Annex J:
Critical Incident Stress Management
I. Introduction

In the aftermath of a disaster, whether it is natural or man-made, the individuals directly involved, both victims and those responding, and sometimes those just experiencing the disaster through the news media, may suffer emotionally. It is estimated that disasters may create significant impairment in 40-50% of those exposed. About 50% of disaster workers are likely to develop significant distress. As many as 45% of those directly exposed to mass disasters may develop post traumatic stress disorder (PTSD) or depression. These are normal reactions to abnormal events. Events such as September 11, 2001, images of war, the shuttle Challenger disaster and similar events may trigger emotional responses that may require treatment.

Of particular concern is the mental state of those responding who experience the effects of the disaster up-close. Particular attention must be given to the worker so that they may remain effective in their response and so that they will not suffer long-term effects from their exposure to the results of a disaster. Disaster responders with high levels of disaster exposure and/or those experiencing long, fatiguing work schedules should be monitored for the possible emergence of post-traumatic stress disorder (PTSD), depression, or alcohol abuse. Mental health screening measures should be used to efficiently and accurately identify those who may be experiencing mental health problems during disaster response and following a disaster.

The ability of other individuals involved, either directly or indirectly, is also of concern. The ability of individuals to return to a pre-event mental state may or may not be possible. However, it is important to refocus individuals back to some sense of normalcy, including those who may have been drawn to the experience of the event through news reports or other media.

A. Purpose

The purpose of this annex is to provide guidance for the mental well being of those responding to a disaster through Critical Incident Stress Management (CISM) interventions.

Resources available for CISM for responders as well as to address the mental health needs of others will be identified where available to include resources of the University of Georgia Crisis Response Team, the Department of Human Resources, and the Red Cross.

II. Situation and Assumptions

- An incident or event has occurred that has caused either or both responders, victims and/or the general public to experience what would be considered a significant emotional reaction to abnormal events.

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• Personnel employed by or volunteering for Georgia Health Sciences Health System are, as a result of a disaster like event or incident, facing an event of significant emotional reaction

• Personnel responding to the incident of event will require some level of CISM briefing

III. Roles and Responsibilities

Georgia Health Sciences Health System has responsibility for the care and well being of its employees and volunteers supporting Georgia Health Sciences Health System, either directly or by coordination with other providers of mental health services. Georgia Health Sciences Health System should provide CISM support for those supporting the Georgia Health Sciences Health System mission, providing crisis interventions as appropriate. The primary resource for CISM will be internally through the Mental Health department and externally through the University of Georgia Crisis Response Team and/or local CISM teams available through other resources.

Red Cross resources will be employed to provide basic services to others. This may include direct intervention by MHDDAD and/or Red Cross counselors at a response center, through a MHDDAD operated helpline, and/or the dispatch of counselors to a location for individual and/or group interventions.

IV. Preparedness

Training of Mental Health Professionals in the area of Crisis Incident Stress Management is critical in the preparation for a CISM incident. Therefore, Georgia Health Sciences Health System Emergency Management in conjunction with State and Federal Resources will make available any and all training related to CISM to the Mental Health professionals within Georgia Health Sciences University and Georgia Health Sciences Health System.

V. Concept of Operations

The goals of crisis intervention are four-fold:

1. Stabilization
2. Symptom reduction
3. Return to adaptive functioning, or
4. Facilitation of access to continued care.  

The following table is taken from the International Journal of Emergency Mental Health and defines the core components of Critical Incident Stress Management and the various interventions that may be applied.

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2 Mitchell, p. 21.
### Table 1: Critical Incident Stress Management (CISM): The Core Components

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>TIMING</th>
<th>ACTIVATION</th>
<th>GOAL</th>
<th>FORMAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2a. Demobilizations &amp; staff consultation (rescuers)</td>
<td>Shift disengagement</td>
<td>Event driven</td>
<td>To inform and consult, allow psychological decompression. Stress management.</td>
<td>Large groups/ Organization</td>
</tr>
<tr>
<td>2b. Crisis Management Briefing (CMB) (civilians, schools, business)</td>
<td>Anytime post-crisis</td>
<td>Event driven</td>
<td>To inform and consult, allow psychological decompression. Stress management.</td>
<td>Large groups/ Organization</td>
</tr>
<tr>
<td>3. Defusing</td>
<td>Post-crisis (within 12 hours)</td>
<td>Usually symptom driven</td>
<td>Symptom mitigation. Possible closure. Triage.</td>
<td>Small groups</td>
</tr>
<tr>
<td>4. Critical Incident Stress Debriefing (CISD)</td>
<td>Post-crisis (1 to 10 days; 3-4 weeks mass disasters)</td>
<td>Usually symptom driven</td>
<td>Facilitate psychological closure. Symptom mitigation. Triage.</td>
<td>Small groups</td>
</tr>
<tr>
<td>6a. Family CISM</td>
<td>Anytime</td>
<td>Either symptom driven or event driven</td>
<td>Foster support &amp; communications. Symptom mitigation. Closure, if possible. Referral, if needed.</td>
<td>Families/ Organizations</td>
</tr>
<tr>
<td>6b. Organizational consultation</td>
<td>Anytime</td>
<td>Either symptom driven or event driven</td>
<td>Foster support &amp; communications. Symptom mitigation. Closure, if possible. Referral, if needed.</td>
<td>Families/ Organizations</td>
</tr>
<tr>
<td>7. Follow-up/ Referral</td>
<td>Anytime</td>
<td>Usually symptom driven</td>
<td>Assess mental status. Access higher level of care, if needed.</td>
<td>Individual/ Family</td>
</tr>
</tbody>
</table>

#### a. Phase One – Preparedness and Prevention

This phase should be accomplished prior to a disaster response. This corresponds to the first intervention described previously in Table 1. This is accomplished through training, to include exercises in which people are forced to consider the implications and realities of the responses that may be required in disaster situations.

