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**In the Midst of a Revolution:
A Explanation and Criticism of Critical Incident Stress Management**

By Danielle Maaks

A revolution is underway, a revolution of mitigation. The affects of this revolution can be found in every manner of life. Children are being taught to balance their diet and exercise to ward off any number of diseases, after centuries of living in flood plains people are relocating to the cliffs, and after a disaster trauma mitigation is used. Mitigation is the act of preparing for an event in order to lessen the affects of the event. Mitigation in most senses is used to mean preventing costly loss of property, but in the psychological community it is being used to prevent psychological damage, damage much more difficult to repair than any property. The method of mitigation most commonly used by those living in the United States is Critical Incident Stress Management (CISM). This technique is being incorporated into agencies which serve millions of people every year, such as branches of the military and the Red Cross. Yet this is a system of mitigation which is understood little by the common public and not empirically established in the scientific community. During my research of CISM, I have learned much about the techniques employed by the practitioners of this model, but could find little evidence of its validity. I have divided my research and conclusions into four sections: methods of research, the basics of CISM practice, criticisms of CISM method, and a annotated bibliography of research.

Methods of Research

In my search for any information regarding CISM I employed a number of resources. The first area I scoured for information is the World Wide Web. Using several search engines, both popular and academic, I was able to find a number of resources. The two, which I frequented for general information and the latest research findings, were The American Academy of Experts in

Traumatic Stress and The International Foundation of Critical Stress. They are both excellent resources for methodical information, but they are both private institutions which screen their material thoroughly before posting it on their sites. The lack of inconclusive or negative findings in the research they post is suspicious. Trying to ward against biased research findings I began looking in trauma, counseling, and medical journals as, well, as popular publications such as the *Washington Post* for more well rounded research. Unfortunately the amount of independent research on CISM is minuscule, and the majority which is available has poor methodology or small populations. I have also received a number of materials from my professor, who has been trained in CISM. The conclusions I draw are based on seventeen works, from widely varied sources, all of which will be discussed in a later section.

The Basics of CISM

Critical Incident Stress Management is a group of techniques used to mitigate the effects of a tragedy or trauma experienced by a group of people. The need for CISM became apparent as the study of Post Traumatic Stress Disorder (PTSD) developed. Veterans of Vietnam were experiencing unusual psychological symptoms by the thousands, and what many veterans of previous wars called “shell shock” was now being recognized as a serious life-disrupting disorder. As the study of PTSD became more mainstream, it was found that other groups in addition to veterans were surviving their tragedy or trauma with PTSD. These other groups include survivors of abuse, witnesses to tragedy, or emergency service personnel who work in trauma and stress every day. It is this group which Jeffery Mitchell focused on when developing CISM. Mitchell

had himself been a Emergency Medical Services Personal and been witness to many of the symptoms of PTSD and other extreme stress related disorders. Originally designed to be used with emergency services personnel, such as firefighters, police, and paramedics, CISM is been adapted to all populations, including children. The American Red Cross as adopted a revised CISM model into their national mental health training. It is because the popularity of this type of psychological model that it is so urgent to produce excellent experimental research on the topic. The cause of CISM's wide spread use could be contributed to its short duration and well rounded approach to coping.

Critical Incident Stress Management is a comprehensive, organized approach for the reduction and control of harmful aspects of stress in emergency situations. It is to be preformed within the first seventy-two hours after a traumatic event. It includes many stages of treatment as, well, as many forms of support. Professional support is offered in the use of pre-incident traumatic stress education, continuing stress education, Critical Incident Stress Teams, professional counseling, and specialty debriefings. CISM also makes use of many non-professional support services such as peer counseling, family support services, and chaplain services. The area which I will most explore is the Critical Incident Stress Debriefing (CISD) process.

CISD is a group of meetings or discussions about a traumatic event. The CISD and defusing processes are solidly based on crisis intervention theory and educational intervention theory. The CISD and defusing processes are designed to mitigate the psychological impact of a traumatic event, prevent the subsequent development of post - traumatic syndrome, and serve as

early identification mechanism for individuals who will require professional mental health follow-up subsequent to a traumatic event. (Everly 1997,10) CISD is very organized and structured; one would employ a seven stage model in the debriefings. These debriefings are to be lead by a trained professional with at least a masters degree in a helping profession. CISD's are broken into seven distinct stages: the introduction, fact, thought, reaction, symptom, teaching, and re-entry stages.

The introduction phase begins by introducing the intervention team members, explaining the process of CISD and setting the expectations of the session. The fact phase is used to obtain a description of the traumatic event from each participant's perspective on a cognitive level. The function of the thought phase is to allow participants to describe cognitive reactions and to transition to emotional reactions. The reaction phase is used to identify the most traumatic aspect of the event for each participant and to identify the emotional reactions. The symptom phase identifies personal symptoms of distress and transitions the volatile back to a cognitive level. The teaching phase educates the participants as to normal reactions to the trauma they experienced and adaptive coping mechanisms which they may employ to "get through" the after effects of the trauma. The re-entry phase is used to clarify any ambiguities about the process or each phase and to prepare for termination of the debriefing.

