Critical Incident Stress Debriefings for Cross-Cultural Workers: Harmful or Helpful?

By Karen F. Carr

What is Critical Incident Stress Debriefing (CISD)?

Most commonly this term is associated with the Mitchell model (Mitchell, 1983). This is a formal, structured process led by trained facilitators (not exclusively mental health professionals) that occurs soon after a potentially traumatizing event. The CISD process involves telling the traumatic story, exploring the thoughts and sensory experiences during the trauma, sharing emotional reactions, teaching common reactions of trauma, and coaching in coping skills. The purpose of CISD is "to prevent unnecessary after effects, accelerate normal recovery, stimulate group cohesion, normalize reactions, stimulate emotional ventilation, and promote a cognitive grip on the situation" (Dyregrov, 1997). It is not therapy. It is one method of crisis support that is intended to be part of a more comprehensive critical incident stress management program. This model allows for peer debriefing programs such that a fire fighter might help to debrief his fellow fire fighters, for example. With specialized training, peer helpers can provide immediate, on site care and make referrals to mental health professionals when there are signs of pathological responses to trauma.

The criticism of Critical Incident Stress Debriefings

"The results of (research) indicate that one-time psychological debriefing for individuals following traumatic events does not prevent the development of later psychological (problems), but it is a well-received intervention for most people. It would be premature to conclude that psychological debriefing should be discontinued as a possible intervention following trauma, but there is an urgent need for (good research)." (Bisson, et. al., 2000)

"Although psychological debriefing represents the most common form of early intervention for recently traumatized people, there is little evidence supporting its continued use with individuals who experience severe trauma….It appears that there is sufficient evidence to recommend that psychological debriefing not be provided to individuals immediately after trauma…. There is consensus, however, that providing comfort, information, support, and meeting people's immediate practical and emotional needs play useful roles in one's immediate coping with a highly stressful event." (Litz, et.al., 2002)

"There is no current evidence that psychological debriefing is a useful treatment for the prevention of post-traumatic stress disorder after traumatic incidents. Compulsory debriefing of victims of trauma should cease." (Rose, et al., 2003)

These are strong words spoken by respected psychologists and they cannot be ignored. However, it is tempting to dismiss these conclusions as being too strong, too broad or too premature. That's because there has not been a lot of research done on debriefing and the research that has been done has often been methodologically flawed. These flaws include debriefings being too short (20-60 minutes), debriefers being inadequately trained or experienced, and debriefings occurring too soon (Wessely, et.al., 2000). Inconsistencies have been found across the studies in method, trauma type, and recipients. Also, few of the studies include appropriate control groups.

Adler et al (2008) describes the reasons these studies have failed to sufficiently test the efficacy of CISD as follows: (a) They targeted primary victims of trauma, which is contrary to the guidelines for group debriefing; (b) they applied debriefings to individuals rather than groups of similarly exposed individuals; (c) they did not adhere to the procedures prescribed by CISD; (d) they failed to detail the content of the intervention or provide treatment validity data; (e) they focused on the impact on traumatic stress and neglected other arguably relevant clinical and organizational outcomes.

Mitchell and Everly have rebutted criticisms of CISD, citing research that has demonstrated positive effects of CISD. Everly and Boyle (2001) conducted a meta-analysis of five previously published studies and demonstrated a large effect size, supporting the argument that the CISD model is an effective tool of crisis intervention and mitigates symptoms of psychological distress. Jenkins (1996) found in a study that CISD was useful in reducing symptoms of acute depression and anxiety after a mass shooting. Wee (1995) found that emergency workers who participated in CISD following a civil disturbance had more rapid reductions in posttraumatic stress symptoms. Leeman-Conley (1990) described the development of a CISM program in a large banking system which included pre-crisis training, group debriefings following crises, and professional counseling when needed. She found that after the implementation of this program, sick leave was reduced by 60 percent and workers compensation claims were reduced by 68 percent. This has clear implications for organizations operating in high stress, high crisis areas.

One of the positive aspects of CISD is its sensitivity to and engagement in work cultures and its emphasis on peer processes. According to Litz (2008), CISD is very appealing to organizations because it is cogent, uncomplicated, involves many disciplines (i.e., clergy, peers), respects and honors work cultures, and instills confidence in management.

