# Critical Issue Analysis - Psychological Debriefing

Psychological debriefing is one form of therapy that is used when traumatic events occur in an individual's life. Individuals who encounter a traumatic event may become distressed and risk developing a psychological illness. Psychological debriefing is an intervention process in which survivors are urged to recount and relive the incident in order to avoid long-term consequences and traumatic stress responses (Halgin, 2009). There are some claims that psychological debriefing is helpful while other claims indicate that there is no therapeutic value in debriefing but it causes no injury to the individual and others who claim that psychological debriefing increases the risk of the individual developing long-term psychological symptoms following a certain events. Some companies, in fear of litigation, require employees who have experienced a traumatic event to undergo psychological debriefing.

Debriefing has its beginnings in the military and is a form of psychological "first aid". General Marshall advocated the use during World War II to gather information from the troops about the fighting day but noticed that debriefing had a morale-building effect as well. Debriefing became popular again in 1983 when J.T. Mitchell published "When disaster strikes, the critical incident stress debriefing process". Mitchell described the debriefing process known as critical incident stress debriefing (CISD) which forms part of the wider strategy called critical incident stress management (CISM). The process of debriefing begins after a traumatic event and is a seven-stage process that occurs in a group session 24-72 hours after the traumatic event. These group sessions are facilitated by trained mental health workers.

Debriefing is different from an early intervention program. Early intervention, also called restorative treatment, is treatment available to individuals that request intervention following a traumatic experience. Early intervention is goal orientated, evidence-based, and

explicit. Early intervention is often used in the treatment of Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder (PTSD). The goal for early intervention is to restore the individual to a pre-trauma state of functioning. This is different that debriefing, where the goal is to reduce or mitigate the negative impact of an event through preventative intervention immediately following the trauma.

Everyone has experienced a time when bad thing happen to people. Sometimes these people develop long-standing psychological damage from these bad things. It is during these events that immediate interventions may take place, through a process called psychological debriefing (PD), to help relieve stress and mitigate or prevent long term psychological damage. Critical incident stress debriefing (CISD) and critical incident stress management (CISM) are two specific forms of psychological debriefing, often used interchangeably, that are compared and contrasted in this paper under the umbrella of psychological debriefing.

In recent years, debriefing has more and more popular. Many organizations use debriefing as a means to help individuals of a traumatic event, such as bank employees that have been involved in a robbery or a police officer involved in a shooting. Some organizations require debriefing as an intervention to reduce exposure to subsequent litigation. While other organizations use debriefing as a means to help individuals deal with the trauma they have experienced. The idea is that it is better to talk about the experience rather than bottle it up. Many individuals that have been part of a debriefing process report that the experience was a positive one.

As stated before, CISD has seven phases. The process begins with a trained facilitator explaining that CISD is not psychotherapy. They explain that CISD is a method used to alleviate stress reactions that have been triggered by the traumatic event. This is called the introduction

stage. The facilitator asks each group member to describe the traumatic event in detail to allow the others in the group understand what happened. This is the fact phase. After each participant has contributed in the fact phase, they move on to the thought phase, which consists of describing their thoughts as the event was occurring. The feeling phase comes next, which is designed to produce some emotional processing of the trauma. The thought is that the participants will benefit from sharing the emotions that were experienced during the trauma. This leads to the reaction phase where the participants are asked if they are experiencing stress or emotions now as a result of sharing the trauma with the group. The facilitator then moves the group to the strategy phase which consists of helping the group see the reactions they are experiencing are natural responses to the trauma they experienced and offers tips for stress management. The last phase, called re-entry, is the phase where the facilitator recaps what has occurred during the session and determines whether or not the participants require further assistance.

Compulsory debriefing, which is mandatory participation in a debriefing process, is used by organizations to fulfill obligations to employees under workplace health and safety commitments. These commitments provide employees who have experienced a traumatic event in the workplace with resources to reduce the possibility of long-term pathology. By providing compulsory debriefing, companies and organizations strive to reduce the risk of litigation after a workplace traumatic event.

There is some controversy over the validity of psychological debriefing. The 2002 Cochrane review (Rose, Wessely, & Bisson, 2001) included 11 studies of psychological debriefing literature found no benefit of PD intervention. The study did, however, exclude 19 other studies because of ‘methodological shortcomings’. The most troubling component of the

review was that it appeared that PD increased the likelihood of developing PTSD compared to no intervention. There was a trial that scored highest in quality ratings and follow-up times were the longest. The study was that of patients admitted to the Cardiff burns unit. The 18-month random study looked at the results of debriefing and no treatment. The study found a significant increase in the rate of PTSD in patients that received PD (Bisson, Jenkins, & Alexander, 1997).

It was difficult to question the benefits of debriefing until these trials were published. Some professionals feel that the negative results of the studies are a result of evaluating a hodgepodge of different types of interventions which leads to seriously flawed studies. Some professionals site that the individuals who are performing the debriefing are untrained and unaware of the sequence of events that need to be done before debriefing is begun which can skew the findings of any study. There are also some questions surrounding the need for debriefing. The thought is that maybe debriefing gets in the way of an individual's natural defense mechanisms which cause the effectiveness of debriefing to be diminished. Possibly the process an individual goes through when being debriefed increases the occurrence of long-term disorders.

Whether or not PD is effective is still up in the air. It is clear that there are some individuals that do have positive outcomes from participating in PD, while others do not. The lesson here is that people are more resilient than they have been give credit for. As professionals we need to recognize that no matter what the motive is or well-meaning our intentions are, there is the possibility that any intervention can do harm as well as good. Psychological debriefing was never intended to be the end all and be all of trauma intervention but rather as a part of a comprehensive therapy solution that helps enable patients to gain access to resources to provide prompt treatment of trauma related disorders.

## References

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