

Effectiveness on Mental Health of Psychological Debriefing for Crisis Intervention in Schools

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Abstract The purpose of this paper is to provide a summary of evidence for the effectiveness and safety of commonly used crisis interventions in schools, such as critical incident stress debriefing (CISD), critical incident stress management (CISM), and psychological debriefing (PD). Two researchers independently searched relevant databases for reviews and meta-analyses in English language peer-reviewed journals using identified keywords. The database search was supplemented by hand searches of the reference lists of database-identified reviews. Selected reviews were compared and analyzed for the effectiveness of CISD/CISM/PD interventions. Research findings suggest that these interventions are ineffective and may be harmful. Evidence of effectiveness of CISD/CISM/PD interventions in schools is very limited. Given evidence of ineffectiveness and potential harm of CISD/CISM/PD interventions in adults and limited evidence of these interventions in schools, there is no compelling reason to implement CISD/CISM/PD following crisis events in schools.

Keywords Critical incident stress debriefing (CISD) · Critical incident stress management (CISM) · Psychological debriefing · Crisis intervention · School

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Psychological debriefing (PD) was first used as an intervention among soldiers during World War I (Litz *et al.* 2002) to boost moral and reduce psychological distress, facilitating returns to the front lines. Critical Incident Stress Debriefing (CISD) was introduced into civilian life in the early 1980s by Mitchell (1983), as a group-based multi-component crisis intervention program for emergency service workers (secondary trauma victims) (Everly *et al.* 2002). CISD is usually applied by a trauma debriefer in seven phases: introduction, the facts, thoughts and impressions, emotional reactions, normalization, planning for the future, and disengagement (Mitchell 1983). In the 1990s, the term CISM was introduced to reference the “overarching umbrella program/system,” of post-traumatic interventions, while the term CISD was reserved for a subcomponent of the CISM program (Everly *et al.* 2000). CISM is also composed of seven elements, including pre-crisis preparedness training, large-group crisis interventions (e.g., demobilizations), defusing, CISD, individual crisis intervention/counseling, family crisis intervention and follow-up, and referral mechanisms for formal assessment if necessary (Everly and Mitchell 1997).

CISD/CISM is the most widely used method of PD globally and has been used in a diverse range of settings and situations (Everly & Mitchell, 1999). For example, it is employed by crisis counselors and mental health professionals as a first response to suicides, accidental deaths and other community disasters. CISD/CISM has also been adopted by defense forces, police forces, banks, hospitals, schools, and other institutional settings.

The application of CISD/CISM/PD is recommended following a crisis or traumatic incident in schools in many countries. For example, a simple Google search identifies numerous school districts throughout the US that have trained personnel in CISD/CISM or consult with CISD/CISM personnel, including Alaska, California, Virginia, New York, and beyond. In Canada, the Ministries of Education of Saskatchewan, Alberta, and British Columbia, endorse CISD as a central component of their strategic response to traumatic incidents that occur within or impact the school community (Alberta Learning: Special Education Branch 1999; British Columbia Ministry of Education 1998; Saskatchewan Learning 2004). Training programs in CISD/CISM for Canadian school personnel are also available (e.g., (Edmonton CISM Conference Committee 2009)). In these school jurisdictions, all school staff, including the administration, teachers and other school support staff, such as psychologists and counselors, are encouraged to apply CISD/CISM with the help of trained personnel from the local mental health community.

The initial enthusiastic adoption of CISD/CISM occurred under the assumption that it offered a safe means to substantially reduce acute symptoms of distress commonly associated with exposure to traumatic incidents, thereby decreasing the risk for PTSD (Everly and Mitchell, unknown). However, recent systematic reviews suggest that the evidence to support its effectiveness in reducing psychological distress or preventing the development of PTSD is at best insufficient, if not negative, and in some cases indicative of harm (Litz *et al.* 2002; McNally *et al.* 2003; Roberts *et al.* 2009; Rose *et al.* 2002). In the current climate that emphasizes evidence-based policies, programs, and interventions for schools, it is critical to clarify the effectiveness of CISD/CISM/PD for use with students following traumatic incidents (Stallard and Salter 2003). This paper provides a summary of evidence on the effectiveness of CISD/CISM/PD for the reduction of psychological distress and prevention of PTSD with a focus on the school setting.

