Critical Incident Stress Debriefing (CISD)

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Introduction and Definition of CISD:

The term "debriefing" is widely used and means many different things. In fact, there are many different types of "debriefings" in use in the world today. Most forms of debriefing do not equate to the "Critical Incident Stress Debriefing." One needs to be very careful and know exactly what type of debriefing they are discussing. Precision in the use of terminology is extremely important. Inaccurate definitions lead to faulty practice and flawed research.

Critical Incident Stress Debriefing *(CISD) is a specific, 7-phase,* ***small group****, supportive crisis intervention process.* It is just one of the many crisis intervention techniques which are included under the umbrella of a Critical Incident Stress Management (CISM) program. The CISD process does not constitute any form of psychotherapy and it should never be utilized as a substitute for psychotherapy. It is simply a supportive, crisis-focused discussion of a traumatic event (which is frequently called a "critical incident"). The Critical Incident Stress Debriefing was developed exclusively for small, *homogeneous groups* who have encountered a powerful traumatic event. It aims at reduction of distress and a restoration of group cohesion and unit performance.

A Critical Incident Stress Debriefing can best be described as a psycho-educational small group process. In other words, it is a structured group story-telling process combined with practical information to normalize group member reactions to a critical incident and facilitate their recovery. A CISD is only used in the aftermath of a significant traumatic event that has generated strong reactions in the personnel from a particular homogeneous group. The selection of a CISD as a crisis intervention tool means that a traumatic event has occurred and the group members' usual coping methods have been overwhelmed and the personnel are exhibiting signs of considerable distress, impairment or dysfunction.

The Facilitators

The CISD is led by a specially trained team of 2 to 4 people depending on the size of the group. The typical formula is one team member for every 5 to 7 group participants. A minimal team is two people, even with the smallest of groups. One of the team members is a mental health professional and the others are "peer support personnel." A unique feature of CISD is that Critical Incident Stress Management trained peer support personnel (firefighters, paramedics, police officers, military personnel, etc.) work with a mental health professional when providing a CISD to personnel from law enforcement, fire service, emergency medical, military, medical, aviation and other specialized professions. A peer is someone from the same profession or who shares a similar background as the group members. Police officers, for instance, who have been trained in Critical Incident Stress Management techniques, are selected to work with police officers who have been through the traumatic event. Fire service personnel with CISM background are chosen to work with firefighters and CISM trained emergency medical or military personnel will be placed on teams running a Critical Incident Stress Debriefing with their respective groups and so on.

Essential Concepts in CISD

A Critical Incident Stress Debriefing is small group "psychological first aid." The primary emphasis in a Critical Incident Stress Debriefing is to inform and empower a homogeneous group after a threatening or overwhelming traumatic situation. A CISD attempts to enhance resistance to stress reactions, build resiliency or the ability to "bounce back" from a traumatic experience, and facilitate both a recovery from traumatic stress and a return to normal, healthy functions.

The Critical Incident Stress Debriefing is ***not*** a stand-alone process and it is only employed within a package of crisis intervention procedures under the Critical Incident Stress Management umbrella. A CISD should be linked and blended with numerous crisis support services including, but not limited to, pre-incident education, individual crisis intervention, family support services, follow-up services, referrals for professional care, if necessary, and post incident education programs. The best effects of a CISD, which are enhanced group cohesion and unit performance, are always achieved when the CISD is part of a broader crisis support system.

Historical Perspective and Theoretical Foundations

Critical Incident Stress Debriefing was developed by Jeffrey T. Mitchell, Ph.D. in 1974 for use with small homogeneous groups of paramedics, firefighters and law enforcement officers who were distressed by an exposure to some particularly gruesome event. It is firmly rooted in the crisis intervention and group theory and practices of such notables as Thomas Salmon, Eric Lindemann, Gerald Caplan, Howard

Parad, Lillian Rapoport, Norman Faberow, Calvin Frederick and Irvin Yalom. The first article on CISD appeared in the *Journal of Emergency Medical Services* in 1983.

Over time, the use of Critical Incident Stress Debriefing spread to other groups outside of the emergency services professions. The military services, airlines, and railroads find the process helpful. This is particularly so when it is combined and linked to other crisis intervention processes. Businesses, industries, hospitals, schools, churches and community groups eventually adopted the Critical Incident Stress Debriefing model as an integral part of their overall staff crisis support programs.

