Beyond the Debriefing Debate: What Should We Be Doing?

By Bryan E. Bledsoe, DO, FACEP, EMT-P, & Donn Barnes, LP

There are few things in EMS that stir up emotion and controversy like the debate over whether we should use Critical Incident Stress Management (CISM), and its primary intervention, Critical Incident Stress Debriefing (CISD), to help our EMS and fire service colleagues deal with stressful events. Proponents of CISM are loyal to the practice and often cite anecdotal evidence as to its effectiveness. Likewise, critics point to various research studies that indicate CISD is ineffective and possibly harmful. In response, CISM proponents try to discredit the negative research studies for a variety of reasons. Finally, critics, in turn, critique the criticism. Where will it end? Perhaps it has.

Some of the world’s foremost researchers on psychological trauma have published a major document that should put the controversy to rest. The document, titled “Does Early Psychological Intervention Promote Recovery from Posttraumatic Stress?” was recently published in Psychological Science in the Public Interest. The Wall Street Journal recently ran a feature on the controversy. The authors are well-respected psychologists who do not have a proprietary interest in CISM or any competing model. They are Richard J. McNally, PhD, of Harvard University (Cambridge, MA); Richard A. Bryant, PhD, of the University of New South Wales (Sydney, NSW); and Andre Ebers, PhD, of King’s College London (London, UK). In this study, they systematically reviewed the world literature on early psychological interventions (including psychological debriefing and CISD) and made several observations and recommendations.

The Rise of CISM

CISM was first introduced to EMS and the fire service in 1983. Originally called CISD, it was adopted widely, although there was little, if any, scientific evidence to support the practice. Operational debriefings were first used in the military, starting with World War I, and used frequently in subsequent military activities. The founder of CISM, Jeff Mitchell, PhD, reasoned that using a similar approach might reduce stress reactions of EMTs, firefighters, police officers and others exposed to what he described as “critical incidents.” Later, the practice was modified for use in other groups, such as military personnel, teachers, social workers, airline personnel—virtually anybody exposed to a “critical event.” In fact, the phrase “counselors will be on hand” has become a common theme for any disaster—regardless of the nature—from school shootings to car wrecks to bad EMS calls.

Following the terrorist attacks on the World Trade Center (WTC) in 2001, more than 9,000 grief and crisis counselors descended on New York City to provide their services. In fact, one organization (Crisis Management International) sent over 350 therapists and rented every available room in a prominent New York hotel. The Church of Scientology sent 800 volunteers to provide “spiritual first aid” to Ground Zero workers. However, they found people too busy with other human needs to take time for counseling or debriefing. Distressed that so few were availing themselves of offered mental health services, the counselors and debriefers determined that all must be in denial—a sure sign of PTSD. Thus, they began to stop people on the street and in hospital lobbies to perform “curbside assessments.” They concluded that PTSD in New York City was significant. However, studies have shown that while PTSD symptoms in Manhattan were high following the attacks, they fell to near normal levels within a few months—a sign of the resilience of humankind to stress. This begs the question, “If PTSD and severe stress reactions are uncommon and only affect a small percentage of the population, why do we provide crisis therapy interventions to all?”

The Science

McNally and his colleagues carefully reviewed the literature supportive of debriefing and contrasted it with literature critical of the practice. They found numerous high-power studies that showed debriefing to be ineffective, while others showed that it, in fact, harmed some. These studies included meta-analyses, randomized controlled trials (RCTs) and several good quasi-experimental studies. However, when they reviewed the studies supportive of CISM they wrote,
"Because of their methodological limitations, these studies fail to provide a convincing case for the efficacy of debriefing to mitigate distress and prevent posttraumatic psychopathology."28

The authors went one step further. They specifically reviewed and, in fact, debunked the arguments used by CISM proponents to try and discredit the negative studies. Some of these arguments include:

- **All of the negative studies looked at individual debriefings.** CISM only advocates group debriefings. Most debriefings provided in clinical practice are individual, not group debriefings. Furthermore, CISM advocates often cite individual debriefing studies when the results are favorable," but discount them when the results are not favorable. CISM proponents have also never demonstrated why an intervention would work when delivered to a group, but not work when delivered individually. While group debriefing may encourage some to talk, it might inhibit others. Finally, if group debriefings were more effective, it would have been demonstrated in the RCTs. However, those studies have failed to show that group debriefings make any difference in regard to PTSD symptoms. In fact, some studies of group debriefings have shown that people actually get worse.41

- **Debriefing was never intended to be a "stand-alone" technique.** The authors illustrate several problems with this reasoning. First, proponents of CISD originally wrote it "will generally alleviate the acute stress responses that appear at the scene and immediately afterwards and will eliminate, or at least inhibit, delayed stress reactions." Proponents of CISM have stated this same thing in other writings.41 Their writings contradict their current assertion. Furthermore, several negative studies used multiple techniques (debriefing, debriefing, education—all provided by CISM-trained debriefers) and still found the practice ineffective.41

- **Researchers are not studying CISM and must test CISM and not just CISD.** CISD is not an intervention, but an umbrella term to describe various things such as education, planning and family support. CISD is the intervention. Thus, you cannot study CISM, but you can study CISD with objective measures.41

- **The surveys show people appreciate debriefing.** Even studies that reported a negative outcome found that people appreciated the debriefing. But, consumer satisfaction ratings probably reflect a polite expression of gratitude on the part of the debriefed subject rather than any effectiveness of CISD. The authors state, "People usually feel better at follow-up and may attribute this to the debriefing, not knowing that, on average, they likely would have been just as well if they had not been debriefed."41

- **Researchers are using the wrong measures to study CISM.** The standard method of study of psychological (and medical) interventions is the RCT. CISM proponents have yet to have a RCT show CISD effective. Also, proponents of CISM say you cannot use measures of PTSD as a gauge for effectiveness of CISD. But, Mitchell reports several studies as supportive of CISD that use PTSD symptoms as a measure.41 It is unclear why favorable studies that use PTSD symptoms as a measure are acceptable while unfavorable studies are not.

- **The negative studies used debriefing on primary victims.** CISD is only for secondary victims such as EMTs and firefighters. Again, proponents of CISM embrace studies that evaluated use of CISD for primary victims when the studies were favorable,41 but discounted them when they were negative. There is no evidence that primary victims suffer a different form of psychological trauma compared to secondary victims.
The debrievers were not properly trained or failed to follow the “Mitchell model,” or otherwise departed from protocol. The authors found several problems with this argument. First, before you can fault someone for not following a specific model, you must assume that the model is valid. No study has ever shown the CISM model of debriefing to be effective. The authors write, “Debriefing advocates seemingly believe that one is entitled to assert the efficacy of debriefing until scientists prove to the contrary.” This is a classic example of circular reasoning. The burden of proof lies squarely on the shoulders of those claiming the efficacy of a specific protocol. Only when a specific protocol has been shown to be effective is one entitled to complain when researchers depart from it. And, in reality, most of the negative studies did use the “Mitchell model” of debriefing—although many modified it for individual debriefings. Furthermore, most of the studies Mitchell says are supportive of CISM deviate more from the “Mitchell model” than do the critical studies.

Martin P. Deahl, PhD, a prominent researcher in this area, makes an important observation about some of the issues discussed here: “Many workers in the field of psychological trauma clearly have powerful vested interests in promoting the efficacy of interventions such as PD [psychological debriefing] that often they themselves developed. Indeed, research grants, as well as the livelihoods of individuals employed by companies contracted to provide debriefing services, might depend on it. The last decade has witnessed the emergence of a ‘disaster industry.’”