A well-designed study compared three groups of traumatized soldiers who received either CISD, Stress Education, or Surveys. They measured the impact on PTSD, Depression, Perceived Organizational Support, Aggression, and Alcohol Use. There were no adverse effects associated with any of the interventions. The CISD intervention was rated the most favorably by participants. Although there were slight improvements on these measures with some participants going through CISD, the overall effects were small. The conclusion was that there were no clear positive effects associated with CISD relative to no intervention, but there were not strong negative effects either. (Adler et al., 2008)

It is worthwhile to examine some of the themes in those studies which have led to the conclusion that CISD is not helpful and in some cases is harmful. In most of these studies, a group of people has been through a similar kind of trauma (e.g., a motor vehicle accident or a severe burn). Some are offered debriefing and others are not. Over time, they are assessed for their post-trauma symptoms, particularly things like post-traumatic stress disorder, depression, or other pathological symptoms. Research has found that the people who received debriefing have not had fewer post-traumatic stress disorder symptoms and in some instances they have had more symptoms than the ones who were not debriefed. This has led to the conclusion that debriefing is not effective and may be harmful in some situations.

Unfortunately the studies have not identified what elements of debriefing might actually be harmful or why some people end up with exacerbated symptoms and others do not. It also is not always clear how improvement is being assessed. Was improvement defined as a lack of anxiety, depression, or post-traumatic stress disorder symptoms? Over what period of time are these symptoms the same or worse than those who have not experienced debriefing? As a temporary state, are some of these symptoms in fact an indication of increased awareness and distress that may motivate them to greater health at a future point? It does not appear that other indices of successful trauma recovery such as quality of support system, spiritual growth and development, increased sense of meaning and purpose in life, or improved coping mechanisms have ever been assessed in connection with the benefits of a debriefing or other forms of crisis intervention following a traumatic incident. If debriefing is not effective or even harmful, why does it seem that a high percentage of those receiving it give a self-report that it was helpful? What are they referring to?

What are the implications for the provision of effective crisis intervention by leaders and peers in cross cultural settings when mental health professionals are not available most of the time? Let's take a closer look at what the research has shown and then I'll draw some conclusions and make some recommendations.

The research done so far has not convincingly demonstrated that critical incident stress debriefings are useful in preventing post-traumatic stress disorder or other pathological reactions to trauma. A question that remains unanswered is whether or not debriefing has beneficial effects that to date have not been measured. For example, is it possible that those who are debriefed at their place of service overseas following traumatic experiences are less likely to leave prematurely than those who are not debriefed? In one study (Lovell, 1999), 33 cross-cultural workers received a debriefing after returning from an overseas assignment. Eighty-two percent of these participants reported that they found the debriefing helpful or very helpful. The remaining participants described it as unnecessary but did not describe it as negative. More objectively, the Impact of Events Scale (Horowitz, et. al., 1979) scores showed significant differences between this group of cross-cultural workers who was debriefed as compared to 145 other cross-cultural workers who were not debriefed. The debriefed group showed a significantly lower level of unpleasant intrusive memories and lower levels of avoidance.

As more research is done, these things will become clearer. In the meantime, we have an ethical responsibility to make sure that we minimize the risk of any harm being done in the psychological debriefings offered.

What might cause CISD to be harmful?

Lack of choice

Some organizations have made CISD mandatory for members experiencing trauma. The rationale for this may be well-intentioned, believing that CISD is a helpful process that a person might not choose due to the stigma of "needing" help following a crisis. Particularly for some populations that have reputations of being "tough" like police officers, fire fighters, and cross-cultural workers, there is a face saving value in being told to go to a debriefing rather than admitting that you feel you need one. Some organizations have required CISD and received initial resistance to the requirement followed by expressions of gratitude once the CISD was completed. In other organizations where CISD is voluntary, some do not choose it and later express great regret that they had not been urged to do so. On the other hand, if a person feels forced to talk about something that they are not ready to talk about, this can be harmful and detrimental to them. Litz (2008) writes that "*CISD is inappropriate because it is a prescriptive approach… (because of) the lack of evidence to support its usefulness as a secondary prevention intervention (Adler et al, 2008), CISD is no longer prescribed by such organizations as the ISTSS and the interagency standing committee of the United Nations."*

