rapidly changing needs. Our efforts here will not only improve our critical incident response but also help enhance every aspect of our service delivery.

Our moral, ethical, and professional interests all converge around one clear invective: We are committed to bringing our clients the best assistance we can muster, maximizing benefit to them while minimizing the risk that even the best interventions inevitably bring to at least some. We cannot accomplish that if we are not open to change and mindful of evidence.

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