Critical Incident Stress Debriefing

Helping public safety employees handle traumatic stress

Brian G. Jatczak

Eastern Michigan University

Abstract

Every public safety employee will be affected by critical incident stress during his or her career. It will have a negative impact on their productivity and personal lives if it is not dealt with early on. The critical incident stress management program has been developed to address this stress within a 72-hour time frame. Critical incident stress debriefings (CISD) are used to help individual responders deal with their stress by talking about it with their peers. Research has shown that CISD helps responders begin the healing process. Public safety employees will benefit by receiving training in CISD and by attending a debriefing after a traumatic event.

A citizen dials 911 and expects a quick response to his call. The police will respond to investigate a shooting, the fire department will douse a house fire, and emergency medical technicians will stabilize an ill person, then transport him to the hospital. Emergency responders are expected to handle these types of incidents, and any other that occur, without fear or hesitation.

These "tough guys" (Miller, 1999) who respond to emergencies encounter highly stressful incidents on a daily basis. Their stress begins when the initial call is received and it is elevated as they drive at high speeds through traffic to get to the scene. The responders' stress will be at an extremely high level when they arrive at the incident. In addition, while responding to a call for service, some responders will visualize the scene in their mind prior to arrival. The current call may even trigger memories from a past incident that was similar to the call the responder is currently driving to (Kates, 2000).

At some point most responders go into "auto-pilot" and function quite well at the scene. They are able to keep their personal feelings and emotions in check, and accomplish whatever needs to be done to quell the situation. But what happens to them when they leave the scene?

Emergency responders are subject to emotional aftershocks after a traumatic event. These aftershocks may appear immediately, or after several days, and can include depression, insomnia and irritability (see Table 1). Each individual responder will react to this stress differently. In most instances, traumatic experiences are long remembered by the involved individuals (Pulley, 2000). If this stress in not addressed early on, responders will suffer permanent emotional trauma that will adversely affect their continued value to the department and cause serious problems in their personal lives (Kureczka, 1996).

SIGNS AND SYMPTOMS OF CRITICAL INCIDENT STRESS

Physical*	Cognitive	Emotional	Behavioral
Chills	Confusion	Fear	withdrawal
Thirst	Nightmares	Guilt	antisocial acts
Fatigue	Uncertainty	Grief	inability to rest
Nausea	Hypervigilance	Panic	intensified pacing
Fainting	Suspiciousness	Denial	erratic movements
Twitches	intrusive images	Anxiety	change in social activity
Vomiting	blaming someone	Agitation	change in speech patterns
Dizziness	poor problem solving	Irritability	loss of or increase in appetite
Weakness	poor abstract thinking	Depression	hyperalert to environment
chest pain	poor attention/ decisions	Intense anger	increased alcohol consumption
Headaches	poor concentration/memory disorientation of time, place or person	Apprehension	change in usual communications
Elevated BP	difficulty identifying objects or people heightened or lowered alertness	Emotional shock	etc...
Rapid heart rate	increased or decreased awareness of surroundings	Emotional outbursts	
Muscle tremors	etc...	Feeling overwhelmed	
Grinding of teeth		Loss of emotional control	
Shock symptoms		Inappropriate emotional response	
Visual difficulties		Etc...	
Profuse sweating			
Difficulty breathing			
etc...			

Table 1. (Adapted from ICISF, 2000)

Critical incident stress has gone by many names in the past, including; shellshock, combat fatigue, traumatic stress and most recently, posttraumatic stress (Kates, 2000). This type of stress has been described as being a normal reaction to an abnormal event. It is a type of stress encountered at incidents that are capable of causing serious injury or death (Mock, 2000). It is characterized by a very intense arousal subsequent to a traumatic stressor or trauma. Traumatic stress overwhelms the body's coping mechanisms, leaving individuals feeling out of control (Everly & Mitchell, 1998). This stress can occur in victims, witnesses, responders, family members and others. By its nature, posttraumatic stress may represent one of the most severe and incapacitating forms of human stress known (Volpe, 1996).