Given that the evidence has not proven that CISD is beneficial according to the outcomes that have been measured, it does make sense that this intervention should be a person's choice rather than forced. The issue of declining the intervention and then later regretting it might be resolved by improving the process of educating people about what CISD is and is not and giving them multiple opportunities over a period of time. It will also be helpful if administrators and leaders are well informed as to the nature and potential benefits of CISD. Policy could be worded such that it is understood that debriefings are standard procedure rather than using coercive language such as "required" or "mandatory." This encourages and supports even the reluctant workers to attend a debriefing, while not forcing the issue for those who genuinely feel it is not in their best interest to attend.

Poor timing

The Mitchell model of CISD has called for interventions to be offered between 48 – 72 hours after the trauma. While this may be ideal timing for some, for others it may be too soon. "There is little data about intervention timing parameters and none that can assist planners and decision makers" (Litz, 2008). Factors such as fatigue, being overwhelmed, still having multiple logistical issues to handle, lack of safety, and ongoing practical support needs (i.e., finances, housing, children's needs) may all interfere with or impair the energy needed to emotionally and cognitively process the traumatic event.

Before a CISD is provided, the debriefer should assess the above factors and discuss with the victim as well as those who know him/her when the best timing for a CISD would be. This might mean 7-14 days or even longer after the event. When crises occur in an overseas setting, the handling of logistics may take much longer and this will need to be taken into account. In the case of a team which is evacuated from a war torn area, the timing of the debriefing is less important than making sure that everyone who should be there is able to attend.

Re-traumatization

An essential part of CISD has been helping the person to describe what happened to them and to go into details about their thoughts and emotions during the event. Adler et al (2008) found that CISD was not more distressing or arousing than the Stress Education intervention. However, some people may actually begin to relive the experience almost as if they were back in the trauma as they describe it. In the context of therapy, this can be a healthy and therapeutic process. But, in order for it to be healing, it has to be accompanied by other therapeutic interventions that bring a sense of safety and calm to the person. In the absence of trained mental health professionals and because CISD is not considered "therapy", it's possible that a person would enter into a very intense emotional state and that the structured debriefing would then end before they have had a chance to experience a sense of calm and safety. Abrupt termination of an emotional process would increase rather than decrease the person's anxiety and could actually lead to more problems. This would be especially true for people who have had past unresolved trauma, people who have anxiety disorders, and people who are experiencing very high levels of anxiety and arousal during or immediately following the traumatic event.

So, there are several important recommendations. One is that if the debriefer notices that a person seems particularly agitated or anxious before the CISD, it's very possible that they are not a good candidate for CISD at that time. It would be best to consult with a mental health professional before going any further. Secondly, if a person exhibits very intense emotions during the CISD and seems to be re-experiencing the event, the debriefer should do everything possible to instill a sense of safety, security, and calm before they leave. This is not done by cutting them off or ending the CISD prematurely, but rather gently guiding them back to the truths and facts that will help them feel grounded, safe, and secure. Finally, participants can be given the opportunity to discuss and make sense of their emotions but should not be pressured or pushed to vividly re-enter the memory.

Vicarious traumatization

This can occur when someone is exposed to a trauma by listening to a particularly horrible or graphic traumatic story that then triggers an emotional reaction that is very similar to the reactions of direct trauma victims. Let's say, for example, that a group of people has been robbed but several from the group directly witnessed a murder during the robbery. As the whole group is debriefed and telling their story, the few that saw the murder describe graphic details of how the person died. This is unnecessary information for the other victims,

particularly those who are more vulnerable and are already having difficulty processing the trauma they went through.

Additionally, children do not need to hear every detail of a trauma that has indirectly impacted them. They need to hear an understandable story that answers their questions, calms their fears, and assures them that they were not to blame. Parents should take care to protect their children from inappropriate adult conversation and excessive media coverage of events.

