A Study of the Critical Incident Stress from a Traumatic Event and Its Management

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ABSTRACT: Caught off guard and "numb" from the impact of a critical incident, employers and employees are often ill-equipped to handle the chaos of such a catastrophic event like workplace violence. Consequently, survivors of such an event often struggle to regain control of their lives to regain a sense of normalcy. Additionally, many who have been traumatized by a critical life-changing event may eventually need professional attention and care for weeks, months and possibly years to come. The final extent of any traumatic event may never be known or realistically estimated in terms of loss, bereavement, mourning and grief. In the aftermath of any critical incident, psychological reactions are quite common and are quite predictable. Critical Incident Stress Debriefing or CISD and the management of traumatic reactions by survivors can be a valuable tool following a life-threatening event. Since the mid-1980s, following many high profile events tied to the United States Postal Service, the need to provide victim assistance to employees in the workplace setting has received more positive attention than ever before. This prevention and intervention movement has gained a lot of momentum with the passage of state and federal legislation designed to protect, provide resources and services to those who are physically or emotionally traumatized in the workplace. As part of a corporate Human Resources Division strategy, an HR administrator can employ, train and deploy trauma specialists to provide direct, face-to-face contact or phone contact as part of an overall Crisis Response Teams (CRT) program. This integrated team acts to off-set risk, mitigate fall-out and enhance recovery and sustainability in the event of an acute or short-term man-man or natural workplace stoppage. Additionally, trauma specialists can be identified in nearby locations if not on site who can respond quickly be being placed on-call or on "stand-by" (ready alert) regardless of the situation. This is an absolute must legally, ethically and morally should a catastrophic event occur.

KEYWORDS: Incident, Stress, Crisis Response Teams

1. INTRODUCTION

A critical incident can be defined as any event that has a stressful impact sufficient enough to overwhelm the usually effective coping skills of an individual. Critical incidents are abrupt, powerful events that fall outside the range of ordinary human experiences. These events can
have a strong emotional impact, even on the most experienced officer or deputy. Research has shown that critical incident stress affects up to 87% of all emergency service workers at least once in their careers. Every year, thousands of law enforcement officers are involved in intense critical incidents that can have serious long-term consequences for them [1].

While most individuals will not develop a post-traumatic stress disorder (PTSD) after a critical incident or traumatic event, virtually every officer will experience marked reactions during and after any life threatening, harrowing or extremely distressing experience. Immediate and short-term reactions are to be expected, and are extremely common. Some individuals may experience a prolonged or a more intensified reaction(s) to a critical incident that may develop into an adjustment disorder, an acute stress disorder, or even PTSD. It is important for every law enforcement officer to learn what the frequent and usual responses to a critical stress are, how to handle his/her reactions, the symptoms of a more acute and possibly debilitating disorder, and ways to build stress resilience.

You remember your critical incident call, probably in great detail. It may have been a call that has changed your life and/or values. An officer-involved shooting, a hostage standoff, a mass suicide, an infant at the bottom of the pool, a family trapped in a burning car, a six year old versus a semi-truck, the domestic violence call from hell, a school shooting, a rape, a natural disaster, a senseless homicide, the situation that hit too close to home, the déjà vu call-the list is infinite. It is important that the definition of a critical incident remain fluid in your mind; what may affect you will not necessarily affect another officer, and vice versa. For example, an officer who has children might be affected by responding to the traumatic death of a child more than an officer who has no children.

2. WHAT HAPPENS DURING A CRITICAL INCIDENT?

During a threatening event the body goes into an autonomic nervous system response. This is also commonly referred to as a hyperarousal state, acute stress response, or the “fight or flight” response. However, law enforcement officers generally don't have the luxury of fleeing in a life or death situation, when a treat is perceived, or the unthinkable is witnessed.

The body and mind go into overdrive during a critical incident to help deal with the situation at hand. Physical gears go into a protection mode; adrenaline is released, there is an acceleration heart and lung activity, blood vessels dilate to allow for muscle tension, pupils
dilate, and intestinal functions are inhibited. Common psychological reactions include excitement, anger, disbelief, intense fear, numbness, or trembling. These reactions may be extremely strong during the incident, and are to be expected [2].

Following the trauma incident it is common for an individual to experience a number of disturbing thoughts, images, and feelings for a few hours to several weeks. Sometimes these reactions may be delayed. Critical incident stress manifests itself physically, cognitively, and emotionally. Although, the symptoms are unpleasant, they are also expected and are a sign that the body and mind is recovering from the stressful event.