Employees and volunteers should receive instruction on basic mental health wellness steps, including the need for supervisors to monitor the performance of those they supervise during disaster events for signs of stress.

A group of employees and/or volunteers should receive basic CISM training.

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3 Mitchell, p. 55.
2. **Phase Two – Detection and Response**

This phase includes the detection of and response to an incident or event of Georgia Health Sciences Health System significance. Depending on who is impacted by the event, an internal CISM response team may be used to perform CISM interventions. If those team members are directly involved in the disaster response, CISM teams may be requested from other jurisdictions or agencies. Those agencies that have CISM teams within the region include law enforcement and fire and emergency medical services.

Georgia Critical Incident Stress Foundation (GCISF) has established a GCISF Crisis Hotline Number with a crisis duty officer who can coordinate CISM team resources as well. They can be contacted at 770-288-7900. (website: www.gcisf.org)

In addition to the normal CISM team response, services may also be requested through the Georgia Crisis & Access Line at 1-800-715-4225. or on-line at www.mygcal.com.

This phase includes the detection of and response to an event of Georgia Health Sciences Health System significance. This response may include interventions 2 through 7 as listed in Table 1.

a. **Demobilization**

Demobilization is used only for large-scale events and may follow an incident within a few days to several weeks. Demobilization is always held away from the scene of the event and those being demobilized are returning to their normal duties. Demobilization consists of a break for food and rest of about twenty minutes and a ten minute presentation. Details are contained in the appendices to this Annex.

b. **Crisis Management Briefing**

The Crisis Management Briefing (CMB) is a practical four-phase group crisis intervention. It is designed to be highly efficient in that it requires from 45 to 75 minutes to conduct and may be used with “large” groups consisting of 10 to 300 individuals. While designed to be used with primary victim civilian populations in the wake of terrorism, mass disasters, violence, and other large-scale crises, it may have applicability in other settings with other populations, as well. The CMB is designed to be used within a comprehensive CISM framework, and should not be used as a “stand-alone” intervention. It is anticipated that, depending upon the crisis event, there will be a need for CISD and individual (1:1) crisis interventions subsequent to CMB. And, as always, arrangement should be made for follow-up assessment and referral for continued psychological care, if needed. Additional details are contained in the appendices to this Annex.
c. Defusing

Post-traumatic stress Defusing and its parallel intervention, critical Incident stress debriefing, are interventions designed specifically for the prevention of post-traumatic stress and PTDS among high risk occupational groups and disaster workers. Defusing is a small group discussion following a critical event, usually provided within eight to twelve hours of the event. The process involves three phases and lasts less than one hour. It is best conducted in a secluded room adequate for the purpose and is attended only by a group with similar experiences from the event.

The three phases include an introduction, exploration and information. These phases are discussed in detail in the appendix to this Annex and includes aids for conducting a defusing intervention.

d. Critical Incident Stress Debriefing

Critical Incident Stress Debriefing and its parallel intervention, post-traumatic stress defusing, are interventions designed specifically for the prevention of post-traumatic stress and PTDS among high risk occupational groups and disaster workers. The modified CISD appears especially suited for mass disasters and community response applications. The process is depicted in the following chart and the stages are defined in the table that follows. Additional information is contained in the appendices.

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4 Mitchell, p. 132.
Stages of CISD

<table>
<thead>
<tr>
<th>Stage</th>
<th>Introduction</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Introduction</td>
<td>To introduce intervention team members, explain process, set expectations.</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Fact</td>
<td>To describe traumatic event from each participant’s perspective on a cognitive level.</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Thought</td>
<td>To allow participants to describe cognitive reactions and to transition to emotional reactions.</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Reaction</td>
<td>To identify the most traumatic aspect of the event for the participants and identify emotional reactions.</td>
</tr>
<tr>
<td>Stage 5</td>
<td>Symptom</td>
<td>To identify personal symptoms of distress and transition back to cognitive level.</td>
</tr>
<tr>
<td>Stage 6</td>
<td>Teaching</td>
<td>To educate as to normal reactions and adaptive coping mechanisms, i.e., stress management. Provide cognitive anchor.</td>
</tr>
<tr>
<td>Stage 7</td>
<td>Re-Entry</td>
<td>To clarify ambiguities, prepare for termination, facilitate “psychological closure,” i.e., reconstruction.</td>
</tr>
</tbody>
</table>

More details are contained in the appendix to this Annex, including aids for conducting a CISD.

e. Individual Crisis Intervention

While the focus of this annex is group intervention and its methodologies, individual crisis intervention may be necessary when individuals are not willing to participate in group intervention or when they start with a group and then withdraw, such as in a CISD. Individual crisis intervention has the potential goals of assessment, screening, education, normalization, reduction of acute distress, triage and facilitation of continued support if needed. It is not psychological counseling intervention, but just allowing individuals to express themselves in a non-group setting.

f. Family Critical Incident Stress Management/Organizational Consultation

Family critical incident stress management and organizational consultation may use any of the other group intervention methods such as individual crisis interventions, crisis management briefings and critical incident stress debriefings.