Objectives

A Critical Incident Stress Debriefing has three main objectives. They are: 1) the mitigation of the impact of a traumatic incident, 2) the facilitation of the normal recovery processes and a restoration of adaptive functions in psychologically healthy people who are distressed by an unusually disturbing event. 3) A CISD functions as a screening opportunity to identify group members who might benefit from additional support services or a referral for professional care.

Required Conditions for the Application of the CISD Process

The Critical Incident Stress Debriefing requires the following conditions:
1) The small group (about 20 people) must be homogeneous, *not* heterogeneous. 2) The group members must not be currently involved in the situation. Their involvement is either complete or the situation has moved past the most acute stages. 3) Group members should have had about the same level of exposure to the experience. 4) The group should be psychologically ready and not so fatigued or distraught that they cannot participate in the discussion.

An assumption is made here that a properly trained crisis response team is prepared to provide the CISD.

The Critical Incident Stress Debriefing Process

Timing

The Critical Incident Stress Debriefing is often *not* the first intervention to follow a critical incident. A brief group informational process may have taken place and distressed individuals may have been supported with one-on-one interventions. Typically, 24 to 72 hours after the incident the small, homogeneous group gathers for the CISD. Intervention delays may occur in disasters. Personnel may be too involved in the event to hold the CISD earlier. They may not be psychologically ready to accept help until things settle down a bit after they finish work at the disaster scene. In fact, it is not uncommon in disasters that the CISD is not provided for several weeks and sometimes longer after the disaster ends. Depending on the

circumstances, a CISD may take between 1 and 3 hours to complete. The exact time will depend on the number of people attending and the intensity of the traumatic event.

Phases in the Critical Incident Stress Debriefing

A CISD is a structured process that includes the cognitive and affective domains of human experience. The phases are arranged in a specific order to facilitate the transition of the group from the cognitive domain to the affective domain and back to the cognitive again. Although mostly a psycho-educational process, emotional content can arise at any time in the CISD. Team members must be well trained and ready to help the group manage some of the emotional content if it should arise in the group.

Phase 1 – Introduction

In this phase, the team members introduce themselves and describe the process. They present guidelines for the conduct of the CISD and they motivate the participants to engage actively in the process. Participation in the discussion is voluntary and the team keeps the information discussed in the session confidential. A carefully presented introduction sets the tone of the session, anticipates problem areas and encourages active participation from the group members.

Phase 2 – Facts

Only extremely brief overviews of the facts are requested. Excessive detail is discouraged. This phase helps the participants to begin talking. It is easier to speak of what happened before they describe how the event impacted them. The fact phase, however, is not the essence of the CISD. More important parts are yet to come. But giving the group members an opportunity to contribute a small amount to the discussion is enormously important in lowering anxiety and letting the group know that they have control of the discussion. The usual question used to start the fact phase is “Can you give our team a brief overview or ‘thumbnail sketch’ of what happened in the situation from you view point? We are going to go around the room and give everybody an opportunity to speak if they wish. If you do not wish to say anything just remain silent or wave us off and we will go onto the next person.”

Phase 3 – Thoughts

The thought phase is a transition from the cognitive domain toward the affective domain. It is easier to speak of what one’s thoughts than to focus immediately on the most painful aspects of the event. The typical question addressed in this phase is “What was your first thought or your most prominent thought once you realized you were thinking? Again we will go around the room to give everybody a chance to speak if they wish. If you do not wish to contribute something, you may remain silent. This will be the last time we go around the group.”

Phase 4 – Reactions

The reaction phase is the heart of a Critical Incident Stress Debriefing. It focuses on the impact on the participants. Anger, frustration, sadness, loss, confusion, and other emotions may emerge. The trigger question is "What is the very worst thing about this event for you personally?" The support team listens carefully and gently encourages group members to add something if they wish. When the group runs out of issues or concerns that they wish to express the team moves the discussion into the next transition phase, the symptoms phase, which will lead the group from the affective domain toward the cognitive domain.

Phase 5 – Symptoms

Team members ask, "How has this tragic experience shown up in your life?" or "What cognitive, physical, emotional, or behavioral symptoms have you been dealing with since this event?" The team members listen carefully for common symptoms associated with exposure to traumatic events. The CISM team will use the signs and symptoms of distress presented by the participants as a kicking off point for the teaching phase.

