

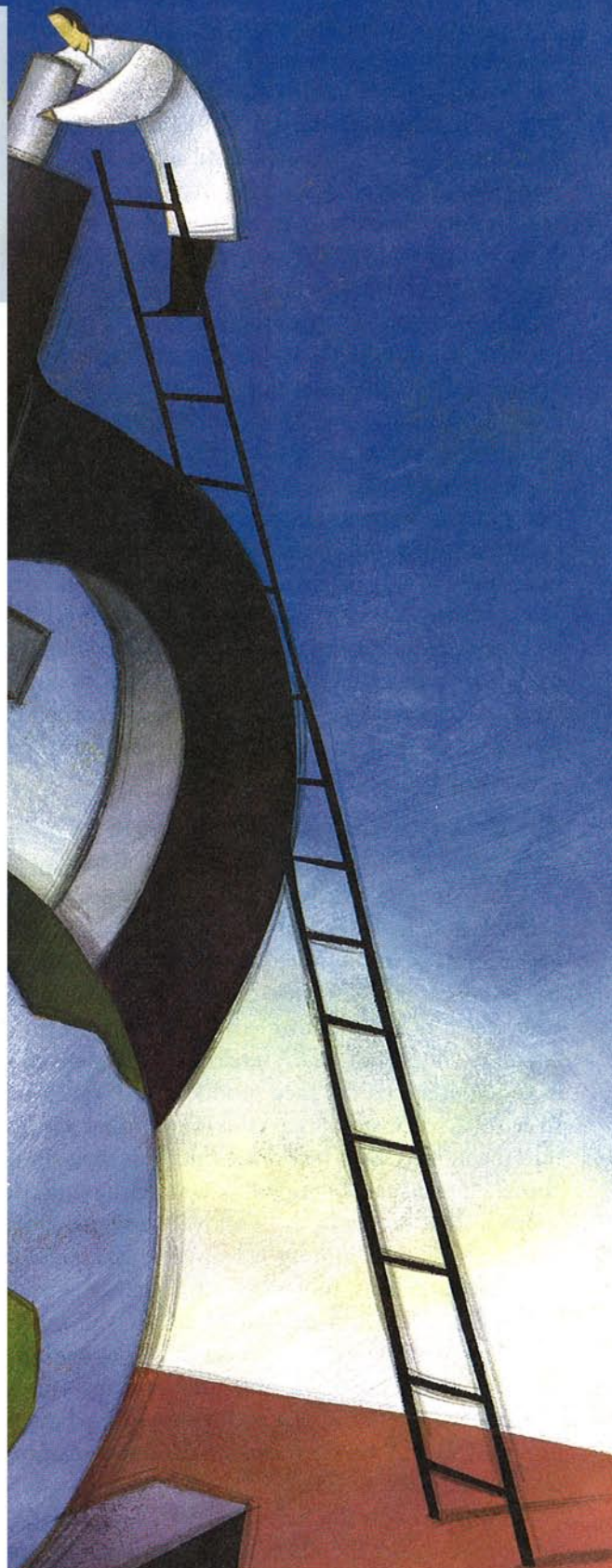
Evidence-Based Practice in EAP

By David A. Sharar

The State of Evidence-Based Practice in EAP

The concept of evidence-based practice, or the notion that the highest quality practice should be based on the best available research, is rapidly becoming an important part of behavioral health and the social service landscape in general (Rosen, 2003), although its influence does not appear to be spreading in the EA field. There are likely extraordinary variations in EA clinical practice patterns, and research findings frequently do not translate into actual practice. Large minorities of EAP practitioners appear to be basing their assessment and intervention practice primarily on practice wisdom, intuition, and experience, rather than on research evidence. The clinical aspects of the EA field, as commonly delivered through a dispersed network of affiliates, likely has practitioners using clinical techniques now known to be ineffective, or the painfully slow adoption of new clinical techniques with known effectiveness. If EA practitioners do not routinely incorporate recent research in their practice, then the field needs to adopt a strategy to bridge this research/practice gap in order to improve efficacy and outcomes.