Other Treatment Modalities

Mainstream researchers have concluded that psychological debriefing and CISM are ineffective and possibly harmful. So, several other strategies have been proposed to help prevent and treat victims of psychological trauma in hopes of mitigating the effects of stress and preventing PTSD. Some of these include:

- **Eye movement desensitization and reprocessing (EMDR).** In EMDR, a therapist moves his or her finger back and forth, and the client is supposed to follow the finger with his eyes. While moving the eyes back and forth the client is supposed to concentrate on an unbearable memory. This supposedly helps with stress. Proponents of EMDR don’t know why it works (if it does). Research supporting the practice is limited at best—but it is widely used by certain practitioners.

- **Thought Field Therapy (TFT).** TFT is a psychotherapy treatment whereby practitioners tap various parts of the body in particular sequences, called “algorithms,” in order to correct unbalanced energy flows known as “thought fields.” The idea is that abnormalities in these thought fields are the cause of psychological disturbance and can be remedied. No credible research supports the practice.

- **Psychopharmacology.** Some advocate the use of medications (benzodiazepines, beta blockers, antidepressants) for stress and the treatment of PTSD. However, research to support the effectiveness of this approach is lacking.

- **Cognitive-behavioral therapy (CBT).** CBT is a form of psychotherapy that emphasizes the role of thinking in how we feel and what we do. Cognitive-behavioral therapists teach clients that when the brain is healthy, it is our thinking that causes us to feel and act the way we do. Therefore, if we are experiencing unwanted feelings and behaviors, we can identify the thinking that is causing the feelings or behaviors and learn to replace this thinking with thoughts that lead to more desirable reactions. CBT is the only therapy that has proven effective in quality research in preventing or treating PTSD. It is usually

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What Should We Be Doing?

First of all, CISM and psychological debriefing (in any form) should no longer be used in emergency services. Advocates of CISM have stated and written that organizations may be placing themselves in legal peril by not providing debriefing for their employees and those affected. McNally and colleagues summed this up well when they wrote, "The executives feared lawsuits should they fail to debrief their employees. Ironically, the executives may have had the liability risk backwards. Given the absence of data showing that debriefing works, and given some studies suggesting that debriefing may impede natural recovery from trauma, companies may be at heightened risk if they do debrief their employees, especially if they fail to provide informed consent (i.e., summarizing all the studies showing no effect for debriefing). And this risk might be especially great if these companies simply debriefed everyone without conducting a formal psychological assessment first."

Several leading organizations have recommended strategies for aiding those in distress and those who are victims of traumatic stress. This strategy is called "psychological first aid" and requires no special training, no certification, and provides no psychological intervention—just meeting basic human needs. It includes:

- Listening
- Conveying compassion
- Assessing needs
- Ensuring that basic physical needs are met
- Not forcing personnel to talk
- Providing or mobilizing company from family or significant others
- Encouraging, but not forcing, social support
- Protection from additional harm

In terms of general guidelines in regard to organizational response to stressful events, the following strategies are recommended:

Small Incidents:

- The mental health needs of those involved in small incidents (in size), including those that result in the deaths of colleagues, should be handled by competent mental health personnel.
- Provide psychological first aid.
- Debriefing should not be provided.
- Mental health personnel should screen affected personnel for up to two months for abnormal responses to stress.

Major Incidents/Disasters:

- The stress of major events can be mitigated by several strategies:
  - Proper use of Incident Command System.
  - Rotating personnel out of the disaster scene.
  - Providing psychological first aid.
  - Debriefing should not be provided.
  - Constant surveillance of personnel by competent mental health personnel for signs of stress.
  - Post-incident surveillance of involved personnel by competent mental health personnel.

Summary

It is clear that it is very difficult to treat trauma-related stress after the fact. EMS and fire personnel must develop personal stress management strategies and have a personal support system in place. Most stresses in EMS are the day-to-day hassles of the job. Occasionally, some of us will be involved in a disaster operation. As with the day-to-day stressors, the best way to manage disasters is...
through planning and preparation. As Lauren Simon Oostrow wrote, "In the end, EMS may want to re-examine the all-American notion that we should always feel good, that stress is bad and that we have to take corrective action to resolve every negative reaction to stress, even if it is normal."

References

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