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5 Mitchell, p. 130.
g. Follow-up/Referral

There are mental health responses that are beyond the scope of CISM. These must be referred to mental health professionals. There should be no reluctance to take this step if there is any concern for the individual’s mental state.

h. Respite/Rehab Centers

Respite/Rehab Centers are important ongoing physical and psychosocial decompression areas established near the disaster site to provide support to personnel. Support provided in these centers includes such things as beverages, light food, protection from weather, and provision of psychological support/stress management. It provides an area for test and/or diversion with such things as television, playing cards, etc. that are appropriate for use in an ongoing event.

Demobilization or Crisis Management Briefings may take place within the respite/rehab center. Informational handouts regarding CISM should be available. This location also provides an opportunity to assess the physical and psychological status and needs or personnel.

VI. Recovery/Mitigation

Recovery is the transition to normal operations. From a mental health view, this may involve a continuation of intervention 7 as described in Table 1. Depending on the nature of the response event, the results could lead to Post Traumatic Stress Disorder, or PTSD, that requires long term care for the person to return to a “normal” mental state. The desire is for individuals and organizations to return to normal functioning. It should be remembered that after traumatic events, individuals’ lives change forever and an organization may be forever changed in their view of disaster response.

VII. Administration and Logistics

a. The CISM team members should maintain records of their activation activities, including any costs incurred in carrying out team activation and responsibilities. Time reports and expense related documentation should be submitted to the Administration and Logistics section on a regular basis or as reasonable.

b. Individuals having CISM team responsibilities should maintain necessary personal items at the ready for possible activation.

VIII. Plan Development and Maintenance

The Georgia Health Sciences Health System Emergency Management Committee in conjunction with the Emergency Management Specialist will conduct an annual review of this plan. Any and all changes will be documented and submitted to the Safety Committee for approval no later than August 30th of each year.
IX. External Agency Review

A copy of this plan will be submitted to:

- East Central Health District – Emergency Preparedness
- Georgia Health Sciences University Emergency Preparedness and Public Safety.
- Richmond and Columbia County EMA
- Other partners upon origination and thereafter as revision occur.

X. Authorities and References


National Center for Post-traumatic Stress Disorder, www.ncpstd.va.gov: Comprehensive list of clinical and research resources, including handouts to assist in working with disaster victims of all ages.

Field Manual for Mental Health and Human Service Workers in Major Disasters, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, www.samhsa.gov


Appendices

Critical Incident Stress Information Sheet\(^6\)
Demobilization\(^7\)
Crisis Management Briefing (CMB)\(^8\)
Defusing\(^9\)
Critical Incident Stress Debriefing (CISD)\(^10\)


\(^6\) Mitchell, pp. 219-220.
\(^7\) Ibid., pp. 85-88.
\(^8\) Ibid., pp. 90.
\(^9\) Ibid., pp. 107-111.
\(^10\) Ibid., pp. 126-129, 131.
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**CRITICAL INCIDENT STRESS INFORMATION SHEET**

You have experienced a traumatic event or a critical incident (any event that causes unusually strong emotional reactions that have the potential to interfere with the ability to function normally). Even though the event may be over, you may now be experiencing or may experience later, some strong emotional or physical reactions. It is very common, in fact quite normal, for people to experience emotional aftershocks when they have passed through a horrible event.

Sometimes the motional aftershocks (or stress reactions) appear immediately after the traumatic event. Sometimes they may appear a few hours or a few days later. And, in some cases, weeks or months may pass before the stress reactions appear.

The signs and symptoms of a stress reaction may last a few days, a few weeks, a few months, or longer, depending on the severity of the traumatic event. The understanding and the support of loved ones usually cause the stress reactions to pass more quickly. Occasionally, the traumatic event is so painful that professional assistance may be necessary. This does not imply craziness or weakness. It simply indicates that the particular event was just too powerful for the person to manage by himself.

Here are some common signs and signals of a stress reaction:

<table>
<thead>
<tr>
<th>Physical*</th>
<th>Cognitive</th>
<th>Emotional</th>
<th>Behavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td>chills</td>
<td>confusion</td>
<td>fear</td>
<td>withdrawal</td>
</tr>
<tr>
<td>thirst</td>
<td>nightmares</td>
<td>guilt</td>
<td>antisocial acts</td>
</tr>
<tr>
<td>fatigue</td>
<td>uncertainly</td>
<td>grief</td>
<td>inability to rest</td>
</tr>
<tr>
<td>nausea</td>
<td>hypervigilance</td>
<td>panic</td>
<td>intensified pacing</td>
</tr>
<tr>
<td>fainting</td>
<td>suspiciousness</td>
<td>denial</td>
<td>erratic movements</td>
</tr>
<tr>
<td>twitches</td>
<td>intrusive images</td>
<td>anxiety</td>
<td>change in social activity</td>
</tr>
<tr>
<td>vomiting</td>
<td>blaming someone</td>
<td>agitation</td>
<td>change in speech patterns</td>
</tr>
<tr>
<td>dizziness</td>
<td>poor problem solving</td>
<td>depression</td>
<td>loss or increase of appetite</td>
</tr>
<tr>
<td>weakness</td>
<td>poor abstract thinking</td>
<td>intense anger</td>
<td>hyperalert to environment</td>
</tr>
<tr>
<td>chest pain</td>
<td>poor attention/ decisions</td>
<td>apprehension</td>
<td>increased alcohol consumption</td>
</tr>
<tr>
<td>headaches</td>
<td>poor concentration/ memory</td>
<td>emotional shock</td>
<td>change in usual communications</td>
</tr>
<tr>
<td>elevated BP</td>
<td>disorientation of time, place or person</td>
<td>emotional outbursts</td>
<td>etc…</td>
</tr>
<tr>
<td>rapid heart rate</td>
<td>difficulty identifying objects or people</td>
<td>feeling overwhelmed</td>
<td>etc…</td>
</tr>
<tr>
<td>muscle tremors</td>
<td>difficulty identifying heightened or lowered alertness</td>
<td>loss of emotional control</td>
<td>etc…</td>
</tr>
<tr>
<td>shock symptoms</td>
<td></td>
<td>inappropriate emotional response</td>
<td>etc…</td>
</tr>
<tr>
<td>grinding of teeth</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>visual difficulties</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>profuse sweating</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>difficulty breathing</td>
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<td></td>
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<tr>
<td>etc…</td>
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</tbody>
</table>
awareness of surroundings etc…

* Any of these symptoms may indicate the need for medical evaluation.

When in doubt, contact a physician.
THINGS TO TRY

- WITHIN THE FIRST 24 – 48 HOURS periods of appropriate physical exercise, alternated with relaxation will alleviate some of the physical reactions.
- Structure your time; keep busy.
- You’re normal and having normal reactions; don’t label yourself crazy.
- Be aware of *numbing* the pain with overuse of drugs or alcohol, you don’t need to complicate this with a substance abuse problem.
- Reach out; people do care.
- Maintain as normal a schedule as possible.
- Spend time with others.
- Help your co-workers as much as possible by sharing feelings and checking out how they are doing.
- Give yourself permission to feel rotten and share your feelings with others.
- Keep a journal; write your way through those sleepless hours.
- Do things that feel good to you.
- Realize those around you are under stress.
- Don’t make any big life changes.
- Do make as many daily decisions as possible that will give you a feeling of control over your life, i.e., if someone asks you what you want to eat, answer them even if you’re not sure.
- Get plenty of rest.
- Don’t try to fight reoccurring thoughts, dreams or flashbacks – they are normal and will decrease over time and become less painful.
- Eat well-balanced and regular means (even if you don’t feel like it).
FOR FAMILY MEMBERS AND FRIENDS

- Listen carefully.
- Spend time with the traumatized person.
- Offer your assistance and a listening ear if they have not asked for help.
- Reassure them that they are safe.
- Help them with everyday tasks like cleaning, cooking, caring for the family, minding children.
- Give them some private time.
- Don’t take their anger or other feelings personally.
- Don’t tell them that they are “lucky it wasn’t worse;” a traumatized person is not consoled by those statements. Instead, tell them that you are sorry such an event has occurred and you want to understand and assist them.
Demobilization

Key Concepts

- Reserve for large scale event
- A debriefing must follow within a few days to several weeks
- CISM team member must provide services
- Never provide it at the scene
- Does not require mental health professional
- One work team after another is processed until all of the personnel involved in the situation have been processed
- Once the demobilization is complete, personnel do not return to the incident. Instead they return to routine duties, or they go home if their duty time is complete
- Keep remarks very brief. Only provide the basic information necessary to hold the personnel together until more definitive work such as a debriefing can be done
- Instruct personnel about interactions with loved ones at home who may be distressed by the incident
- Instruct personnel how to obtain help if they need it before the debriefing is provided
- Be available to personnel if they would like to discuss the incident privately
- Assure that the command staff also receive support
- Provide low fat, low sugar, low salt foods that have complex carbohydrates in the food service area
- Avoid caffeine products in food service
- Allow commanders to announce the next steps for the personnel after the demobilization concludes
- Be familiar with demobilization material in the *CISD: An Operations manual*…
- Additional information may be found in the *CISD: An Operations Manual, 3rd edition*, (Mitchell and Everly, 2001)
Demobilization

Definition: Quick informational and rest session applied when operations units have been released from service at a major incident that requires over 2/3 of all available personnel (typically more than 100). It serves a secondary function as a screening opportunity to assure that individuals who may need assistance are identified after the traumatic event.

Length of time: 10 minute information section from CISM team member
20 minutes for food and rest

Best applied: Immediately after work teams have been released from the major incident and before personnel return to normal duties.

Target: Teams of workers. DEOC shift, dispensing site teams (may be broken down by function based on size of site), ambulance units, perimeter control teams, Neighborhood Emergency Help Center shift, Acute Care Center shift (may be broken down by function), entry teams, search teams, dog teams, squads, special units, etc. Each team receives its own demobilization session.

Provided by: Trained Critical Incident Stress Team members only.

Location of Demobilization: Two large rooms. One to provide the information sessions in small work groups, the other to provide the food and rest. The facility should be near enough to the scene to be convenient to transfer personnel there when they have been released from the incident.