The EA field is on shaky ground if we act as though the principles of evidence-based practice do not apply to EAP. It is surely in the interests of our constituents (e.g., employers and individual clients) to have better, more evidence-based information to guide our clinical and professional judgments. The critical questions are how to cultivate an evidence-based field, how to procure the applicable evidence, how to decide what constitutes evidence, and how to change the way EA practitioners make decisions. The predominant delivery model of using a dispersed network of subcontracted EAP clinicians makes educating these providers and influencing their practice patterns very difficult. In terms of the clinical aspects of EA work, quality is ultimately the product of client-provider interactions, so focusing on an EA vendor's ability to influence practices at the affiliate level is critical.



We simply cannot view the creating and consumption of research as a nuisance or inconvenience rather than a critical driver of quality improvement. To drive this point further, consider a recent review of published EAP evaluation studies during the 1990s (Csiernik, 2004). Csiernik found 39 studies: four examining needs assessments, 12 case studies, five client-satisfaction studies, nine cost-benefit analyses, and nine process evaluations. Csiernik concluded that over one-third of these studies were descriptive in nature and most of the others “would not withstand the scrutiny of an undergraduate research methods course.”

Csiernik goes on to say that EAP is “a field with great promise and much talk but at best negligible support both academically and organizationally for research.” (p. 32) The EAP field simply has not produced research on a level commensurate with its involvement in providing services to the American workforce. It is also clear that merely publishing and disseminating empirically supported interventions does not usually lead to their use in practice (Addis, 2002; Proctor and Rosen, 2003). There is currently only one peer-reviewed journal focused on EAP related issues, *The Journal of Workplace Behavioral Health* (formerly the *Employee Assistance Quarterly*), and there is a clear need for larger numbers of authors who have conducted EAP effectiveness to share research that is all too often deemed proprietary or confidential to particular organizations.

CISD: A Controversial Example of Evidenced-Based Practice in EAP

One concrete example of the prevalence of a popular intervention in EAP that seems to be based on clinical experience and intuition rather than research evidence is the use of critical incident stress debriefing (CISD) services as a component of a critical incident stress management (CISM) response. The majority of EA vendors and programs offer CISM as an important part of their product line. CISD is a specific, structured, seven-step group crisis intervention process within the “menu” of CISM services. Critical incidents in the EAP context are usually defined as a sudden, unanticipated situation that occurs in the workplace and produces a high degree of distress among employees. Examples include workplace accidents, robberies, homicides, suicides, assaults, terrorist attacks, and natural disasters. Varying types of responses may be utilized by an EAP, depending on the intensity of the event and the culture of the organization, although a group CISD is a commonly-utilized intervention provided by EA vendors and practitioners in response to workplace incidents.

CISD, as originally developed by Mitchell (1983), was intended to reduce the effects of trauma for emergency service personnel. The CISD model assumes that exposure to trauma is a precursor to the development of psychosocial symptoms, and that proximal intervention is necessary to prevent the

development of these symptoms. The intervention is based on the premise that group disclosure among affected individuals produces beneficial results (Mitchell, 1988). Activities include normalizing feelings, encouraging discussion by reviewing facts of the incident, surfacing thoughts and feelings, supporting an individual’s coping mechanisms to relieve anxiety, and identifying employees with severe reactions (Mitchell, 1988). The group intervention is supposed to be conducted by trained mental health providers and uses the assistance of a trained peer, when available (Mitchell, 1988). Attendance by affected employees is sometimes mandatory and usually strongly encouraged, and election to discontinue the CISD is discouraged. One important part of the process is the “teaching” phase where group facilitators provide education regarding symptoms the affected group may develop in the coming days and weeks following the incident.

