

Psychological Guidelines for a Medical Team Debriefing after a Stressful Event

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Medical and rescue workers are at risk of developing mental syndromes including post-traumatic stress disorder after disasters and it is widely accepted that they should be offered a preventive intervention. The Israel Defense Force Medical Corps has developed psychological guidelines for the medical forces: a medical team debriefing after treating the injured as a preventive intervention for an event that may be experienced as stressful. The main purpose of the debriefing is to investigate the circumstances of the event, analyze the medical team's functioning, and draw the relevant conclusions and the manner of their implementation. The purpose of the guidelines is to enhance mental coping, possibly prevent stress reactions, and help in screening individuals in need of further professional intervention for stress reactions. These guidelines are suitable for similar interventions in other professional teams.

Introduction

The participation of countries of "the west" in fighting in various areas in the world, and an increase of terror in those countries, has focused the interest in treatment of mental casualties of stressful and disastrous events. The events of September 11, 2001, the fright caused by the anthrax envelopes, the continuing chemical, biological, and atomic threat, the war in Iraq, and threats of war in other areas of the world have raised the need for managing the treatment of mental stress victims by the psychiatric services of western countries.¹

Post-traumatic stress disorder (PTSD) was first included in the classification guide of the American Psychiatric Association (Diagnostic and Statistical Manual of Mental Disorders, Third Edition) in 1980.² For the first time, common mental symptoms prevalent in trauma survivors were defined as a psychiatric disorder with both definition and treatment. Little has changed in the diagnosis in the subsequent two manuals, despite extensive research done on this subject.

In recent years, knowledge has accumulated concerning the risk of developing mental syndromes, including PTSD, in rescue and medical forces after disastrous events. Stress reactions were described in police officers, paramedics, and ambulance team members who treated survivors of a highway collapse in a California earthquake in 1989,³ in American Red Cross workers who treated Los Angeles earthquake survivors in 1994,⁴ in fire-

fighters who extracted and rescued people from the government building in Oklahoma City in 1995,⁵ and in police officers who rescued survivors from a fire in a discotheque in Sweden.⁶

Rescue workers exposed to bodies and death in disastrous events are at a high risk for development of PTSD and PTSD symptomatology.⁷ PTSD symptoms found in morgue workers who handled bodies of the deceased in the Persian Gulf War in 1990 to 1991 were in direct relationship to the amount of exposure to bodies and body parts.⁸ Exposure to the horrors of the Holocaust caused mental stress symptoms in workers who founded the Holocaust museum in Washington.⁹ Screening of military health care workers for post-traumatic symptoms after a traumatic event revealed levels similar to the levels of PTSD after September 11.¹⁰ PTSD symptoms were as prevalent among military health professionals in Turkey exposed to traumatic events as those in other settings or occupations.¹¹

Because of the understanding that workers in health and rescue organizations involved in managing disasters are prone to developing various psychological reactions, it is an acceptable approach to offer these workers a preventive intervention: coping with stress in disaster events—"critical incident stress management."^{12,13} The preventive intervention should be comprehensive, reduce the underlying stress, prevent development of stress reactions, and screen for those in need of continued treatment. The intervention usually includes a group meeting in which members share their experiences of the traumatic event in a method called "psychological debriefing" (debriefing, psychological debriefing). The term "debriefing" is used to describe both single session psychological interventions for stress-related casualties led by mental health workers and sessions administered to rescue workers and military forces after their missions. This causes lack of clarity as to the purpose of the interventions and influences their results. One of the purposes of this article is to clarify this important issue.

Psychological debriefing was recommended by the taskforce guidelines of the International Society of Traumatic Stress Research in 1997 for treatment of PTSD¹⁴ and was included in the guidelines as a primary treatment of this disorder.¹⁵ According to these guidelines, psychological debriefing was recommended as a single-session crisis group intervention, administered by mental health professionals (psychologists, psychiatrists, or social workers), to decrease and prevent undesirable psychological sequelae after traumatic events, through emotional processing, by ventilation, normalization, and preparation toward possible future problems. Psychological debriefing focuses on reactions existing in the present, through avoidance of psychiatric labeling, and emphasis on the normality of the reactions. The participants are given the explanation that they are normal people who have experienced an abnormal event.

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Psychological debriefing has been supported by findings first discovered by the principal historian of the American armed forces in World War II, General S. L. A. Marshal.¹⁶ Marshal and his team members carried out enquiries of the battles, in which the participants told their battle story the way they remembered it, chronologically, and the interviewers reacted empathically and nonjudgmentally. This process, "historical group debriefing," raised the morale in many of the participants, often changing their attitude toward the battle results. The context of this army procedure is totally different from the process of psychological debriefing: one is a debriefing of a group of soldiers, maintaining their command structure, whereas the other is a single-session treatment of stress casualties who often have no connection between each other apart from being exposed to the same trauma.

It is unclear whether psychological debriefing is effective in prevention or treatment of those suffering from stress reactions. There are disagreements between investigators in relation to the necessity of conducting debriefing and even claims that it may be dangerous in some cases.^{17,18} Both the American Psychiatric Association and the Veterans Administration Department of Defence Practice Guidelines do not recommend "critical incidence stress debriefing" (CISD).

The argument exists for three main reasons: 1) unreasonable expectations from a single-session intervention—it is illogical to expect that psychological debriefing will be the only solution to prevent PTSD. Debriefing may be a necessary ingredient in a comprehensive intervention for disaster-related stress problems, but it should not be considered the one and only intervention. 2) Lack of sufficient controlled research on this subject, as this intervention is relatively new and has not been researched thoroughly. 3) Various methods of debriefing held by heterogeneous therapists from different backgrounds, all headed under the same headline of "psychological debriefing." The term "debriefing" describes both professional enquiries concerning the professional's team functioning conducted after the event and psychological therapeutic interventions, usually single session, conducted by mental health professionals.