These phases are integral to the proper use and success of CISD. Anyone leading a debriefing should be carefully trained to keep the structure and intent of CISD as close to the standard as possible. (Mitchell 1996, 98) It is important to note that CISD is not therapy, it is an exercise in

debriefing and does not take the place of support systems or professional counseling. It is used to normalize the survivors reactions to extreme situations. CISD also gives the survivors of a tragedy information on how to cope in a healthy fashion and what agencies or support services can help if they have difficulty coping. Another important facet of CISD is it can help pin point those who might need counseling, before they fall through the cracks. Used properly CISD can , in my estimation, play a integral role in the maintenance of mental health for emergency service personal.

Criticisms of CISM

The vast majority of opinions about CISM I have come across in my research have been nothing but positive. There are a few studies which bring up questions that must be addressed, as everyday CISM is being adapted in different ways to work with a ever widening scope of population. The first and most damaging observation researchers of CISM must concede to is the lack of experimentation attesting to the validity of this methodology. The progression and integration of CISM techniques have expanded to the general population so fast science has been unable to create a solid foundation of experimental support for this technique. If this foundation of experimentation were in place the other remaining criticisms of CISM could be addressed with probability and statistical data, however, because of the decided lack of experimentation one must address the criticisms of CISM with logic and supposition instead of fact.

The element of this technique which is most obviously controversial is the mandatory attendance of those involved in the trauma. At first glance, I took this as an affront to all I had been taught in Psychology, it seems to go against the very principal of individual differences - the

same principle that makes therapy and counseling so exciting and challenging. Isn't herding everyone into one type of intervention denying a person's right to individual grieving? In the case of CISM I must disagree with my own initial observation. Upon closer study of the subject, a number of reasons surfaced which made mandatory attendance, not only acceptable but an excellent practice. Mandatory attendance does not mean that the person must participate. If they choose to they could remain silent during the course of the intervention. If one does not participate, why must they be involved in the intervention? First, the group went through the disaster together and each person played a role, without each role being represented the complete picture is not brought out in the debriefing and all other participants would suffer because of that. By being present they also show support for their co-workers, which is important during the emotional aftermath of a disaster. Another by-product of mandatory attendance is that those who would often grieve in private would be exposed to others' interpretation and reactions to the event, thus normalizing whatever emotions they have and giving a different perspective on the traumatic event. This normalization is a key factor in CISD, where often in trauma people have skewed memories of the events and begin to feel terribly isolated by their emotions and reactions to the trauma they experienced. If involved in a debriefing, even as a passive bystander, the emergency service person is exposed to a number of different interpretations of the event and is not isolated in their emotions since many others in the group probably feel similarly.

The second criticism of CISM involves the length of the intervention. This criticism is a simple misunderstanding of CISM's purpose. I thought a three hour or less debriefing was

certainly not enough to get someone through a traumatic event. If one would look at the purpose and structure of CISM it is explained that it is not therapy or counseling. It is used to normalize the emotional and cognitive reactions after a traumatic event before coping mechanisms, which might interfere with healing, take effect. Its other primary directive is to educate the survivors to recognize coping mechanisms, positive and negative, in themselves, and to know the resources available in the area if they need more help dealing with the situation. CISM is not therapy nor does it pretend to be; it is a crisis intervention and educational debriefing model. If used in its proper context, I believe it is effective in its objectives.

Conclusion of CISM/CISD Technique

During my research I found many testimonials to the effectiveness of CISM/CISD in an abundance of environments and with a wide range of populations. After familiarizing myself with the principals of the technique and the goals of the interventions the method seemed to be a wonderful idea. To be able to reach people, before they have built up a psychological wall around the issue they are facing and before they learn to cope by employing negative escapism, would be a dream of many therapists. The technique seems to make perfect sense. However, Psychology is a science based on experimentation and statistical “proof”, and without that Critical Incident Stress Management is simply another unfounded theory. Unfortunately, in the community’s rush to use these new techniques, it never stopped to ask if there was proof it worked. CISM needs a strong foundation of experimentation before it is adapted to use in every population and should have had such a foundation before giant organizations, like the American Red Cross and the military,

incorporated it into their arsenal of defense against burn out and PTSD of their members. In the future, as society becomes more focused on preventing than curing, CISM techniques will be used on a steadily growing number of populations. Maybe as the need for CISM increases the call for testing of its basic principals will too and through experimentation CISM can evolve and grow with the populations it will serve