Methodology

Two researchers independently searched PubMed, Cochrane Library, PsycINFO, ERIC, and CINAHL databases for systematic reviews and meta-analyses in English language peer-reviewed

journals using the keywords “critical incident stress debriefing”, “CISD”, “critical incident stress management”, “CISM”, “psychological debriefing,” “crisis intervention,” and “post traumatic stress distress intervention”. The above searches were repeated with the addition of the keyword “school” to identify studies of interventions in school settings. The database search was supplemented by hand searches of the reference lists of database-identified reviews. Any systematic reviews and meta-analyses that discussed and compared the effectiveness of the application of CISD/CISM/PD in mitigating psychological distress and/or preventing the onset of PTSD after a traumatic event were included. Systematic reviews/Cochrane reviews are protocol-driven reviews of primary research in healthcare and health policy. They investigate and evaluate the evidence for the effects of interventions for prevention, treatment, and rehabilitation in a systematic manner. Cochrane Reviews are internationally recognized as the highest standard in evidence-based health care and use a predefined, rigorous, and explicit methodology. Thirteen publications discussed below were identified as “key articles” based on the above-stated inclusion criteria for this summary. They include two Cochrane reviews of PD for PTSD (Roberts *et al.* 2009; Rose *et al.* 2002), a systematic review from the United States Task Force on Community Preventive Services evaluating the effectiveness of interventions to reduce psychological harm from traumatic events among children and adolescents (Wethington *et al.* 2008), two reviews of early psychological interventions for trauma (Litz *et al.* 2002; McNally *et al.* 2003), two meta-analyses of post-trauma debriefing (Cuijpers *et al.* 2005; van Emmerik *et al.* 2002), a review of psychological treatments that cause harm (Lilienfeld 2007), and three meta-analyses authored by the developers of CISD/CISM (Everly and Boyle 1999; Everly *et al.* 2002; Everly *et al.* 1999). The research studies cited in this paper are international in nature, originating from the USA, UK, Netherlands, and Norway.

Results

Evaluations citing no effect or adverse effects

Two Cochrane reviews of PD interventions for the prevention of PTSD indicate that they neither prevent the onset of PTSD, nor reduce psychological distress compared to control treatments in adults (Roberts *et al.* 2009; Rose *et al.* 2002). The review by Rose and colleagues summarizes the results of 15 randomized and quasi-randomized trials of PD published between 1979 and 2004, and includes a meta-analysis of the results of a subgroup of studies ($n=9$) with follow-up times ranging from 1 month to 3 years. The key finding of this meta-analysis is that participants (both primary and secondary victims of trauma) receiving PD interventions (single-session individual psychological intervention that involved reworking/reliving/recollection of the trauma and subsequent emotional reactions) reported no difference in onset of PTSD, and no reduction in PTSD severity compared to those who did not receive this intervention. Two studies with follow-up times of 13 months and 3 years found adverse effects of PD that evidence higher PTSD and overall anxiety symptoms. No preventive effect on risk of diagnosis or severity of depression or diagnosis of anxiety disorders, including PTSD, was found. The review by (Roberts *et al.* 2009) reports the findings of 11 studies of the effectiveness of multiple session early psychological interventions to prevent PTSD. No significant difference was found between treatment and control conditions for diagnosis of PTSD for any multiple session early psychological intervention, including CISD. Additionally, with regards to the CISD

intervention, there was no significant effect of treatment on posttraumatic symptoms (measured by Impact of Events Scale) at either 1 or 3 months follow-up. The Cochrane reviews conclude with recommendations against the routine use of single session individual debriefing (Rose *et al.* 2002) and multiple session early psychological interventions (Roberts *et al.* 2009) after a traumatic event.

Subsequent to the Cochrane review of single session individual debriefing (Rose *et al.* 2002), Litz *et al.* (2002) examined a subset of five methodologically sound randomized controlled trials (RCTs) of CISM intervention for individual primary victims of trauma originally included in the Cochrane review, and calculated a negative mean effect size for PTSD given PD intervention (Cohen's $d = -0.11$, 90% confidence interval: -0.32 to $+0.10$). This negative mean effect size indicates that trauma survivors who had received the PD intervention had more severe PTSD symptoms at follow-up than those who had received the control intervention. More recently, an evaluation of psychological treatments that cause harm by Lilienfeld categorized CISM as a "level 1 potentially harmful therapy" (probably harmful for some individuals) due to a heightened risk for posttraumatic stress symptoms that has been demonstrated in multiple RCTs (Lilienfeld 2007).