Dr. George Everly estimates that at any given time 15-32% of all emergency responders will be dealing with a reaction to posttraumatic stress, and there is a 30-64% chance that they will have a reaction to it during their lifetime (Mock, 2000). Furthermore, law enforcement officers have a 20-30% chance of developing Posttraumatic Stress Disorder during their careers (Brumback, 1999).

That being said, exposure to one critical incident does not mean a responder will have a stress reaction (Pulley, 2000). In law enforcement for instance, one incident may cause a stress reaction in one officer, but not in another officer who witnessed the same thing. It may take an officer being exposed to several traumatic incidents before he/she has any type of reaction. However, left untreated, this stress can lead to Posttraumatic Stress Disorder (Kates, 2000). Public safety administrators are beginning to realize the need to assist the responders with their emotional well-being. They realize that a physically and emotionally fit employee is more productive and efficient. They are beginning to ask their

commanders, "What assistance is available for emergency responders who are experiencing this harmful critical incident stress?"

Critical Incident Stress Management (CISM) represents a comprehensive system of interventions, which are designed to prevent and/or mitigate the adverse psychological reactions that so often accompany public safety functions. According to the International Critical Incident Stress Foundation (2000), CISM interventions are especially directed towards the mitigation of posttraumatic stress reactions. CISM works to decrease the effects of critical incident stress early on, before reactions become rooted.

CISM is designed to be "comprehensive." By using the term comprehensive, I mean the CISM program spans the entire three phases of the crisis spectrum: 1) the pre-crisis phase, 2) the acute crisis phase, and 3) the post-crisis phase (Everly & Mitchell, 1998). It is based on the belief that crisis intervention techniques should have multiple components to achieve maximum effectiveness.

The seven core components of CISM are summarized in Table 2. Briefly stated, demobilizations are rarely used. They are reserved for very large, disaster type, events. A defusing is a one on one interaction between a trained individual and a responder who has a concern about an incident. It is informal and usually takes place immediately after an incident (Pulley, 2000). The most common type of intervention in use today is the debriefing. Debriefings may be defined as group meetings or discussions about a traumatic event (Mitchell & Everly, 1998).

CRITICAL INCIDENT STRESS MANAGEMENT

THE SEVEN CORE COMPONENTS

INTERVENTION	TIMING	ACTIVATION	GOALS	FORMAT
1 Pre-crisis preparation	Pre-crisis phase.	Anticipation of Crisis	Set expectations. Improve Coping Stress management.	Group Organization
2. Demobilization & Staff Consult(rescuers); Group Info. Briefing for civilians, schools,businesses.	Post-crisis; or Shift disengagement.	Event driven.	To inform, consult. Allow psychological decompression Stress mgmnt.	Large Group Organization
3.Defusing	Post-crisis.(within 12 hrs)	Usually symptom driven	Symptom mitigation. Possible closure. Triage.	Small group.
4. Critical Incident Stress Debriefing(CISD)	Post-crisis. (1 to 7 days)	Usually symptom driven Can be event driven	Facilitate psychological closure. mitigation. Triage.	Small group.
5. Individual crisis intervention (1:1)	Any time. Anywhere.	Symptom driven	Symptom mitigation. Return to function, if possible. Referral, if needed.	Individual
6. Family CISM; Org. consultation.	Any time.	Either symptom driven or event driven.	Foster support, communications. Symptom mitigation. Closure, if possible. Referral, if needed.	Organizations.
7. Follow-up; Referral	Any time.	Usually symptom driven	Assess mental status. Access higher level of care.	Individual Family.

Table 2. (Adapted from Everly & Mitchell, 1997).

Critical Incident Stress Debriefing (CISD)

Critical incident stress debriefing, or CISD, has been organizationally formalized for law enforcement and emergency services by Jeffrey Mitchell and his colleagues (Mitchell & Bray, 1990; Mitchell & Everly, 1998). The "Mitchell model" of CISD is now implemented in public safety departments throughout the United States, Britain, and other parts of the world.