I recommend forming several groups and debriefing them separately according to the intensity of traumatic exposure. It would also be appropriate to set limits on the details of what is shared in the group setting but to be sure to give each person an individual opportunity later to share all the details they need to. This would need to be done sensitively and without shaming or shutting down the person who may be sharing the details. The risk of vicarious traumatization is also high for the debriefers and they will need to work through their own emotional reactions to the stories they have heard.

Superficiality

CISD has had such popularity that some have been tempted to think of it as a "cure-all" for trauma. Therefore, a danger for debriefers or for trauma victims would be to assume that a CISD has adequately addressed all of the traumatic reactions such that a person does not need follow up care. CISD needs to be seen as one response in a series of responses with each individual potentially requiring a different range of responses. The level and intensity of intervention needed will depend on things like the severity and intensity of the trauma as well as the victim's history, personality, and support system. Some will do fine with no debriefing, some will benefit from a debriefing only, some will need sensitive, trained peers as companions for a time, and others will need more specialized therapy in order to recover from the traumatic experience. CISD should not be seen as a substitute for therapy. And those who would benefit from therapy should not be seen as weaker or as less resilient than those who would not. In fact, the opposite may be true.

If peer responders are providing crisis debriefing in the absence of mental health professionals, they should be well trained to recognize PTSD symptoms and to understand how to consult with and make a referral to a mental health professional when needed. This means that the debriefer will need to take adequate time and not rush through the process.

CISD should also not be seen as a substitute for practical helps. It is recommended that shortly after a traumatic event, immediate practical, social and emotional support should be offered (Bisson, 2008). This kind of support should be ongoing and not limited to a one time intervention.

What might be the benefits of offering CISD?

CISD has not been proven to prevent the development of Posttraumatic Stress Disorder (PTSD), Major Depressive Disorder, or any other pathological reaction. Still, many people report that CISD has helped them and that they feel better afterwards. What is the reason for this and how could these positive effects be measured? Some have suggested that debriefings or at least some kind of "psychological first aid" do accomplish the goal of providing support, education, screening, and linkage to resources (Raphael & Ursano, 2002). Psychological First Aid (Raphael, 1977) is "a flexible conversational approach that provides comfort, support, connectedness, information, and fosters coping in the immediate interval." (Litz, 2008).

Social support as well as perception of organizational support during and after a crisis affects ability to cope with it and overall resilience (Forbes & Roger, 1999; Keane et. al., 1985). A specific goal of CISD then should be to improve or affirm support systems. There are many opportunities during debriefings to highlight the support that peers have given each other during a crisis. Also, debriefers can be in the unique role of coaching organizational leaders to provide ongoing support to trauma victims.

The educational aspects of debriefing can also add to a person's sense of mastery and control, which is directly related to their ability to cope with a situation. Educational handouts about common reactions to trauma give people an opportunity to identify, anticipate, and talk about their own traumatic reactions. This is a key aspect of the debriefing and provides something tangible for both adult and child victims. An educational component is embedded in most of the interventions that have been shown to be effective in reducing post-trauma symptoms (Bisson, 2008).

Linkage to resources is another beneficial aspect of debriefings. This might include facilitating people to: find peers who have experienced similar things; have meaningful contact with family and friends who are able to be supportive; be reminded of spiritual resources; or arrange follow up appointments with a mental health professional.

Another potential benefit of CISD is that it can help victims begin to articulate what has happened to them and to face it in a way that protects them from using avoidance as a defense mechanism. Avoidance is one aspect of PTSD and is often a key element of anxiety disorders. If the person can be assisted in talking about what has happened in an atmosphere of trust, safety, and low anxiety, it will counteract the tendency to use avoidance as a means of self-protection.

CISD also gives the debriefer the opportunity to observe and assess those who may need further care. Assessing a person's risk for complications following trauma is a key element of crisis intervention and an essential skill for potential debriefers.

CISD in context

Crisis intervention involves a spectrum of activities and responses that cover a time period before, during, and after the crisis. Before the crisis, behaviors that focus on preparation for

crisis, building trust, deepening relationships, and enhancing coping resources are helpful. During the crisis, the focus is on survival and the practical aspects of managing the situation well. After the crisis, the victims need emotional support, the presence of caring and clear leadership, good information sharing, and any psychological intervention that will be beneficial. One must not minimize or forget the importance of practical supports, which sometimes are better remembered, and even more appreciated than professional interventions. This might include provision of money, replacement of personal items, care of children, options for future employment, or the opportunity to continue their work even if from a distance (Fawcett, 2002).