Two other meta-analyses evaluating the effectiveness of PD in adults also found no effect or adverse effect of debriefing on onset (Cuijpers *et al.* 2005) and severity (van Emmerik *et al.* 2002) of PTSD symptoms. van Emmerik *et al.* (2002) compared the effects of seven studies of CISM interventions, non-CISM interventions (30-min counseling, education, and historical group debriefing) and no intervention, and found no evidence to suggest that CISM interventions significantly reduced PTSD symptoms. In fact, the available data indicated a detrimental effect of CISM on PTSD symptoms as compared to a positive effect of non-CISM interventions or no intervention on symptoms after follow-up ranging from 1 day to 36 months. Furthermore, this review concluded that following the occurrence of a traumatic event, providing no treatment was significantly better than applying CISM or CISM-type interventions. Cuijpers *et al.* (2005) investigated the effect of psychological intervention on the prevention of mental disorders in adults. Meta-analysis of the results of three studies examining prevention of PTSD resulted in an overall increased but non-significant risk of PTSD in individuals receiving PD after a follow-up time ranging from 99 days to 13 months.

Psychological debriefing in the school setting

Research pertaining to the effectiveness and safety of CISM/CISM/PD in the school setting is limited (Wethington *et al.* 2008). The authors of the Cochrane review of this topic noted that they were, "unaware of the evidence base surrounding debriefing in children" (16 years or younger; Rose *et al.* 2002). Our literature search yielded a number of descriptive studies discussing strategies for development of crisis intervention policies, protocols, and teams in schools, and case examples of CISM/CISM/PD interventions in school settings, especially after student suicide (postvention). However, no randomized controlled trials or quasi-experimental controlled trials of CISM/CISM/PD interventions in the school setting were identified.

The USTFPCS recently conducted a review of psychological interventions to prevent harm from traumatic events in children and adolescents (Wethington *et al.* 2008). The review states that based on the results of the single study that matched criteria for inclusion in the analysis (Stallard *et al.* 2006), there is insufficient evidence to determine the effectiveness of PD on posttraumatic psychological symptoms in children and adolescents (Wethington *et al.* 2008). That study, which investigated the use of CISM in post-road traffic deaths for children and adolescents, found that both intervention and control groups

achieved considerable improvements at follow-up, and that the debriefing intervention did not result in additional gains compared to the control group.

Evaluations citing positive effects

On the other hand, there is also some literature supporting the effectiveness of CISD/CISM/PD in adults. Three meta-analyses evaluating peer-reviewed and controlled investigations found PD (Everly *et al.* 1999), CISD (Everly and Boyle 1999), and CISM (Everly *et al.* 2002) to be effective in reducing symptoms of psychological distress. Effect sizes ranged from large for CISM (Cohen's $d > 1.0$) and CISD (Cohen's $d = 0.86$) to medium for PD (Cohen's $d = 0.54$). However, substantive criticism has been levied against the methodologies used in these analyses [e.g., (Deville and Cotton 2003; Litz *et al.* 2002; McNally *et al.* 2003)]. For example, none of the studies reported by Everly and colleagues were included in either the Cochrane review or in the meta-analysis conducted by van Emmerik and colleagues (Chemtob *et al.* 1997; Deahl *et al.* 1994; Hytten and Hasle 1989; Kenardy *et al.* 1996). Furthermore, a number of studies included in the publications by Everly and colleagues could not be located by independent searches of the literature, nor could the effect sizes in two studies be replicated when independently calculated by other researchers (Deville and Cotton 2003). An extensive review of the effectiveness of PD for the promotion of recovery from posttraumatic stress (McNally *et al.* 2003) indicated that due to serious methodological limitations including lack of control, lack of randomization, lack of pre-debriefing assessment, lack of clarity about protocol (timing of debriefing, individual vs. group, PD vs. CISD vs. CISM vs. psychotherapy), and brevity of follow-up, the studies adduced in support of PD failed to, “provide a convincing case for the efficacy of debriefing to mitigate distress and prevent posttraumatic psychopathology”. Notably, the meta-analyses by Everly and colleagues did not evaluate the effectiveness CISD/CISM/PD for reducing risk of onset or symptoms of PTSD or any other psychiatric disorders. These criticisms may be even more concerning given the close ties between the authors of some of the “positive” CISD/CISM studies and the developers and marketers of CISD/CISM programs.