According to the Mitchell model, following a critical incident, there are a number of criteria a supervisor can use to decide if he/she will provide a debriefing for personnel. These include: (1) many individuals within a group appear to be distressed after a call; (2) the signs of stress appear to be quite severe; (3) personnel demonstrate significant behavioral changes; (4) personnel make significant errors on calls occurring after the critical incident; (5) personnel request help; (6) the event is unusual or extraordinary (Miller, 1999).

The structure of a CISD usually consists of the presence of one or more mental health professionals and one or more peer debriefers, i.e. fellow police officers or emergency service workers who have been trained in the CISD process and who may have been through critical incidents and debriefings themselves. A typical debriefing takes place within 24-72 hours after the critical incident, and consists of a single group meeting that lasts approximately 2-3 hours. Shorter or longer meetings are determined by the circumstances (Mitchell & Everly, 1998). The debriefing is completely confidential, and is seen as a tool to help reduce human suffering.

The formal CISD process consists of seven standard phases:

- Introduction: The introduction phase of a debriefing is when the team leader introduces the CISD process and approach, encourages participation by the group, and sets the ground rules by which the debriefing will operate. Generally, these guidelines involve issues of confidentiality, attendance for the full duration of the group, however with non-forced participation in discussions and the establishment of a supportive, noncritical atmosphere.

- Fact Phase: During this phase, the group is asked to describe briefly their job or role during the incident and, from their own perspective, some facts regarding what happened. Usually, a few individuals provide core facts while others fill in the missing details (Pulley, 2000). The basic question is: "What did you do at the scene?"

- Thought Phase: Touching on the emotional aspects begins during the thought phase. The CISD leader asks the group members to discuss their first thoughts during the critical incident: "What went through your mind after you came back from auto-pilot?"

- Reaction Phase: This phase is designed to move the group participants from the predominantly cognitive level of intellectual processing into the emotional level of processing. "What was the worst part of the incident for you?" This is the most intense phase of the process. Not everyone will feel comfortable sharing his or her feelings in this

phase. However, listening to the others talk about their feelings during this phase of the debriefing will be beneficial in and of itself. Many participants will discover that the reactions they had or are currently experiencing are similar to the feelings and reactions of their peers.

- Symptom Phase: This phase begins the movement back from the predominantly emotional processing level toward the cognitive processing level. Participants are asked to describe their physical, cognitive, emotional, and behavioral signs and symptoms of distress (see Table 1) which appeared (1) at the scene or within 24 hours of the incident, (2) a few days after the incident, and (3) are still being experienced at the time of the debriefing: "What have you been experiencing since the incident?"

- Teaching Phase: Information is exchanged about the nature of the stress response and the expected physiological and psychological reactions to critical incidents. The process of critical incident stress, stress reactions, and techniques to decrease stress are explored. This serves to normalize the stress and coping response, and provides a basis for questions and answers: "What can we learn from this experience?"

- Re-entry Phase: This is a wrap-up, in which any additional questions or statements are addressed, referral for individual follow-ups are made, and general group solidarity and bonding are reinforced: "How can we help one another the next time something like this occurs?" and "Was there anything that we left out?"

For a successful debriefing, timing and appropriateness are important. The consensus from the literature supports scheduling the debriefing toward the earlier end of the recommended 24-72 hour window (Pulley, 2000). To keep the focus on the event itself and to reduce the potential for singling-out of individuals, some authorities recommend that there be a policy of mandatory referral of all involved personnel to a debriefing or other appropriate mental health intervention (Horn, 1991; Mitchell, 1991). However, in other cases, mandatory or enforced CISD attendance may lead to passive participation and resentment among the assigned personnel, and the CISD process may quickly become a boring routine if used indiscriminately after every incident, thereby diluting its effectiveness in those situations where it really could have helped. Departmental supervisors and mental health consultants must use their common sense and knowledge of their own personnel to make these kinds of judgment calls.

The effectiveness of CISD has been empirically validated through qualitative analyses, as well as through controlled investigations (Everly & Mitchell, 1997). However, CISD is not meant to be the cure all for every officer. It may satisfy the needs of some officers, and only start the healing process for others. CISD debriefers are trained to recognize those officers who may need additional assistance. After the formal debriefing is complete, the debriefers will stay behind to talk with those officers who want to speak to them on a one on one basis. This is a perfect time for debriefers to provide the person with the name and phone number of nondepartmental support groups or counselors.

