International Critical Incident Stress Foundation, Inc.
HELPING SAVE THE HEROES

CISM VERSUS PEER SUPPORT

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The turf battle between CISM and peer support has gained considerable traction over the last few years, at least in terms of the first responder community's use of crisis management services. In a perfect world, the best fit is for these two models to complement one another, but it appears that the listening ears for this premise have disappeared. The reasons for disfavor falling upon all things CISM remains elusive at this point in time, though it does appear to stem from outside than the mental health community in more recent times. Seemingly, this derailment is falling square on the shoulders of the first responder community.

In the face of overwhelming and devastating critical incidents that disrupt the first responder's ability to obtain some degree of control when their worlds spin out of it, CISM may be the most likely and beneficial choice, as the process is conducted by trained and certified team members who have been fully vetted to conduct this process. This is in order to facilitate returning to full functioning on the job and a greater degree of psychological stability. Critical incidents are sudden, unexpected, and disruptive traumatic events that exceed the realm of ordinary human experiences, even for first responders. CISM enables first responders in crisis to stabilize sufficiently to be able to return to duty when events overwhelm effective coping abilities, as this applies to both individuals and groups. "CISM gets the first responders' feet back on the ground, the brain back into gear. Peer support gets the person better." (Dorie, 2022).

Other than the fact that both CISM and peer support utilize peers, this is the culmination of any similarities between these two interventions. The good news is that these interventions can readily augment one another.

The bottom line is that creating an ethos of compassionate caring for one another as a means of affirming one's value and worth is an invaluable component of wellness, but too often absent within the first responder culture. These are investments in promoting resiliency and more importantly, in people. (Dorie, 2021, 2022).

With respect to peer support, a critical incident does not have to have occurred in order for peer support teams to be activated. Peer support involves face to face emotional support, stress reduction, the provision of clarity and awareness of underlying issues, improvement of decision-making and problem-solving abilities, and the de-escalation of conflicts that may arise on the job. The underlying premises of peer support involve the provision of compassionate support for those struggling, regardless of the issues at hand, as the process works to diminish the experience of alarm and distress that accompany high levels of stress reactivity. More specifically, peer support should be employed as a means of reducing the stress inherent in daily problems and issues pertaining to relationships, work-related problems, and mental health challenges, as well as the clarification and identification of thoughts, feelings, behaviors, and belief systems that result in conflicts and poor decision making, both at home and on the job. These are considered supportive interventions, typically in-house, that call upon trained peers to provide support, hope, and compassionate care for first responders facing overwhelming life, personal, marital and work-related difficulties, as well as obstacles that exceed their ability to manage them effectively.

Peer support providers must be trained and vetted as mentors or peer coaches (Dorie, 2021, 2022). Peer support must be proactive in terms of promoting wellness and resiliency. Although it is beyond the scope of this article, there are concerns that peer support personnel who are not licensed mental health professionals, often trained solely by local, regional, and national training bodies, may not be adequately trained or supervised to offer evidence-based practices or trauma-responsive techniques as touted by some peer support networks. This constitutes treading on dangerous territory and is very clearly outside the realm of what any peer support team should offer those in need, regardless of the degree of training and experience among non-mental health professionals. By observation and the reports of several members of the SWOCISM team, as well as first responders in the local community, serious concerns have been expressed regarding exposure of peer support teams to any level of scrutiny or standards of care by certification and supervision.

My personal experiences have been that peer support sometimes consists of no more than a brief "how are you doing check-in" and little more in the way of interactions than a yes or no response. Very recently, I was informed by a member of a peer support team for one of our larger local departments that members of the team have little, if any, peer support training whatsoever. He was not sure that any team members carried any type of certification. There is no guarantee of confidentiality. Though based upon the experiences of local CISM team and the personal reports of first responders impacted by less than acceptable peer support practices, there is every reason to suspect that this has become a relatively widespread practice and a tremendous disservice to first responders in need of what exceeds such improper, untested, unreliable, and risky practices.