Discussion

This summary analysis of reviews of the effectiveness of CISD/CISM/PD underscores the point that the use of such interventions conflicts with evidence of their ineffectiveness in preventing the development of PTSD or any other psychiatric disorders. By interfering with normal processes that work to ameliorate emotional distress and the remembering of emotional experiences, psychological debriefing may interfere with the natural central nervous system post-traumatic recovery process which consists of a complex interaction between memory consolidation and memory retrieval. As noted by McNally *et al.* (2003), “[p]rofessionals working with trauma survivors may have too quickly concluded that the initial disinclination of survivors to discuss their trauma constitutes a form of dysfunctional avoidance likely to hinder recovery.” In fact, studies have shown that only about 10% of trauma survivors seek out mental health professionals to discuss their experience (Rose *et al.* 1999). This natural intermittent processing favored by most survivors may allow them to deal with the trauma while at the same time dealing with the everyday problems they face when rebuilding their lives after trauma, and may prevent survivors from becoming overwhelmed by their experience (McNally *et al.* 2003).

Finally, while memory of traumatic events naturally fades, it may be that re-experiencing of traumatic events retards this natural process of attenuation (McNally *et al.* 2003).

The lack of controlled studies of CISD/CISM/PD in school settings is furthermore inconsistent with the application of these interventions in schools. What is concerning is that there exist policies and practices promoting the use of CISD/CISM/PD interventions in some schools—despite the lack of evidence of effectiveness in children and adolescents and the presence of evidence of possible harmful effects in adults. Globally, the Inter-Agency Standing Committee of the United Nations no longer recommends, “single-session psychological debriefing for people in the general population as an early intervention after exposure to conflict or natural disaster” (IASC 2007).

Therefore, given the lack of school-based research on effectiveness of CISD/CISM/PD interventions, and given the presence of evidence for their ineffectiveness and potential harm in adults, we argue that there is no compelling reason to support their provision to individuals after trauma, including children and adolescents in school settings.

So what should school mental health professionals and policy makers consider when faced with the question of what may constitute an appropriate crisis intervention in schools? Recently, a worldwide panel of trauma intervention experts identified the following five *empirically supported* intervention principles that should be used in post-trauma intervention and prevention efforts (1) promotion of a sense of safety, (2) promotion of calm, (3) promotion of a sense of self- and community efficacy, (4) promotion of connectedness, and (5) promotion of hope (Hobfoll *et al.* 2007). While randomized controlled studies are needed before any potential interventions can be identified as *evidence-based*, some schools may still feel compelled to “do something”. Psychological first aid (PFA), although requiring empirical validation, is recommended as an *evidence-informed* guideline to assist in the recovery of trauma survivors through the provision of comfort, support, connectedness, information and other coping strategies (Litz 2008, Litz *et al.* 2002; McNally *et al.* 2003; Raphael *et al.* 1996; Uhernik and Husson 2009). PFA can be provided to students through direct contact with professionals or indirectly through interaction of PFA provider with parents/caregivers (Pynoos and Nader 1988; Ruzek *et al.* 2007). School mental health professionals can consider how best to apply PFA strategies to address students’ needs and provide appropriate support in the aftermath of trauma, and tailor that intervention to the population and setting in which it is provided. Specific actions to be taken after a traumatic event, based on “core actions” of PFA (Ruzek *et al.* 2007), are shown in Table 1.