Anatomy of a Debriefing

I am a member of the Washtenaw Area Critical Incident Stress Management Team. During my tenure with the team, I have assisted at many area debriefings. At each debriefing, I have seen people benefit from the discussions that take place. Below I will outline an actual debriefing that was held, keeping the identity of the participants confidential. I believe this summary will provide a clearer understanding of the debriefing process and highlight its benefits.

Here are the facts of the incident. A school bus made a routine stop to drop several children off after school. The bus driver activated the proper warning devices on the bus. Several children exited the bus, and for some unknown reason, began to walk on the sidewalk toward the rear of the bus. The children had been taught to go to the front of the bus to cross the street. One child walked to the front of the bus as instructed. The bus driver was watching the children walk to the rear of the bus and did not see the 9-year-old girl walk in front of the bus. Thinking all the children were accounted for, the driver drove the bus forward, striking the girl and dragging her seventy-five feet before frantic parents signaled the bus driver to stop. An unconscious girl lay on the ground, surrounded by other children and parents, when emergency responders arrived.

The first responders began to administer first aid to the child, but soon realized her injuries were fatal. Even with this knowledge, they continued to work on the girl, realizing the effect pronouncing her dead at the scene would have on the children and parents who were watching. She was transported from the scene and died enroute to the hospital. This traumatic incident had a devastating effect on those responders involved. Many began to

suffer from critical incident stress immediately after the incident. Fortunately, agency commanders recognized the stress indicators exhibited by the responders and a CISD was scheduled within 48 hours of the incident.

The debriefing started with the introduction phase. The team member from the mental health profession laid the ground rules, stressed confidentiality, and introduced the team members. During the fact phase, the participants were asked to state their name and explain what their role or function was during the incident. I was surprised when two of the debriefees passed during this phase. In a debriefing, if someone is uncomfortable and is going to pass, it usually occurs during the reaction or thought phase. When I observed the two participants take a pass so early on in the process, I realized just how devastating the impact of this incident was on them, and I prepared myself for a long debriefing session.

During the thought phase, many of the debriefees talked about their first thoughts after they left the scene. In the public safety tradition, many were thinking about the child, her parents, all the witnesses and the bus driver, not themselves. These responders experienced a very traumatic event, however, they were still thinking about the effects this incident was going to have on others. They would soon realize they had their own issues to deal with. As for the two debriefees that passed during the fact phase, they passed again during the thought phase. I continued to watch them as others spoke. They kept their heads downs, and were continuously weeping. I knew the team needed to help them, but I wasn't sure how we could get them to open up.

Then something happened quite suddenly. We began the reaction phase of the debriefing, and to my surprise, the first person to speak was one of the debriefees who

passed earlier. He spoke about his own child who went to the same school as the victim. He spoke of how hard it is for him to drive down the street where the child was hit by the bus. He opened up so much that everyone in the room was in tears. At that moment, I knew this debriefing had impacted him in a positive way. The other debriefee who had passed previously also spoke. He talked about the dreams he had the previous two nights. He talked about the child's handprint that he saw on the grill of the bus, imprinted there as she tried to stop the bus from hitting her. He also realized that the training site for his department was right down the street from where the incident occurred, and he wasn't sure if he could drive down that street anymore. These are issues each and every responder to that incident will have to manage the rest of their lives.

Needless to say, everyone was quite emotional following the reaction phase. Many of the debriefers, including myself, have children at home or have handled similar incidents. Hearing others speak of their feelings regarding this traumatic event brought back to me memories of incidents I was involved in several years prior. I had moved these memories to the back of my mind, out of my short-term memory. But they are always present, ready to emerge without notice.

The debriefing continued after the participants composed themselves. We moved from the symptom phase to the teaching phase. We ended by asking each individual what they were going to do in the short term to help themselves manage with their feelings and their stress. Many said they were going to go home and hug their children, some said they were going to exercise, and others said they were planning to speak to their clergy. All of these are great ways to cope with traumatic stress and should help the debriefees get their lives back on track. I truly believe that if these responders did not attend this debriefing

their suffering would never have been addressed, causing them more serious problems in the future.