You responded, you did your job, and the outcome was positive, unfortunate, or both. It is over, but you still feel out of sorts. No one who responds to a traumatic event is totally untouched by it; nor will anyone have the exactly same reaction to the same incident. You cannot predict how powerful an incident will be or what effects it will have on you. You may be seasoned and tough, but you are also human. Remind yourself that having physiological and/or psychological responses after a critical stressful incident are not signs of weakness or that you are going crazy, these responses are actually quite normal.

The most commonly reported reactions after a critical incident include:
- Anxiety about being involved in a similar event
- Fear for the safety of yourself or loved ones
- Preoccupation about the stressful event
- Avoidance of situations or thoughts that remind you of the incident
- Flashbacks where you mentally re-experience the event
- Physical symptoms: muscle tension, fatigue, headaches, nausea, bowel problems
- Decreased interest in usual activities, including sex and appetite
- Feelings of sad or loneliness
- Disbelief at what has happened; feeling numb, unreal, isolated, or detached from other people
- Insomnia, frequent awakening, disturbing dreams or nightmares
- Increased startle response
- Problems with concentration, or memory (especially aspects of the traumatic event)
- A misperception of time
- Guilt and/or self-doubt related to the traumatic event
- Anger or irritability at what has happened; at the senselessness of it all

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3. WHAT IS CRITICAL INCIDENT STRESS MANAGEMENT?

Critical Incident Stress Management (CISM) is the structured assistance for a normal reaction to an abnormal event. It describes the human reaction to critical incidents - any situation faced for example by a controller, which causes him or her to experience unusual strong emotional reactions. All CISM activity aims to moderate the impact of Critical Incident Stress and to speed up the return to the pre-incident phase [3]. A CISM programme consists of three phases:

- Information
- Training
- Support

CISM addresses different people and services in and outside the organisation. Its several steps help the persons affected cope with their Critical Incident Stress (CIS) reactions thanks to direct and immediate intervention. In this way, it may be possible to decrease the probability of consequential disorders. CISM is a comprehensive, systematic and multi-component approach to the management of CIS.

3.1 History of Critical Incident Stress Management

The history of critical incident stress management lies in military operations. The first mention of it was during the American Civil War. Soldiers suffering so-called Combat Stress were considered to be in league with the enemy and were ridiculed, imprisoned or even shot. Only in later years was Combat Stress recognised as a human reaction to the horrors of war and intervention techniques were developed to overcome the phenomenon.

Nowadays we speak of Critical Incident Stress when we describe our reaction to a shocking event. Incidents and accidents in aviation often have enormous impact on every human and every organisation involved [4].

What is CISM?

Critical Incident Stress Management (CISM) is the structured assistance for a normal reaction to an abnormal event. In ATS it describes the human reaction to critical incidents:
“any situation faced by an air traffic controller, which causes him or her to experience unusual strong emotional reactions”.

All CISM activity aims to moderate the impact of Critical Incident Stress and to speed up the return to the pre-incident phase. CISM exists to mitigate the normal, usually negative, emotions and thoughts, which result from critical events occurring in the work environment. In doing so CISM facilitates a more rapid return to the ‘normal’ functioning and thus has benefits for the individual and for the organisation in which they work.

CISM methods are secondary preventive measures which consist of discussions about the incidents in the form of structured individual and group discussions and help the persons affected regain their ability to apply coping strategies. Most of the time these discussions are performed by colleagues who have qualified in CISM programmes (the so-called CISM peer diffusers or CISM peers) or by Mental Health Professionals (MHPs) who are qualified CISM experts. None of the CISM techniques can, or should be, regarded as psycho-therapeutic measures [5].

CISM Measures
CISM comprises the following measures:

Preventive teaching and training measures
• Training courses for managers, members of staff, colleagues and relatives of the above-mentioned professional groups or organisations;
• Different modules, depending on the individual target groups.

Individual crisis intervention
• Structured (individual) discussions with qualified CISM peers or MHPs on site or immediately after the incident or mission;
• Safer model as a one-to-one intervention method.

CIS defusing
• Structured discussions in groups performed by CISM peers or MHPs up to 24 hours after the incident or mission

CIS debriefing
• Structured discussions in groups performed by MHPs and CISM peers between 72 hours and four weeks after the incident/mission

Demobilisation
• Quick informational and rest sessions applied when a group of professionals have been released from service after a major incident. Among other purposes it serves as a

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screening opportunity to assure that Individuals who need assistance are identified after the traumatic event.

_Crisis Management Briefing (CMB)_
- Briefings in large groups performed immediately after the incident/mission; these briefings serve the purpose of providing information about CIS reactions and their consequences and about available support.