Goals: 1. Assess well-being of personnel after major incident
2. Mitigate impact of event
3. Provide stress management information to personnel
4. Provide an opportunity for rest and food before returning to routine duties
5. Assess need for debriefing and other services

Process: 1. Establish an appropriate demobilization center
2. Check in units as they arrive
3. Keep work teams together for demobilization
4. Assign a CISM trained team member to provide information to the group
5. Limit the information section to ten minutes
6. Provide twenty minutes to rest and eat
7. Let participants know if a debriefing is planned
8. Provide a handout on stress survival suggestions

Contraindications: 1. Not for routine events
2. Not for small sized events
3. Not a substitute for debriefing
4. Not for line of duty death (instead use the modified CISD described in the CISM: Advanced Group Crisis Intervention Course)

Demobilizations are very rare. They are reserved for large scale incidents such as disasters.

A defusing can substitute for a demobilization if the size of the incident allows for the lengthier defusing process and if the personnel are not too weary. If they are too tired, it is better to just give them the shorter demobilization process and let the personnel get rest.

No one except the team member presenting in the demobilization has to speak. No questions are asked. If someone wants to speak, he may. Work groups (police, fire, EMS, Georgia Health Sciences Health System, etc.) are usually not mixed.

Demobilization Components:
1. Check in by unit
2. CISM team member gives 1—minute talk on stress survivial skills:
   a) describe typical reactions
   b) list signs and symptoms
   c) provide brief suggestions on surviving stress reactions
   d) invite anyone who wants to make a statement or ask questions to do so (most people have little or nothing to say during a demobilization)
3. In a separate room provide food and rest for twenty minutes until personnel are restored to routine non-disaster functions.
4. Command or supervisory person makes announcements and personnel are restored to normal duties.
During any demobilization the following topics are usually covered:

- An introduction of the speaker
- A review of the demobilization process. A statement that the speaker is only going to take ten minutes to provide some important information that may prevent stress or help personnel to cope with it faster and easier. A prolonged (e.g., a military operation) may require a longer information segment (up to 30 minutes)
- A statement that some may already have stress symptoms, some may develop them later, and some may escape them altogether
- Assurance that stress symptoms are normal under the circumstances
- A warning that stress symptoms could become dangerous or disruptive to the personnel if they are ignored
- Descriptions of common cognitive, physical, emotional and behavioral signs and symptoms of stress
- Specific advice on eating, resting, avoiding alcohol and drugs, conversing with loved ones, coping with the media, and other helpful hints to recover from stress
- An announcement of debriefings to follow in a week or so after the demobilization
- A brief statement to encourage the participants to ask questions or to make any comments they might wish
- A summary statement from the speaker
- Distribution of the handout material
Crisis Management Briefing
Key Concepts

The Crisis Management Briefing (CMB) is a practical four-phase group crisis intervention. It is designed to be highly efficient in that it requires from 45 to 75 minutes to conduct and may be used with “large” groups consisting of 10 to 300 individuals. While designed to be used with primary victim civilian populations in the wake of terrorism, mass disasters, violence, and other large-scale crises, it may have applicability in other settings with other populations, as well. The CMB is designed to be used within a comprehensive CISM framework, and should not be used as a “stand-alone” intervention. It is anticipated that, depending upon the crisis event, there will be a need for CISD and individual (1:1) crisis interventions subsequent to CMB. And, as always, arrangement should be made for follow-up assessment and referral for continued psychological care, if needed.

PHASE ONE: The first phase of CMB consists of bringing together a group of individuals who have experienced a common crisis event. In response to a school crisis, for example, an assembly could be held in the auditorium. Depending upon the number of students, one grade could be addressed at a time, or other divisions of the student body could be used. In response to a workplace crisis, a company meeting room could be used, or a room could be rented at a local hotel or commercial meeting facility. In response to mass disasters, large-scale violence, or terrorism, local school auditoriums could be used to address the civilian populations that would correspond to the respective school districts. Announcements to that effect could be made via radio, television and internet sites. Obviously, the CMB would be repeated until all constituents have been addressed within the given circumscribed area/population. This act of assembly is the first step in reestablishing the sense of community that is so imperative to the recovery and rebuilding process.

PHASE TWO: Once the group has been assembled, the next intervention component is to have the most appropriate and credible sources/authorities explain the facts of the crisis event. In many instances, the choice of a respected and highly credible spokesperson assists in the development of the perceived credibility of the message and the belief that the actions and support will be effective. The ethos of the spokesperson contributes to the effectiveness of the message/information being disseminated. Objective and credible information should serve to: 1) control destructive rumors, 2) reduce anticipatory anxiety, and 3) return a sense of control to victims. Without breaking issues of confidentiality, the assembled group should receive factual information concerning that which is known and that which is not known regarding the crisis event.

PHASE THREE: The next step is to have credible healthcare professionals (if available) discuss the most common reactions (signs, symptoms, and psychological themes) that are relevant to the particular crisis event. For example, in the case of a suicide, the psychological theme of suicide should be addressed. In the case of terrorism, the dynamics of terrorism should be discussed. Common signs and symptoms of grief, anger, stress, survivor guilt, and even responsibility guilt among survivors, friends and others should also be addressed.

PHASE FOUR: The final component of the CMB is to address personal coping and self-care strategies that may be of value in mitigating the distressing reactions to the crisis event.
Simple and practical stress management strategies should be discussed. Community and organizational resources available to facilitate recovery should also be introduced. Questions should be actively entertained as appropriate.