What can a leader/administrator do?

Leaders are in a unique role of being able to give people time off, tweaking the budget to give more financial resources, writing a letter to supporters, arranging for meals, etc. These kinds of actions speak volumes of care and concern and facilitate the healing process. Oftentimes, it is these acts of kindness performed by a leader that will be most remembered by crisis victims as they recount the experience of support they received.

Given that pre-crisis preparation has been cited as an important variable in coping with crises (Danieli, 2002), it seems a wise investment of time and resources for leaders to make sure that they and others who will give care during a crisis should receive crisis management or crisis care training.

In elaborating on leadership styles important in times of crisis, Fawcett (2002) asserts that team cohesion and trust in competent leadership – factors that must exist before the crisis – are key elements in promoting healthy adaptation to the crisis event. In recommending pre-crisis training for leaders he mentions things such as team cohesion, morale, and consultative leadership style as a way of increasing social support and reducing stress.

Since trust, strong relationships, and managing stress are such key elements of coping with crisis (Noy, 1991), workshops that focus on communication, relationships, stress management, and trust building could benefit not just leaders but all cross-cultural workers. Agency leaders can play a key role in encouraging their members to get this kind of training and can follow up to find out how these principles are being applied.

In World Vision's studies related to the efficacy of debriefing they found anecdotally that the level of organizational support was actually more important than the debriefings (Fawcett, 2002). Specifically the staff reported that the presence of a senior manager during and following a critical event was perceived as a demonstration of organizational support and care and was a significant factor in how they coped with the trauma. Leaders can make a big impact through phone calls, e-mails, and personal visits when they are communicating support, concern, and care as well as a commitment to help and stay involved.

Final conclusions and recommendations

As we've taken a closer look at psychological debriefing, five areas have been identified that could contribute to the process being harmful for recipients. These areas are lack of choice, poor timing, re-traumatization, vicarious traumatization, and superficiality. Recommendations have been given to try to help prevent these potential pitfalls from occurring with the debriefings we provide in cross-cultural settings. In summary, the recommendations include:

- Improve the process of educating people (leaders and victims) about what CISD is and what it is not and give trauma victims multiple opportunities over time to receive debriefing.

- Before a CISD is provided, assess the victims' level of fatigue, practical support needs, sense of being overwhelmed, and anxiety levels in order to determine if it is the right timing for the debriefing. Consult with a mental health professional if there are any questions about the level of anxiety.

- When debriefing participants express very intense emotions in the debriefing, help to instill a sense of safety, security, and calm before they leave the session. Do not force or coerce a person to express intense emotions. However, when they do express emotions, do not communicate that it is wrong or detrimental to express those emotions.

- Consider doing separate debriefings with smaller groupings according to the intensity of traumatic exposure so that people do not have to hear graphic details of events that did not directly involve them. Also, children should be protected from all the details of the adult's thoughts and fears during a shared event.

- Remember that CISD is one part of a broader spectrum of crisis intervention. Take care to provide follow up and to assess if the person needs more intervention beyond a one-session debriefing. Do not underestimate the value of practical helps and ongoing support.

- As leaders recognize their unique and critical role in providing support, they can facilitate spiritual, practical, and emotional care that may have an even more lasting impact than debriefings.

We must continue to search for the best and most excellent ways of caring for those who have been traumatized and injured on the battlefield. Some would say that offering a poor debriefing is better than offering nothing at all. But, preliminary research seems to indicate that a debriefing that is done poorly could actually be worse than offering nothing at all. The critical research gives us a sober warning – debriefings need to be done by well-trained personnel and within the parameters for which it was intended. If they are offered in this way,

they can provide a very valuable support and structure for overseas workers to process and manage the distress that comes from the traumas they endure. The above recommendations are made with the goal of continuing to grow and improve in the crisis intervention services offered to cross cultural workers experiencing traumatic events so that they will be encouraged to continue their works of service.

For Further Study:

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