_Support by the family/organisation_
- Counselling and/or training for relatives and organisations of particularly affected professional groups. Counselling for relatives/organisations after a critical incident has occurred.

_Follow-up / referral_
- Follow-up following CISM peer counselling is recommended. Typically this may be one to one and for two to three sessions.
- If required, the persons affected may be referred to experts, doctors or therapists for further measures (therapy).

4. THE SCIENTIFIC EVIDENCE

Although there are numerous studies pertaining to CISM and psychological debriefing, most are anecdotal and of poor scientific quality. The better studies seem to indicate that CISM is, at best, ineffective. Furthermore, some research seems to indicate that CISM may actually make people worse. Two of the better studies were meta-analyses of other published studies of CISM and psychological debriefing. Meta-analyses of randomized controlled trials, when properly conducted, represent the highest level of scientific validity [6].

The more valid the study, the closer it is to the truth. A well-conducted meta-analysis allows for a more objective appraisal of the evidence, thus leading to resolution of uncertainty and disagreement. In addition, it may reduce the probability of false negative results and thus prevent undue delays in the introduction of effective treatments into clinical practice [7].

The first meta-analysis evaluated seven studies that specifically examined single-session debriefings performed within one month after a traumatic event. Five of the studies specifically evaluated CISM, and three evaluated non-CISM interventions (a historical group debriefing, a 30-minute counseling session, and education). Six of the reviewed studies
utilized non-intervention controls. The researchers reported that non-intervention and non-CISM interventions were found to have improved symptoms of PTSD, but CISM did not improve symptoms and may, for some, have retarded natural resolution. Stated another way, persons who received no intervention and those who received non-CISM interventions actually fared better than those who received CISM interventions. Furthermore, the researchers found that CISD did not improve natural recovery with respect to other trauma-related disorders [8].

5. CONCLUSION

Why doesn’t CISM work? It appears that CISM and other forms of psychological debriefing may actually interfere with the natural recovery process inherent in normal individuals. The alternation of intrusive and avoidant thoughts characterizes normal psychological processing following a traumatic event that may be disrupted by this approach to intervention. CISM may also lead affected personnel to bypass established personal support systems (family, friends, coworkers, clergy) usually used for non-occupational-related crises in the belief that the CISM session should be sufficient to alleviate their distress. Furthermore, a certain amount of time appears necessary for an individual to process the psychological impact of exposure to a traumatic event, and no external stimulus or program may be capable of shortening this interval.

Thus, what role should mental health play in modern emergency services? Several organizations and researchers have addressed this issue. Leading psychological researchers who specialize in traumatic stress, NIMH22 and the WHO23 have recommended that competent mental health personnel provide psychological first aid to trauma survivors. This includes such things as listening to rescuer concerns, conveying compassion, assessing needs, ensuring that basic physical needs are met, and protecting the rescuer from further harm. Most important, those who do not wish to talk should not be compelled to talk. For those who want to talk, somebody should be there simply to listen—not to provide any sort of care or intervention. In addition, education and information can be provided to better help personnel understand psychological trauma, specifically what to expect and where to get help if needed. If additional help is needed, affected personnel should be referred to competent, licensed mental health professionals with experience treating trauma-related stress. Psychological first
aid is not an intervention technique, but only provides practical supportive care while at the same time respecting the wishes of those who may not want to discuss what happened or are not ready to deal with a possible onslaught of emotional responses in the early days following exposure.

They do, however, recommend that competent mental health personnel be available within two months of a critical incident to screen and assist any personnel who may be developing stress-related symptoms or PTSD.

Recently, the negative effects of CISM were described to me by a paramedic who works in a small town in Texas. Following a call where a child died, she and coworkers were forced to attend a CISM session. She reported that none of the personnel involved were particularly distressed after the call, and she felt the CISM session was unnecessary. After the session, she reported that all who attended were uncomfortable and actually felt worse. She felt the facilitator chastised them for not feeling particularly bad after the call. It was not a positive experience.

Several years later, this paramedic's partner was accidentally killed. Following this tragedy, the EMS service she worked for assured that her physical and emotional needs were met. No CISM or debriefing was provided, but they arranged for her to speak with a professional therapist, who simply allowed her to talk. She reported that in contrast to her earlier CISM session, she felt much better after the latter approach and was able to return to work sooner than expected.

The last thing we want to do is provide a service that may actually harm our colleagues. Like many archaic and anecdotal EMS practices, CISM is a bad idea and does not work. Let's put it behind us and practice, instead, simple psychological first aid.

REFERENCES