Phase 6 – Teaching

The team conducting the Critical Incident Stress Debriefing normalizes the symptoms brought up by participants. They provide explanations of the participants' reactions and provide stress management information. Other pertinent topics may be addressed during the teaching phase as required. For instance, if the CISD was conducted because of a suicide of a colleague, the topic of suicide should be covered in the teaching phase.

Phase 7 – Re-entry

The participants may ask questions or make final statements. The CISD team summarizes what has been discussed in the CISD. Final explanations, information, action directives, guidance, and thoughts are presented to the group. Handouts maybe distributed.

Follow-up

The Critical Incident Stress Debriefing is usually followed by refreshments to facilitate the beginning of follow-up services. The refreshments help to "anchor" the group while team members make contact with each of the participants. One-on-one sessions are frequent after the CISD ends.

Other follow-up services include telephone calls, visits to work sites and contacts with family members of the participants if that is requested. At times, advice to supervisors may be indicated. Between one and three follow-up contacts is usually sufficient to finalize the intervention. In a few cases, referrals for professional care may be necessary.

Research:

The research on CISD is quite positive if two conditions are present. The conditions are:

1. Personnel have been properly trained in CISM.
2. Providers are adhering to well published and internationally accepted standards of CISM practice.

Note: Without exception, every negative outcome study on CISD to date has not used trained personnel to provide the service and they have violated the core standards of practice in the CISM field. For example, they have used the CISD for individuals instead of homogeneous groups. The Cochrane Review (Wessely, Rose and Bisson, 1998) summarizes the negative outcome studies on CISD. In that review, 100% of the studies were performed on individuals. When a group process designed for homogeneous groups is used on individuals, it changes the inherent nature of the process itself and also what is being measured. In addition, the negative outcome studies applied a group process model to individuals for whom the CISD process was never intended. The Cochrane Review studies covered dog bite victims (*9% of the studies*), auto accident victims (*45% of the studies*), burn victims (*9% of the studies*), relatives of actual victims in an emergency department (*9% of the studies*), sexual assault victims and women who had a miscarriage, a cesarean section, post partum depression and other difficult pregnancy situations (*28% of the Cochrane Review studies*). The CISD small group process was not designed to manage any of these types of cases. It was developed for use with small, homogeneous groups such as fire fighters, police officers, military and emergency services personnel. CISD should be used for staff, not primary victims.

The paragraphs below present an overview of some of the positive outcome studies. There are many more beyond what can be addressed here.

Bohl (1991) assessed the use of CISD with police officers. Police officers who received a CISD within 24 hours of a critical incident (N=40) were compared to officers without CISD (31). Those with CISD were found to be less depressed, less angry and had less stress symptoms at three months than their non-debriefed colleagues.

Bohl (1995) studied the effectiveness of CISD with 30 firefighters who received CISD compared with 35 who did not. At three months, anxiety symptoms were lower in the CISD group than in the non-CISD group.

In a sample of 288 emergency, welfare, and hospital workers, 96% of emergency personnel and 77% of welfare and hospital employees who worked on traumatic events stated that they had experienced symptom reduction which was attributed partly to attendance at a CISD (Robinson & Mitchell, 1993).

After a mass shooting in which 23 people were killed and 32 were wounded, emergency medical personnel were offered CISD within 24 hours. A total of 36 respondents were involved in this longitudinal assessment of the effectiveness of CISD interventions. Recovery from the trauma appeared to be most strongly associated with participation in the CISD process. In repeated measures anxiety, depression, and traumatic stress symptoms were significantly lower for those who participated in CISD than for those who did not (Jenkins, 1996).

After a hurricane, Chemtob, Tomas, Law, and Cremniter (1997) did pre- and post-test comparisons of 41 crisis workers in a controlled time-lagged design. The intervention was a CISD and a stress management education session. The intervention reduced Posttraumatic stress symptoms in both groups.

In naturalistic quasi-experimental study emergency personnel working the civil disturbance in Los Angeles in 1992 were either given CISD or not depending on the choice of command staff. They had worked at the same events. Those who received CISD scored significantly lower on the Frederick Reaction Index at three months after intervention compared to those who did not receive it (Wee, Mills, & Koehler, 1999).