What happened during this debriefing that helped these two individuals open up and share their thoughts and feelings? I think it was rather simple. These two individuals initially did not want to talk about their feelings. In law enforcement, and other public safety occupations, responders are expected to handle anything that happens. They are told early on in their training that they should not show any type of emotion, they should keep their feelings and thoughts to themselves, and they are told "don't take the job home with you."

I believe these two individuals felt that way, and had never spoken to co-workers about their feelings in the past. The turning point for them came when they heard their peers talking about their own feelings. They realized that their feelings and emotions were similar to their peers. They also realized that their thoughts and feelings about the incident were normal reactions to the traumatic stress they were experiencing. I always tell reluctant participants that even if they pass at every phase, they are helping the other debriefees by listening and supporting them. They may even benefit from what the other participants have to say, which is what I believe happened to these two people at this debriefing.

When the debriefing is over and all the participants have left, the debriefers have a group meeting to discuss how the debriefing went. They talk about how the discussions during the debriefing affected them personally. Many times I have listened to others speak and have been reminded of similar incidents I was involved in. This is the time for the debriefers to talk about their thoughts and feelings before heading home.

Training

The safeguarding of public safety personnel cannot stop with providing them with the equipment to do their job. It is incumbent on public safety administrators to prepare their employees for traumatic incidents by providing them with training that includes a presentation outlining strategies for coping with the emotional aftermath of traumatic events that occur all too frequently in their profession.

Critical incident stress training should begin in the basic academy. Employees should be given information on the signs and symptoms of critical incident stress, and the debilitating effects of Posttraumatic Stress Disorder. This will allow them to recognize this stress manifesting itself within themselves and others. Supplemental training should occur throughout their careers.

Many public safety personnel feel it is not socially acceptable to show their emotions. They see it as a sign of weakness. To show weakness is to lose control, and they have been trained to be in control at all times. This is inbred into their thought process in the academy and during their probationary period. They are told if they can't handle the stress, get out of the profession. They are given the unrealistic stereotype that they must keep up like "Superman" or "Wonder Woman" (Felt, 1992). Basically, they are trained to hide or deny their emotions.

Training in critical incident stress, posttraumatic stress syndrome, and psychological follow-up after a traumatic event is known to help decrease the percentage

of officers who will develop Posttraumatic Stress Disorder (Mock, 2000). Given the fact that most public safety employees will encounter critical incident stress during their career, failure to train them about how to prepare for it, recognize it, and deal with it is pure negligence.

Trainees should also be given an overview of the debriefing process. Confidentiality of the process should be stressed. This will make them more comfortable with the debriefing process and prepare them for future debriefings.

Conclusion

Clearly, public safety administrators can no longer afford to ignore the issue of traumatic stress caused by involvement in critical incidents. Department's can be held liable in court for ignoring lingering stress-related problems. Courts have made significant cash awards to employees whose department did not provide them with professional assistance (Kureczka, 1996). Thus, it is in the best interests of public safety administrators to identify those incidents that cause traumatic stress and address the effects early on. Organizing a debriefing within 48 hours of a traumatic event is a good way to initially address the traumatic stress. Failure to do so could prove detrimental to the department operationally and financially.

Department administrators should establish policies and procedures that enable employees to get help when they need it. Attendance at debriefings should be mandatory

for all responders to a critical incident that is likely to cause critical incident stress. When necessary, follow-up care should be provided by a department psychologist without cost to the employee. To have the greatest impact, intervention services should be part of an integrated program within the department, and have full administrative commitment and support (Miller, 1997).

Employees suffering from critical incident stress or Posttraumatic Stress Disorder need not succumb to its debilitating effects. With proper support from the department, use of the debriefing process, and counseling from a professional when needed, public safety employees and their families will learn to deal with the trauma and its aftermath. The department will then be able to retain a valuable, productive, and healthy employee.

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