A meta-analysis of seven recent clinical trials of CISD interventions published in *The Lancet* by van Emmerik (2002) found that individuals who received non-CISD interventions as well as individuals who received no intervention showed improvement at follow-up while individuals who received CISD showed no improvement. Additional efficacy research on CISD conducted by Gist, Lubin, and Redburn (1998), Mayou, Ehlers, and Hobbs (2000), and numerous other peer-reviewed studies showed no evidence of superior resolution for debriefed employees versus those who declined; no significant impact on employees at two and three years post-incident; a statistically significant trend toward worsening in resolution indices for those accepting CISD; and a clear preference for informal sources of support and coping that correlated with effective resolution. Most telling, in the Mayou, Ehlers, and Hobbs study (2000), those who had high levels of intrusion symptoms and received the CISD fared worse than those with high levels of intrusion symptoms who did not receive the CISD. Perhaps learning what symptoms to expect in the teaching phase leads to an increase in self-directed focus that may, in theory, cause more of those symptoms to occur. These scientific studies have resulted in numerous calls for caution and restraint in the use of CISD. Despite these calls, the debate within the EAP field was minimal and the promotion of CISD as an important EAP intervention seems to continue with little diminution, largely due to the popularity and intuitive appeal of CISD as a way for EAPs to be visible and helpful during times of crisis for an organization. According to Gist (2002), the problem is compounded in practice where the enterprise of debriefing is “dominated by a prolific subculture of secondary providers whose understanding of these highly complex issues is limited to proprietary workshops and magazines rather than empirically guided professional practice” (741). In a related article, Gist goes on to say, “The jury has returned the verdict on efficacy [of CISD]. The trial is over. And the question of efficacy is pretty much settled for everyone but the CISD

intervention marketers” (Deville and Cotton, 2004).

Crisis Care Network (CCN), the largest provider of critical incident response services in the US, acknowledges in a White Paper on best practices in critical incident response for EAPs that “some of the specific intervention approaches we’ve traditionally employed [most specifically CISD] have fared less than well in controlled scientific investigations. That means we have to rethink our approaches and adapt them to reflect emerging evidence” (www.crisiscare.com). Rather than trying to justify and maintain the current status of CISD, CCN is moving toward “psychological first aid” and other promising evidenced-based approaches that respects the privacy and natural resiliency of affected employees.

Naturally, Mitchell (2004) and other proponents of CISD have responded to the evidence against the use of CISD with their own concerns (see www.icisf.org):

The term “CISD” is confused and intermingled with the term “CISM,” and CISD is only one component of a comprehensive CISM response. The negative outcome studies represent a “hodgepodge of different types of interventions which do not equate to an actual CISD” (Mitchell, 2004).

Many of these studies misattribute poor outcome to the CISD rather than “injury severity” at intake. This could be a design flaw in the methods of the clinical trials on CISDs.

Other evaluation methods beside randomized clinical trials need to be examined and included before allegations of harm (in the use of CISD) are made.

CISD should be evaluated within the context of CISM, as CISD may serve to increase acceptability of subsequent interventions provided in a CISM response.

CISD is commonly promoted and accepted as a strong message that management cares about the well-being of employees. Even though outcomes on

specific symptoms may be poor, the therapeutic context has some positive effect since most participants report the CISD was helpful (Carlier, 2000). (Note: This may be due to feelings of gratitude for EAP staff rather than actual clinical efficacy).

Contrasting Viewpoints of Evidenced-Based Practice

CISD is only one example of the problem of using evidenced-based practice in EAP, and the difficulty of deciding what constitutes evidenced-based practice. The continued use of “pseudoscientific” intervention extends beyond EAP and is embedded in the broader field of behavioral health and the social service professions (Proctor, 2003; Rosen, 2003). Despite growing recognition of the need and appropriateness for evidenced-based practice in behavioral health intervention, researchers continue to place the burden of utilization on practitioners (Rosen, 2003), contributing to a type of alienation between researchers and practitioners. Researchers should not underestimate the challenges faced by the practitioner, who is trying to apply generalizations from research to unique clinical presentations. This includes EA practitioners attempting to provide assistance and support following a workplace disaster.