In 1994 over 900 people drowned in the sinking of the ferry, *Estonia.* Nurmi (1999) contrasted three groups of emergency personnel who received CISD with one group of emergency nurses who did not receive CISD. Symptoms of posttraumatic stress disorder were lower in each of the CISD groups than the non-CISD category.

When CISD is combined with other interventions within a CISM program the results are even stronger. In a study on traumatized bank employees (Leeman-Conley, 1990), a year with no assistance for employees was compared with a year in which a CISM program was used. Employees fared better with the CISM program. Sick leave in the year in which the CISM program was utilized was 60% lower. Additionally, workers compensation was reduced by 68%.

Western Management Consultants (1996) did a cost benefit analysis on a CISM program for nurses. The study involved 236 nurses (41% of the work force). Sick time utilization, turnover and disability claims dropped dramatically after the program was put in place. The cost benefit analysis showed $7.09 (700% benefit) was saved for every dollar spent on building the CISM program.

A recent evaluation of group crisis interventions was undertaken by Boscarino, Adams and Figley (2005). People working in New York City at the time of the World Trade Center attacks on September 11, 2001 who were offered crisis intervention services by their employers were compared to other workers whose

employers did not offer any form of organized crisis intervention services. Assessments conducted at one and again at two years after the traumatic events of September 11, indicate that those who received group Critical Incident Stress Management services demonstrated benefits across a spectrum of outcomes in comparison to workers without crisis intervention services. Lower levels of alcohol dependency, anxiety, PTSD symptoms, and depression were among the outcomes that indicated a marked difference between those receiving CISM services and who were not offered such services.

The reader is also directed to the reviews already performed on CISM (Hiley-Young & Gerrity, 1994; Dyregrov, 1997, 1998; Flannery, 2001; Everly et al., 2001, Mitchell, 2003a, 2004b). The following paragraphs summarize the research issues in the CISM field.

With the exception of randomized controlled studies by Deahl et al. (2000) and Campfield and Hills (2001) studies supportive of CISM and the small group CISD are all quasi experimental designs. Randomized controlled trials are certainly encouraged, however, the opportunity to conduct them under disaster field conditions may be extremely difficult or impossible (Jones & Wessely, 2003).

Further Readings and References

American Psychiatric Association (1964). *First aid for psychological reactions in disasters.* Washington, DC: American Psychiatric Association.

Bohl, N. (1991). The effectiveness of brief psychological interventions in police officers after critical incidents. In J.T. Reese and J. Horn, and C. Dunning (Eds.) *Critical Incidents in Policing, Revised (pp.31-38).* Washington, DC: Department of Justice.

Bohl, N. (1995). Measuring the effectiveness of CISD. *Fire Engineering,* 125-126.

Boscarino, J.A., Adams, R.E. & Figley, C.R. (2005). A Prospective Cohort Study of the Effectiveness of Employer-Sponsored Crisis Interventions after a Major Disaster. *International Journal of Emergency Mental Health,* 7(1), 31-44

Campfield, K. & Hills, A. (2001). Effect of timing of critical Incident Stress Debriefing (CISD) on posttraumatic symptoms. *Journal of Traumatic Stress*, 14, 327-340.

Caplan, G. (1964). *Principles of preventive psychiatry.* New York: Basic Books.

Chemtob, C., Tomas, S., Law, W., and Cremniter, D. (1997). Post disaster psychosocial intervention. *American Journal of Psychiatry*, 134, 415-417

Deahl, M., Srinivasan, M., Jones, N., Thomas, J., Neblett, C., & Jolly, A. (2000). Preventing psychological trauma in soldiers. The role of operational stress training and psychological debriefing. *British Journal of Medical Psychology*, *73*, 77-85.

Dyregrov, A. (1997). The process in critical incident stress debriefings. *Journal of Traumatic Stress, 10, 589-605*

Everly, G.S., Jr., Flannery, R. B., Jr., Eyler, V. & Mitchell, J.T. (2001). Sufficiency analysis of an integrated multi-component approach to crisis intervention: Critical Incident Stress Management. *Advances in Mind-Body Medicine*, 17, 174-183.

Farberow, N. L., & Frederick, C. J. (1978). Disaster relief workers burnout syndrome. Field Manual for Human Service Workers in Major Disasters. Washington, DC: US Government Printing Office.

Flannery, R.B. (1998). *The Assaulted Staff Action Program: Coping with the Psychological Aftermath of Violence.* Ellicott City, MD: Chevron Publishing.