Each group participant should leave the CMB with a reference sheet that briefly describes common signs and symptoms, common stress management techniques, and local professional resources (with contact names and telephone numbers) available to recovery.

Timing for the CMB is highly situation-specific and flexible. The CMB can be repeated as long as it proves to be useful.
Crisis Management Briefing

**Definition:** A large group crisis intervention technique. Designed for use with large groups or primary victims (up to 300 at a time). May be implemented with civilians after disasters, students after school-related incidents, employees after work-related crises. It has application with large groups of emergency services personnel and military units.

**Applications:** Terrorism, disasters, community violence, school crises, work-place and military crises.

**Length of time:** 45-75 minutes (depending on the response and interactions of group members.

**Goals:**
1. Provide information
2. Rumor control
3. Reduce sense of chaos
4. Provide coping resources
5. Facilitate follow-up care
6. Engender increased cohesion and morale
7. Assess further needs of group
8. Restore personnel to adaptive function

**Process:**
Step 1: Assemble participants
Step 2: Provide facts regarding crisis
Step 3: Discuss and normalize common behavioral/ psychological reactions
Step 4: Discuss personal and community stress management. Direct toward further resources

**Note:** One or two question and answer segments are usually used. Some facilitators take questions after Step 2 and again after Step 4. Others prefer just one question and answer period after Step 4.
Defusings and demobilizations substitute for each other. One or the other is provided for the incident, not both.

Defusings outnumber the formal debriefing almost two to one.

A well run defusing will accomplish one of two things:

i. A defusing may eliminate the need to provide a formal debriefing.

ii. A defusing will improve the willingness of the personnel to communicate in the formal debriefing if one is necessary.

The defusing is made up of three parts, unlike the debriefing which has seven parts.

People in a defusing may speak or be silent. There is no condition that would imply a requirement to speak. There is no order in a defusing. Participants add to the conversation as they wish.

No note taking or recording is allowed.

Occasionally, it is necessary to combine various groups of emergency personnel (police, fire, nursing, emergency medical) together for a defusing. This is only done when all the parties were involved together in the incident and when they know each other well and are accustomed to working with each other.

**Defusing Components:**

1. **Introduction**
   - Introduce facilitator
   - State purpose
   - Motivate participants
   - Set rules
   - Stress confidentiality
   - Reassure participants it is not an investigative process
   - Ask the participants to finish the process
   - State goals
   - Describe process
   - Offer additional support

2. **Exploration**
   - Ask personnel to describe what just happened from their viewpoint
   - Ask a few clarifying questions
   - Share experiences and reactions
   - Assess need for more help
   - Reassure as necessary

3. **Information**
   - Accept/summarize their exploration
• Normalize experiences and/or reactions
• Teach multiple stress survival skills
• Stress importance of diet and the need to avoid alcohol, fat, sugar and salt
• Rest/family life
• Recreation/exercise

Many teams have been making more frequent use of defusings with good results and they are strongly encouraged. They are more immediate and less complicated than debriefings. They occur when the group members’ emotional guards are down and their needs are high. Groups in crisis are more open to help (the right kind at the right place and time). Defusings carefully provided at the right time may lesson or eliminate the need to do a full debriefing. Teams that use defusings regularly report that the debriefings that follow are usually better (more powerful) than the debriefings provided without the benefit of the defusing.

Defusings are small homogeneous group meetings conducted within eight hours of the conclusion of the event. They are conducted at a facility away from the scene – never at the scene. If a delay beyond eight hours occurs, it is best not to do the defusing but to plan for a debriefing and, to provide individual services until the debriefing occurs. An exception to the eight-hour rule is in some exceptionally distressing event. In that case, twelve hours may be a more useful cut off time. However, it is recommended that in line of duty deaths, a modified debriefing is provided instead of the defusing. The modified CISD is taught in the CISM: Advanced Group Crisis Intervention course. In the case of a disaster, the demobilization (de-escalation) is a direct substitute for the defusing. One or the other is provided, not both.

A defusing is aimed at the core working group that was most seriously affected by the event, i.e., a nursing unit, a truck company, a SWAT team or an ambulance crew. In most cases, it is best to provide a separate defusing for each of the homogeneous groups involved in the incident. A decision on a combined or separate defusing is up to the CISM team providing the defusing process and is only done when all of the various groups know each other and work together frequently.

Defusings may be provided by teams of CISM trained peers, chaplains and mental health professionals, depending on the circumstances of the event. The defusing is an opportunity to observe the symptoms of distress and made some decisions as to whether or not a debriefing is going to be required.

If the personnel in the defusing have “unfinished business,” very intense reactions to the traumatic experience or no reaction whatsoever, these conditions may suggest that the need for follow-up with full seven phase CISD several days later. Good assessment skills on the part of CISM team members is essential.

Follow-up services are always necessary after a defusing to assure that the personnel are managing their stress adequately. Those follow-up services may be on an individual basis by phone or brief casual contacts or with entire groups in the form of full seven-phase CISD.
Defusing

**Definition:** A shortened version of the debriefing provided within hours of a traumatic event.

**Length of time:** 2—45 minutes is the usual length. (Debriefings usually take 2-3 hours)

**Best applied:** Must be provided within 8 hours of an incident. If possible, it should be provided immediately (one to two hours) after the incident.

**Target:** Small homogeneous groups of emergency workers, usually six to twenty people. Multiple defusings for different groups of emergency workers (nurses, paramedics, police officers, fire fighters, etc.) may be provided for the same incident.

