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## **Reclaiming Process in Crisis Intervention: A Review of Critical Incident Stress Debriefing (CISD)**

The Mitchell model of Critical Incident Stress Debriefing provided a useful psycho-social tool in single incident crisis intervention at a time when few models were available. It formalised processes of group support that often emerge spontaneously, though there will always be some who prefer to withdraw. However, the rapid spread of CISD led to poor implementation and practice, with many deviations from its original aims and applications. It was even used in situations of mass destruction involving on-going and multiple trauma. Many myths about its goals (eg it is a treatment, a therapy, or cure-all) and protocol have emerged that have been perpetuated by research and reports in professional journals.

In this paper, I argue for a return to the principles and original intentions of debriefing along with more detailed attention to assessment of the specifics of each situation. Only then should debriefing be considered along with other recovery programmes and interventions. I also argue that the research paradigms used in current research cannot always fairly assess the value of debriefing.

### **What is CISD?**

CISD is the most widely known and used form of psychological stress debriefing. It was designed by Dr Jeffrey Mitchell in the USA in the early 1980's after years of development with paramedic teams. It is based on well grounded theories of crisis intervention and group support.

*The purpose of CISD* was to establish the correct facts and group consensus about the incident, normalise reactions, mobilise internal and external coping resources and identify when further help is needed. It was never intended as a therapy or counselling session or treatment for individuals, nor as a stand-alone intervention. Rather, it provided the base from which other support or treatment could proceed if needed. It was also intended as part of an on-going programme which included pre-incident preparation, defusing (a simpler more immediate form of debriefing) and a whole range of management and psychological support over the immediate and longer-term post-trauma period. This meant it was most effective when used sparingly for the worst single critical incidents in organisational settings where the stability and resources made the implementation and organisation of such a programme possible.

### *What went wrong?*

CISD spread rapidly in various parts of the world, especially in the Emergency Services. Several factors contributed to the speedy take-up of CISD: the charisma and marketing skills of Mitchell and his organisation; the usefulness of CISD to practitioners; the need by organisations for something to offer staff teams after a disaster when no one knew quite what to do. Unfortunately, the seemingly simple 7 stage protocol belied the more complex processes needed for its correct implementation and application. CISD began to be used by

organisations that did not understand or want to resource proper crisis management programmes. Practitioners with little training in group skills and unskilled in the subtle application of CISD began to use it in a simplistic manner, often viewing it as a treatment for individuals rather than a crisis management intervention. Debriefing came to be seen as a magical cure-all demanded after any type of crisis, and when it failed to do so it was viciously attacked. The term entered public discourse and the media and was used to cover any type of post-disaster intervention.

*How did research contribute to the confusion?*

The popularity and indiscriminate use of CISD not surprisingly led to a back-lash from some quarters, notably from clinical psychologists and psychiatrists with access to research funding whose preferred research paradigm was the traditional scientific positivist, quantitative approach. This paradigm requires methods for research that can be standardised, controlled, stripped of any variable context and measured. The outcomes of the method have to be quantifiable.

I would argue that several factors make this type of research unsuitable for evaluating debriefing. First, the impact of trauma is all-encompassing, affecting not just all aspects of the individual but their socio-economic context as well. This means that one support strategy alone is unlikely to be sufficient for recovery. Second, human-beings have self-determining natures which are both creative with and resistant to change. They can therefore decide what use they will make of any intervention offered to them. This effect is multiplied when the intervention is designed for a group.

The effect of debriefing on people cannot be tested and measured as if it were a pill. However, a study of the research shows that often it is. The impact is only judged in terms of measurable symptoms and whether these are reduced as a result of one brief 'debriefing' session i.e debriefing is being viewed as a treatment of an individual's symptoms – a purpose for which it was not designed. A further study of the research shows that the 'debriefing' being given deviates a long way from the original criteria for its use and its protocol. The research often tests 'debriefing' on direct victims of trauma. These victims may be physically injured and medicated. They may be debriefed within hours of arriving in hospital soon after their traumatic incident. Rather than a carefully assessed group session individuals are subjected to an intense 1:1 session of detailed recall of their incident, catharsis and education conducted by people with very little training in debriefing (in one case, medical students). Such research cannot be said to be testing Mitchell's CISD model but rather the debriefing method designed by the researcher for inappropriate people in situations unsuitable for CISD. Doing research at such vulnerable times in this way risks causing further distress and is not the best situation for people to give their consent to be researched. In defending their position, Mitchell and Everly write:

“What we have learned so far about debriefings is that when they are applied inappropriately as stand alone substitutes for psychotherapy or when they are studied in research projects replete with methodological flaws they render mixed or negative results. When debriefings are clearly defined and applied properly in the context of a broader, comprehensive, systematic programme, they produce consistently positive results!” Mitchell and Everley, 1998

Such research can seem irrelevant to field-practitioners working in unpredictable situations far removed from clinical and laboratory style settings. This is so after single incidents as much

as after large-scale multiple incidents. Indeed many professionals would find it difficult to support the use of some of the techniques used in the research because of the vulnerability of a person so soon after an incident. The lack of opportunity for building rapport and the use of questionnaires for follow-up would go against many support practices. Nor do the situations used in the research have the stability and pre-planning required for the proper application of Mitchell's CISD model within a CIS Management programme.

## **Alternatives**

So what can practitioners working in unplanned situations do? On the one hand, much of the research that claims to discredit debriefing uses techniques which divert a long way from the original models. On the other hand, the situations and organisation required for the Mitchell model are seldom available to us. Over the last 14 years, I have developed a system of assessment and a menu of choices which free me from the trap of trying to get one method to fix every situation. Flexibility, variety and creativity along with outcomes determined more by the clients than the practitioners are not easily measured and do not fit well into traditional scientific research methods. I have therefore made a paradigm shift to Action Research methods which value research in the moment of action and the production of useful knowledge instead of trying to find one truth for all circumstances.

I call this model Site-specific Critical Incident Review and Action (see fig 1). The term Site-specific recognises that no two incidents are the same and the people involved never are. The words Review and Action recognise that the nature of the process is essentially social, educative rather than psychological, medical. The medical is not precluded, but nor is not the dominant or only aspect of the trauma experience to be given attention. Thus the emphasis on symptoms and cures, to the exclusion of all the other aspects of a person's journey after trauma, is reduced. Control for what happens in that journey stays with the person.

The model considers the 4 principle variables found in any helping situation in a disaster or part of a disaster. The variables are:

### *The incident*

Assess its scale, nature, significance and details which define its uniqueness. Is it an incident that has directly hit a community, nation or is it more separate, with victims drawn from a wider area? Is it political; criminal; technological; or environmental, with or without elements of human mismanagement? Are the perpetrators internal or external? Is it a single incident, a series of incidents, on-going or complex?

### *The people involved*

Define all the characteristics of people involved and look at the significance of the incident to them. Assess their vulnerability to stress reactions in terms of the risks from exposure to the incident, the support available to them, their history and current situation. Consider them both as individuals and as members of various groups and communities, noting whose needs may be denied and for what reasons.