Flannery, R.B., Jr. (2001). Assaulted Staff Action Program (ASAP): Ten years of empirical support for Critical Incident Stress Management (CISM). *International Journal of Emergency Mental Health*, 3, 5-10.

Flannery, R.B. (2005). Assaulted Staff Action Program (ASAP): Fifteen years of Empirical Findings. Paper presented at the 8th World Congress on Stress Trauma and Coping: Crisis Intervention: Best Practices in Prevention, Preparedness and Response. Baltimore, Maryland, USA February 16-20,

Frederick, C. J. (1977). Crisis intervention and emergency mental health. In Johnson, W.R. (ed), *Health in Action.* New York: Holt, Rinehart and Winston.

Hiley-Young, B. & Gerrity, E.T. (1994).Critical Incident Stress Debriefing (CISD): Value and limitations in disaster response. *NCP Clinical Quarterly,* 4, 17-19.

Jenkins, S.R. (1996). Social support and debriefing efficacy among emergency medical workers after a mass shooting incident. *Journal of Social Behavior and Personality, 11,* 447-492.

Jones, E. and Wessely, S. (2003). "Forward Psychiatry" in the military: it's origins and Effectiveness. *Journal of Traumatic Stress,* 14 (4), 411-419.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry,* 101, 141-148.

Mitchell, J. T. (1983). When disaster strikes … The critical incident stress debriefing process. *Journal of Emergency Medical Services*, *13*(11), 49 – 52.

Mitchell, J.T. (1986). Teaming up against critical incident stress. *Chief Fire Executive,* 1(1), 24; 36; 84.

Mitchell, J.T. (2003a). *Crisis Intervention and Critical Incident Stress Management: Aresearch summary.* Ellicott City, MD: International Critical Incident Stress Foundation.

Mitchell, J.T. (2003b). Major Misconceptions in Crisis Intervention. *International Journal of Emergency Mental Health,* 5 (4), 185-197

Mitchell, J.T. (2004a). Characteristics of Successful Early Intervention Programs. *International Journal of Emergency Mental Health*, 6 (4), 175-184.

Mitchell, J.T. (2004b). *Critical Incident Stress Management (CISM): A defense of the field .* Ellicott City, MD: International Critical Incident Stress Foundation.

Mitchell, J.T. & Bray, G. (1990). *Emergency Services Stress: Guidelines for preserving the health and careers of emergency service personnel.* Englewood Cliffs, NJ: Prentice Hall.

Mitchell, J.T. & Everly, G.S., Jr., (2001). *Critical Incident Stress Debriefing: An operations manual for CISD, Defusing and other group crisis intervention services, Third Edition.* Ellicott City, MD: Chevron.

Mitchell, J.T. & Everly, G.S., Jr. (2001). *Critical Incident Stress Management: Basic Group Crisis Interventions.* Ellicott City, MD: International Critical Incident Stress Foundation.

Nurmi, L. (1999). The sinking of the Estonia: The effects of Critical Incident Stress Debriefing on Rescuers. *International Journal of Emergency Mental Health,* 1, 23-32.

Parad, L., & Parad, H. (1968). A study of crisis oriented planned short –term treatment: Part II. *Social Casework*, *49*, 418-426.

Robinson, R.C. & Mitchell, J.T. (1993) Evaluation of psychological debriefings. *Journal of Traumatic Stress*, 6(3), 367-382.

Salmon, T. S. (1919). War neuroses and their lesson. *New York Medical Journal*, *108*, 993-994.

Wee, D.F., Mills, D.M. & Koelher, G. (1999). The effects of Critical Incident Stress Debriefing on emergency medical services personnel following the Los Angeles civil disturbance. *International Journal of Emergency Mental Health,* 1, 33-38.

Wessely, S., Rose, S., & Bisson, J. (1998). A systematic review of brief psychological interventions (debriefing) for the treatment of immediate trauma related symptoms and the prevention of post traumatic stress disorder (Cochrane Review). *Cochrane Library*, Issue 3, Oxford, UK: Update Software.

Western Management Consultants. (1996). *The Medical Services Branch CISM Evaluation Report.* Vancouver, B.C.: Author.

Yalom, I. (1970) *The theory and practice of group psychotherapy.* New York: Basic Books.