**Provided by:** Trained Critical Incident Stress Management team members only.

**Location of Defusing:** Neutral environment free of distractions.

**Goals:**
1. Mitigate the impact of the event.
2. Reduce cognitive, emotional and physiological symptoms.
3. Accelerate the recovery process.
4. Assess the need for debriefings and other services.
5. Identify individuals who may need additional assistance.

**Process:**
1. Establish a non-threatening social environment.
2. Allow rapid ventilation of the stressful experience.
3. Equalize the information among all of the group members.
4. Restore cognitive processing of the event.
5. Provide information for stress survival.
6. Affirm the value of the personnel.
7. Establish linkages for additional support.
8. Develop expectancies for the future.

**Contraindications:**
1. Usually not applied to disasters, except as part of a larger CISM program and only for small groups that have experienced extremely stressful circumstances.
2. Demobilizations are often utilized for large scale incidents and may be used instead of defusings.
3. Line of duty death. It is more helpful to use the 5 phase modified CISD process described in *CISM: Advanced Group Crisis Intervention*.

Introductory Remarks for Defusing
These remarks will help a CISM team to begin a defusing. It is not necessary to state each item. The needs of the group and their experience with previous group crisis intervention techniques may help to guide the CISM in starting the defusing. At times additional guidelines might need to be presented by the team. Do not read these guidelines to the participants. They should be conversationally presented by the team members.

- Hello, my name is __________ and I am a member of the CISM team. My partner in this defusing is __________ and we will work together to guide you through this brief conversation about the event you just experiences.

- Each of you has a little different view of the event and we want you to feel comfortable discussing your own experience of the situation. We are not here to critique the situation or your performance. So we are asking that you do not criticize your colleagues. If things happened that need to be corrected, they can be addressed in a different process than this one.

- We simply want to give everyone an opportunity to say what each person believes is important about this situation. Then we want to give you some useful information that will help you recover form the experience.

- No one has to talk.

- There is no specific order in this process. Speak up when you would like to add something to the conversation. Remember we want to do this in a positive, helpful manner that provides good information that ultimately benefits each of you.

- One comment you might make can clarify this experience for others in the group. This process is about unit cohesion and the ability to return to normal work. We find that when people talk about things, it often puts experience in perspective and helps them to learn something that is useful in future circumstances.
- This process is not part of an investigation. It is for you and your unit. No reports are made to your supervisors. Only some suggestions about what might help your unit are give to the supervisors. What you say in this process will be held in confidence by the CISM team. We ask that each member of your group hold the information to themselves. Each of you needs to know that he or she can trust the other members of your group. You may speak to others as much as you choose. But, you may not speak about other people in your group. Please, no note taking.

- What we are doing today is “guided conversation”. It is not psychotherapy nor is it a substitute for psychotherapy.

- We will not take very long to get through this process. We will stay as long as you need us to so we do not have to rush. These conversations usually last under an hour.

- If anyone would like to talk to either of us on the CISM team, we will be around for a while after the session concludes.

- If we need to get together again later to help take the edge off this event, we are certainly willing to do that. We’ll decide on that after this session is over.

- It will help m CISM teammate and I to know a bit about what you went through so that we can give you the best information toward the end.

- If someone can give us a thumbnail sketch of the situation we would appreciate it.

- Sometimes it helps to know who got involved first and who came in next.

- We do not need a lot of detail. An overview will do. Sometimes we will need to ask a few questions so that we are clear about the main aspects of the situation.

- Okay, let’s begin. Anyone who could give us an overview of the situation and what happened.
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Critical Incident Stress Debriefing

Key Concepts

CISD and defusing interventions appear to derive their effectiveness from several aspects of their phenomenology:

b. EARLY INTERVENTION. CISD is most typically utilized as an early intervention strategy, often employed within hours of the traumatic event. Thus the CISD is mobilized before traumatic memories may be concretized and perhaps distorted and overgeneralized.

c. OPPORTUNITY FOR CATHARSIS. Catharsis refers to the ventilation of emotions. CISD provides a safe, supportive, structured environment wherein individuals can ventilate emotions. In a review of studies specifically investigating the relationship between the disclosure of traumatic events and stress arousal, it was concluded that disclosure of traumatic events leads to reduced stress arousal and improved immune functioning.

d. OPPORTUNITY TO VERBALIZE TRAUMA. CISD not only gives individuals the opportunity to release emotions, but the opportunity to verbally reconstruct and express specific traumas, fears and regrets. The successful treatment of post-traumatic reactions is largely based upon the patient’s ability to reconstruct and integrate the trauma using the verbally expressive medium, as well as express feelings (catharsis).

e. STRUCTURE. CISD provides a finite behavioral structure, i.e., a group debriefing represents a finite beginning and a finite end, superimposed upon a traumatic event representing chaos, suffering, and a myriad of unanswered questions.

f. GROUP SUPPORT. CISD, in its classic application, employs a group education model. The value of using a group format to address distressing issues is well documented. The group format provides numerous healing factors intrinsic to the group format itself. Among them are the exchange of useful constructive information, catharsis, the dissolution of the myth of a unique weakness among individuals, the modeling of constructive coping behavior, the opportunity to derive a sense of group caring and support, the opportunity to help oneself by helping others and, perhaps most importantly with regard to trauma, the generation of feelings of hope.