### *The context*

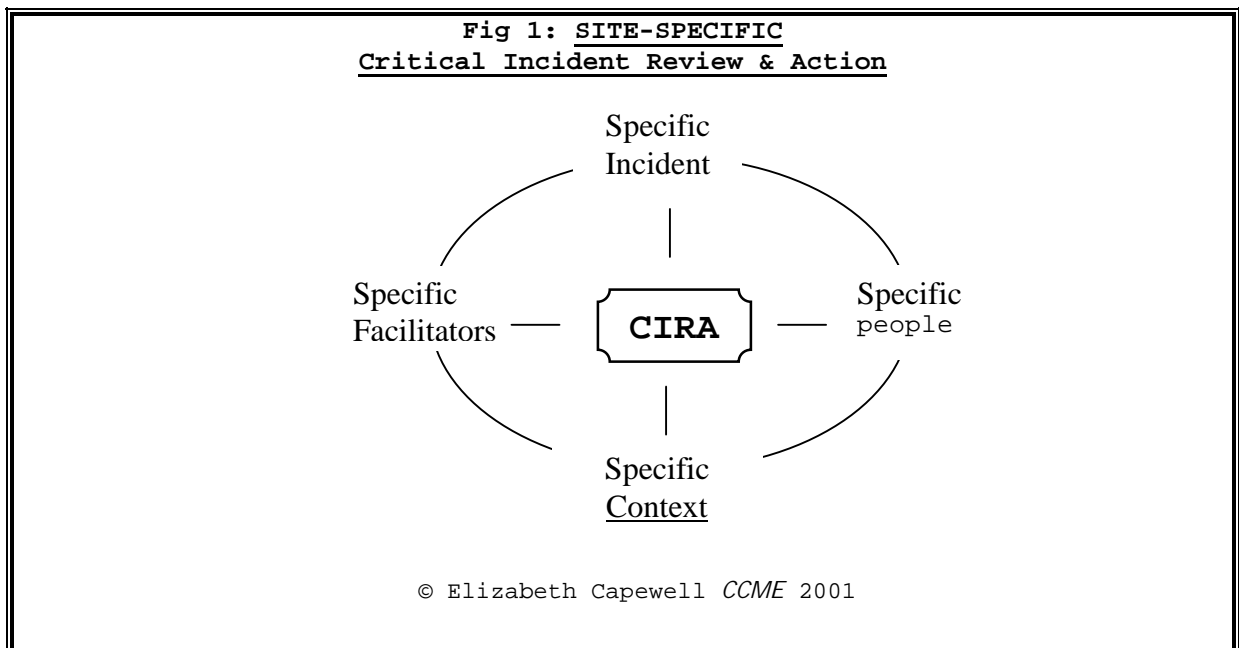
Consider the political, social, cultural and economic context. Has the event hit a community, an organisation, or special community such as a school . What is your role and status. Who is in charge, who has power? Are you working in a planned and prepared context or are responses having to be created spontaneously?

### *The helpers*

Assess who is available to offer support? What are they trained to do? How adaptable are they to new conditions? What resources are available? How sophisticated are existing services in the area? What external services are available and acceptable? How will everyone work together? Adapting methods which helpers already do well is preferable to applying methods for which people are not trained and for which the conditions are not appropriate.

Such an array of variables requires either that those responding have a wide range of skills in their tool-bag or that enough people exist with varying skills and attitudes that allow co-operation.

If resources and the situation allow more organised forms of support, then there are still choices to be made about whether it is offered to individuals, groups, or families or a combination of these. If group debriefing is deemed appropriate, then further choices need to be made about which method to use. Over the last 14 years I have most often used Dr Ofra Ayalon's 'Empowerment Model' with its emphasis on the groups styles of coping or facilitated creative group processing frameworks, underpinned by the principles of the Mitchell CISD model.



In general the less organised the situation and the more complex the incident and its significance, the greater the range of support and follow-up needed. The support needs to attend to all levels - individual, group through to community and organisational systems. It also needs to be holistic with interactions between educational, social, spiritual and medical support. Stigmas about seeking help need to be addressed by preventative, pro-active methods. Reactive services rarely work alone without the stepping-stones of pro-active services to help people feel confident to use them. A menu of types of support possible is provided in Fig 3.

### **Fig 3: Menu of immediate post-trauma support methods**

#### **Large-scale, systemic programmes**

- CIM programmes for communities: information, rituals, creative expression, stress prevention and education, development of coping skills, conflict resolution, psycho-social services.

#### **Methods for groups**

- Group meetings - information sharing and support.
- Formal planned CISD with follow-up (eg Mitchell's model)
- Ad hoc Critical Incident Processing (eg Ayalon's model)
- Family work
- Staff team processing of the crisis experience
- Group therapy

#### **Methods for individuals**

- Practical and humanitarian support
- Emergency crisis intervention
- Non-clinical work: support, counselling, brief therapies
- Clinical interventions – psychological, psychiatric and medical
- Complementary therapies and relaxation techniques
- Telephone help-lines
- Spiritual support
- Self-help
- Specific trauma treatments e.g. EMDR, clinical hypnotherapy.
- Treatments for consequential problems such as depression, relationship problems, anger management

Nothing, however, should become a tablet of stone or a fixed cure-all, automatically used in a disaster because it was used at the one before. A vital element of recovery is the discovery of a person's or community's unique ability to deal creatively with chaos. It does not have to be done alone or without facilitation and there will always be limits to what we know and have available. But the final choices made about the journey after trauma and its outcome must rest with the person or community concerned.

#### **References**

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For a full list of references, comments and information about training, please contact the author: ccme.org@which.net