The question of how to define and utilize evidenced-based practice seems to be a controversial one with two contrasting positions. The first position, offered by some observers, such as Persons (2003), argues that practitioners are routinely called upon to help clients make decisions about alternative treatments, and that randomized clinical trials (and some quasi-experimental studies) are designed to specifically assist in these decisions. This type of positivist, quantitative research, Persons (2003) argues, is the gold standard of evidence, accepted by the scientific community and the lay public, and practitioners have an ethical

responsibility to use this type of research to guide their intervention choices. It can answer the question of, “what type of intervention is best for this type of problem or disorder?” For example, would a cognitive-behavioral intervention, coupled with a referral for pharmacotherapy, be the treatment of choice for a major depressive episode for this client? Should an EAP clinician working with a bulimic client make a referral to a practitioner who is insight-oriented and psychodynamic? Under what specific circumstances should CISD be used (if ever) as a component of a CISM response? Persons (2003) argues that clinical trials can help answer these questions about types of interventions, and practitioners have a responsibility to inform clients about the findings of research that are relevant to their condition before selecting an intervention or treatment plan. In the example of CISD, the evidence from clinical trials (using experimental and quasi-experimental designs) indicates a finding of *caveat emptor* (buyer beware) and perhaps even *caveat venditor* (seller beware) (Deville and Cotton, 2004).

The second contrasting position believes the use of positivist, quantitative research to inform practice is mechanistic, dehumanizing, and insensitive to personal and cultural diversity (Rosen, 2003). Tyson (1995), in an extreme view, even implies that the use of positivistic, quantitative research in clinical practice is tantamount to the relinquishing and subordination of counseling and social work values. Silberschatz (2003), holding a more moderate but related view, believes that positivist, experimental studies are valuable, but they fail to meet practitioner needs for several practical reasons: First, experimental research provides information about average cases, not specific, unique cases seen in practice. Second, protocols used in research guide the treatment of single conditions, whereas most clients have multiple, co-

occurring problems. Third, even when clients seek help for single conditions, the protocols in research provide practitioners with little assistance in overcoming obstacles, such as noncompliance and practitioner-client relationship issues.

It is admittedly difficult to adapt research findings and protocols for an “average” client to fit the needs of a “particular” client in a practitioner’s office. Silberschatz (2003) states that what needs to be specified and replicated is not a “brand-name intervention with a strict treatment manual” but identifiable processes of client change and practitioner behaviors that bring these changes about. Quantitative research in behavioral health and the helping professions, from a practitioner point of view, commonly lacks both external and ecological validity (since the method must assure that differences between two groups are attributable only to the intervention). Controlled studies use “participants,” not “clients,” and participants differ markedly from actual clients. In the case example of CISD, following something as complicated as a workplace disaster or major incident, isolating variables and assessing their effects in a controlled environment is an extremely complex endeavor. Other methodologies besides clinical trials, such as qualitative inquiry, have the potential to shed light on the CISD question.

Despite the sharp differences between these two positions on how to define and utilize evidenced-based practice, there seems to be a mounting need in EAP in publishing the results of single-case studies and naturalistic studies, and these methods (and paradigms) should also inform and influence evidence-based practice. The EA field acutely needs studies that measure outcomes valued by purchasers, and translate outcomes into cost-related measures. However, the EAP field, for obvious reasons, badly needs a large-scale, multisite, rigorous study using a strong mixed method design that has general application to a broad workforce. This type of study should compare the effectiveness of various types of EAP models and CISM approaches. The more difficult challenge (both within the EAP field and the broader helping professions such as social work, counseling, and psychology) is how to help practitioners cope with the dilemma of applying research findings to individual cases.

The Future

The future of EAP is less sustainable without a stronger research base, particularly as employers (and their consultants) focus more on data and metrics to guide decisions about resource allocation. EAP sorely needs critical review articles that pull together the multiple single case studies around practice-relevant topics. Even though EAP associations hold international, national, and regional meetings, far too few sessions at these meetings include research-based findings and implications for practice. The new *Journal of Workplace Behavioral Health* (published by Haworth) is an opportunity

for EAP scientist-practitioners, researchers, association leaders, and consultants to advance the applied use of evidence in EA practice. ■

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