After provision of immediate assistance, it is also important that additional care be provided to those most at risk for developing post-traumatic stress symptoms and those who request it. Follow-up assessments and screening tools should be applied to measure and detect survivors’ mental health symptoms that could suggest the development of a mental disorder such as depression, delayed stress reaction or PTSD (Brewin 2001; Litz *et al.* 2002; McNally *et al.* 2003; Raphael *et al.* 1996). Professional assessment and referral to appropriate health providers should be arranged for students or school personnel demonstrating such symptoms. It is also necessary to train educational and support staff to identify individuals who continue to show substantial symptoms of distress after the incident and to refer them to appropriate mental health care providers for treatment. For children and adolescents who show symptoms of PTSD after an experience of trauma, there is strong evidence that individual or group cognitive behavioral therapy (CBT) is effective in reducing symptoms (Wethington *et al.* 2008). In light of these findings, the USTFPCS recommends that public and private organizations that provide assistance to traumatized people (e.g., schools) consider providing CBT to traumatized individuals (Wethington *et al.* 2008).

Table 1 Specific Actions to Be Taken after a Traumatic Event in a School Based on “Core Actions” of PFA (Ruzek *et al.* 2007) with Selected Examples Based on Personal Experience (SK) are Shown Below

Contact and engagement	<p>Provider...</p> <p>Introduces oneself, describes role, and asks for permission to talk to survivors</p> <p>Focuses on identifying and helping meet immediate needs of survivors</p>
Safety and comfort	<p>Provider...</p> <p>Ensures immediate physical safety of self and others</p> <p>Identifies individuals or environmental factors that may be harmful, dangerous, or unsafe</p> <p>Provides physical and emotional comfort, and promotes psychological sense of safety</p>
Stabilization (if necessary)	<p>Provider...</p> <p>Attempts to calm survivors and reduce distress using developmentally appropriate language</p> <p>While most expressions of strong emotion do not require stabilization, in case of extreme distress, enlists aid of family or friends, offers quiet place, offers quiet conversation, helps focus on manageable thoughts and feelings, helps ground in the present moment</p> <p>Example:</p> <p>Allow students and teachers access to a “quiet space” where they can congregate after school hours for a short but reasonable length of time, should they wish to do so.</p>
Information gathering	<p>Provider...</p> <p>Identifies immediate needs and concerns of survivors, focusing on immediate post-disaster circumstances but also evaluating need for immediate referral, additional services, or follow-up contact with mental health services providers.</p>
Practical assistance	<p>Provider...</p> <p>Problem-solves with survivors to meet immediate needs and concerns, generates solutions, and assists with practical responses</p> <p>Example:</p> <p>Help students connect with parents/caregivers by enlisting use of school telephones, making use of cell phones, and writing emails.</p>
Connection with social supports	<p>Provider...</p> <p>Assists with re-establishing contacts with parents/caregivers or other support persons, in locating and contacting parents/caregivers, and in making contact with parents/caregivers</p> <p>Educates survivors about importance of social supports, and on how to be supportive to others; in cases of socially isolated individuals, provides direct social support or connects with support groups</p>
Information on coping support	<p>Provider...</p> <p>Gives brief education about the disaster, normal stress reactions, and positive coping skills to both survivors and parents/caregivers</p> <p>Provides assistance in addressing immediate needs, reducing psychological distress, addressing immediate concerns, and supporting positive coping skills</p> <p>Example:</p> <p>Train school staff to identify students who continue to show substantial symptoms of distress 4-6 weeks after the incident.</p>
Linkage with collaborative services	<p>Provider...</p> <p>Helps establish links between survivors with further need of mental health services and the appropriate professionals</p> <p>Provides referrals</p>

Table 1 (continued)

<p>Example:</p> <p>Arrange for follow-up assessments and screening to measure and detect students' mental health symptoms that could suggest the development of a mental disorder such as depression, delayed stress reaction or PTSD, and arrange for professional assessment and referral to appropriate health providers for individuals demonstrating such symptoms.</p> <p>In the case of a suicide, arrange for monitoring of risk for suicide in immediate peer group of deceased, and refer to appropriate healthcare providers those who require mental health intervention.</p>

Alternatively, Cognitive Behavioral Intervention for Trauma in Schools, an intervention that has been empirically validated for use in school-aged youth, could also be provided to individuals demonstrating significant psychological distress weeks after the trauma has passed (Ngo *et al.* 2008). In the meantime, appropriate and scientifically valid research studies, unencumbered by financial or ideological biases should be developed and implemented, and the results should be widely disseminated to educators, administrators, and public officials responsible for health and educational matters.

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