It is strongly recommended that in the aftermath of such traumatic events as line of duty deaths, suicides of a colleagues, mass casualties, mass shootings, the death of a child or significant events impacting children, serious work-related injuries, victims(s) being known to agency personnel, or prolonged critical incidents resulting in negative outcomes, CISM teams should be activated (Dorie 2021). This short-term form of crisis response applies extremely well to agencies exposed to frequent critical incidents, especially when first responders/employees are inundated with emotions that interfere with their ability to perform their duties and responsibilities. Far too often, cumulative trauma results in the onset of longstanding and lifelong psychological injuries, particularly when silence remains unbroken and allowed to fester for days, weeks, months and sadly, for lifetimes (Hogeland, 2017).

In recent months within the Southwest Ohio locale, a tragic active shooter incident occurred inside a large factory setting. The SWOCISM Team was alerted and remained on standby to provide defusings and debriefings to personnel on all three shifts. In lieu of this, management made the decision to offer only EAP services, leaving employees in crisis and untreated, as many of the promised services were never materialized, leaving employees fearing for their lives as they were forced to return to work with all of its traumatic reminders of that fateful day. Several employees resigned shortly thereafter.

Following the Oregon District Mass Shooting in Dayton, Ohio in the early morning hours of 4 August 2019, the second author of this article and another member of the Southwest Ohio CISM Team (much credit is given to former firefighter/paramedic Lee Jean Heller for her involvement) were notified of the need for immediate services by the command staff of the Dayton Police Department. Defusings for the 6 Dayton police officers who engaged the shooter were provided within 3 hours of the event, followed by several hours of defusings for every police officer, firefighter, and paramedic who were on scene during this massacre, in which 9 innocent people lost their lives, with multiple innocent civilians injured. Unfortunately, many of those who were on scene were never notified of the provision of this service and simply could not be “captured” by their command staffs in the ensuing chaos surrounding this tragic event. During the subsequent weeks, debriefing services were offered by the SWOCISM Team, but none were ever requested. The widespread and damaging impact of this decision continues almost 4 years into the aftermath of this horrifically tragic event. As the psychologist tasked with coverage of 40 police departments and 7 fire departments, I have seen escalating numbers of both self-and department referred first responders, rampant PTSD in the aftermath of critical incidents in far too many cases, and in the resignation of a small number of police officers who were never able to successfully transition back to duty. Furthermore, peer support, per the reports of a significant number of police officers, was completely insufficient in resolution of the psychological crises precipitated by this event. Nevertheless, the peer support model reigns supreme for many of these departments. Suffice it to say that had a full complement of both CISM and peer support services been offered, many of these first responders likely would not have been directly or self-referred for psychological services. It is also my experience that some of those charged with the decision-making concerning the provision of crisis intervention services may be poorly educated regarding the limitations and benefits of both CISM and peer support services.

As a retired US Army psychologist and the former Chief Psychologist for the US Army Reserve, I am acutely aware of the unequivocal necessity and infinite value of CISM in the wartime

theater. Deployed 4 times in support of Operation Desert Storm, Operation Iraqi Freedom, and Operation Enduring Freedom (JTF-GTMO and Afghanistan) and on Combat Stress Control Teams for 3 of these deployments, our primary mission was to provide all level of combat stress control and psychological services to deployed troops for all branches of the Armed Forces and Department of Defense contractors. This required mobilization of mental health assets far into the battlefield whenever called upon and whenever transportation by convoy or Blackhawk helicopter were available. CISM provided for the wellbeing of thousands of military personnel, often under fire and under the most unimaginable hardships and adverse conditions. The effectiveness of these interventions was proven countless times over, more often than not making it feasible for Combat Stress Control personnel to become embedded in combat arms units for a considerable number of additional mental health services to be requested and provided for the duration of CSC deployments, as tremendous trust and rapport developed as a direct result of the debriefing process.

Battle-tested, it seems safe to say that this holds true for the first responder community as well. CISM and peer support really can co-exist peacefully. The truth is that peer support is a distinct element of the entire CISM package of interventions. It is upon us to assess each situation as to which interventions have the best goodness of fit, based upon the circumstances of each critical incident. The onus is upon us in both the mental health and first responder communities to assure that this comes to pass for the wellbeing of those who place their lives on the line for the rest of us.

References

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