g. PEER SUPPORT. Although mental health professionals oversee the CISD process, it is peer-driven. Peer support interventions offer unique advantages over traditional mental health services, especially when the peer-group views itself as being highly unique, selective, or otherwise “different” compared to the general population.

h. OPPORTUNITY FOR FOLLOW-UP. The CISD process represents an entry portal where potential victims can engage in group discussions, information exchange, and support. It also represents a mechanism wherein individuals who do not require formal psychological care can be identified and helped so as to maximize the likelihood of rapid and total recovery.
Critical Incident Stress Debriefing

Definition:  
*The Critical Incident Stress Debriefing (CISD) is a structured, small group crisis intervention process.* It is an active, temporary and supportive small group process that focuses on building up a group’s resistance to traumatic stressors. The CISD also focuses on the group’s resilience (the ability of a group to “bounce back” from a traumatic exposure). Finally, the CISD emphasizes unit cohesion and unit performance and the ability of the group to recover from a traumatic event and to resume its normal functions.

CISD is *Not*:  
CISD is not any form of:

a. Psychotherapy  
b. A substitute for psychotherapy  
c. Professional counseling  
d. A treatment for PTSD or any mental or physical disease or disorder  
e. A cure for PTSD or any mental or physical disease or disorder  
f. An organizational problem solving process for administrative problems

Target:  
Small, homogeneous groups who have experienced the same traumatic event.

Application Criteria:  
1. Small, **homogeneous group** (e.g. police officers on the same unit, a company of firefighters, nurses tending patients in an disaster setting).

2. The small group has **completed its mission** or the event has moved beyond the acute phases.

3. The members of the small group have encountered **about the same level of traumatic exposure** to the traumatic event.

Goals:  
1. Lower tension and mitigate a small group’s reaction to a traumatic event.

2. Facilitation of normal recovery processes of normal people within a small group who are having normal reactions to an abnormal event.

3. Identification of people within a group who might be in need of additional individual support or, in some cases, a referral for professional psychotherapy.

Best Applied:  
The Critical Incident Stress Debriefing (CISD) is ordinarily provided between 24 and 72 hours after a traumatic event. In some
situations, such as a disaster in which people have continuous exposures to the event over time, a CISD may not be provided until several weeks have passed. Providers must consider the issue of psychological readiness for assistance. No help, no matter how skilled, is really useful if it is provided at the wrong time.

**Length of time:** A CISD may last between 1 and 3 hours depending on two primary factors:

**Providers:** Only people who are properly trained in CISM and specifically in the small group process of the CISD should provide the service to traumatized groups. Untrained providers present a serious threat. Research in the field does indicate that the greatest problems in crisis intervention arise when 1) people are untrained to provide the services or 2) when they violate standard procedures.

**Location:** Neutral environments that are free of distractions are the best location for a CISD. They should be reasonably comfortable. The location should afford privacy and be accessible.

**Process:** There are seven steps to a Critical Incident Stress Debriefing. They are:

- Introduction
- Fact
- Thought
- Reaction
- Symptom
- Teaching
- Re-entry
Sample Prompts: **INSTRUCTION**

The CISM team members providing the CISD process spend about ten minutes describing the process and laying out the basic guidance.

**FACT**

It would help if you could give us a very brief overview of what happened during the incident. We will start over here on my left and go around the circle. Anyone who does not wish to speak may “pass” and we will go right on to the next person. Going around the room gives everyone the opportunity to speak if they wish. We do not need elaborate details. Just a few lines that tells us who you are, what your job was during the event and a brief thumbnail overview of the situation will be enough.

**THOUGHT**

What was your first or most prominent thought while you were going through the experience? Some people may have more personal thoughts and others might have had some strange thoughts. Whatever went through your minds is okay. So, what was your first thought when you realized you were actually thinking and not just functioning on automatic mode? By the way, this is the last time we will go around the entire circle. After this if you want to join the discussion you can make a comment at any time.

**REACTIONS**

What was the very worst thing about this event for you personally? Another way to phrase that question is to ask if you could go back to the situation and magically erase one aspect of the experience, even if the outcome was the same, what one piece would you most want to erase?

**SYMPTOM**

What signals of distress did you pick up in yourself either while the situation was going on or in the few days that have passed since it ended? In other workd how did your mind, your emotions, your body or behaviors react or change as a result of this traumatic event?

**TEACHING**

Now that we have heard what happened, how you thought about it, the worst part and the signals of distress you have experienced we will give you some information which we believe will help to put things in perspective and help you recover and return to your normal duties and your home life. The CISM team normalizes the
experience of the group members and provides practical guidelines to help them recover.

**RE-ENTRY**

The main functions of the re-entry is to answer any questions from the group members and to summarize the discussion and provide any additional guidelines that can assist in their recovery.

**Contraindications:**
- Heterogeneous groups
- Individuals (Do not use a group process on individuals especially wounded primary victims):
  a) Injured
  b) Severe shock
  c) Ill
  d) In physical pain
  e) Medicated
  f) Showing signs of psychosis
  g) Suicidal
  h) Hospitalized
  i) Bereaved
  j) Extremely fatigued
  k) Under severe emotional distress
  l) Brittle, fragile or labile
  m) Dealing with overwhelming property losses
- Highly resistant personnel.
- Never attempt to force highly resistant personnel to participate in any small group crisis intervention process.
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