Team discussions after treating the injured is a professional enquiry routinely conducted in every Israeli Defense Force (IDF) medical unit and the term debriefing seems appropriate. "Psy-

chological debriefing" seems the appropriate term, if it is conducted according to psychological principles. One must remember that the intervention is not psychotherapy.

Treating the injured can cause stress reactions and treatment under fire can be connected with actual danger to the treatment team, increasing the chance of stress reactions. The medical team debriefing can have a preventive effect, as was attributed to the historical group debriefing, even more so as the leader of the debriefing is usually the medical unit commander and not a stranger to the unit. Proper use of the debriefing procedure may also screen for individuals in the unit suffering from acute stress, in need of further professional intervention by mental health officers. In addition, at the end of the debriefing, the medical commander, the physician, can decide if there is a need for a therapeutic group intervention, especially when there is a high level of anxiety in many of his/her soldiers.

We developed the procedure and the guidelines portrayed here, which were validated by a consensus group of 10 combat-experienced senior IDF psychiatrists, mental health officers, and military physicians. Following a round of remarks, all experts agreed on the final draft of the guidelines. Then, we tested the procedure during a medical officers course in the IDF Medical Corps Academy and technical points (e.g., length of the procedure) were modified. It has been changed through simulations by doctors with active field experience, taught in the last year to doctor trainees in the school of military medicine, and has been distributed to all the physicians in the IDF.

The guidelines have become a fundamental element in the IDF Medical Corps comprehensive program for the prevention of PTSD in medical team members. However, these guidelines are only one element of the comprehensive assessment and treatment plan offered by the IDF Medical Corps as displayed in Table I.

Medical Team Debriefing after an Event: Guidelines for the Unit Physician

Background

The medical team's debriefing, held after every event that includes treatment of injured, is instrumental in maintaining

TABLE I
PREVENTION, IDENTIFICATION, AND TREATMENT OF POST-TRAUMATIC EVENTS AMONG MEDICAL CORPS PERSONNEL

Components
Preventive
Education on combat acute stress reaction (ASR)/PTSD identification and treatment (taught in junior and senior courses in the IDF Medical Corps Academy)
Education about the debriefing guidelines
Practice of treatment of combat ASR/PTSD victims in the Academy and in IDF units
Practice of the debriefing guidelines in the Academy and in IDF units
Identification
Screening the medical unit staff for ASR symptoms by the unit's commander during the debriefing process
Other screening for ASR symptoms by the commander and by mental health officers, military psychiatrists, and military physicians after combat
Treatment
(Early as possible) treatment of symptomatic medical personnel with combat ASD symptoms, by:
— The unit's commander (a physician) and other military physicians
— The unit's mental health officer (a clinical psychologist or a psychiatric social worker)
— The IDF Mental Health Department Central PTSD Clinic and/or the IDF Mental Health Department Career Personnel Mental Health clinics (both with multidisciplinary therapist staff of psychiatrists, psychologist, psychiatric social workers, art therapists, etc.)

and improving both personal and team functioning. Constructive discussion of the interventions given, including possible alternatives that may improve treatment in the future, enhances the professional sense of the team members, adds to the cohesion of the medical unit, and establishes the leadership of the commander and leading professional of the medical team. Talking after a difficult event takes place enables an emotional processing of the experience in a way that is natural and professional.

When the team encounters injuries and situations that are visually disturbing such as in events with multiple casualties, acute stress or prolonged stress reactions may develop and cause considerable dysfunction and distress. Processing the experience as close as possible to the event may prevent the development of these syndromes. The situation most suited for this emotional processing is the medical team debriefing guided by the leader of the team—the unit's physician.

The main goal of the discussion is to clarify the circumstances of the event and the functioning of the medical team, analyzing whether changes in treatment procedures are needed and their subsequent implementation. This should be done in a way that promotes effective emotional coping and prevents stress reactions.

Hopefully, all of the team members who took part in the activity will be included in the discussion. For example, in the regiment, this would include all of the regiment's medical team such as paramedics, drivers, radio personnel, and those in charge of evacuating the injured and securing the medical team, etc.

Goals of the Discussion

1. Reviewing all that happened in the event to create a complete and coherent picture, including all of the treatments given to the casualties by the team.
2. Analysis of the team's functioning in the event, concluding whether there are necessary changes to be made and the method of their implementation.
3. Creating a feeling of professional capability, personal and team resilience, and trust in the professional leadership of the commander and physician.
4. Enabling expression of thoughts and feelings, validating different reactions to the event as normal and universal, leading the discussion toward a positive reframing of actions taken, while communicating the expectancy of the team's continued proper functioning.
5. Screening of team members who may develop acute stress reactions and their referral for diagnosis and treatment.

Time and Place

The discussion will take place as close as possible to the end of the event. The preferred location is a room/tent that allows open conversation without interruptions. If the event ended in the middle of the night and the team members are tired, the talk should be delayed until the morning after a good night's rest. The length of discussion should be at least 30 minutes to 1 hour, depending on the magnitude of the event.

Stages of the Debriefing

1. Opening: 5 to 10 minutes (less, if this is not the first discussion, but one must never skip this stage).

2. Discussion phase: 20 to 30 minutes, depending on the number of participants, the complexity of the event, and the previous relationships of the team members.
3. Gathering of strength and summing-up stage: 20 to 25 minutes.

Opening Stage

The Purpose of the Opening. To clarify the goals of the debriefing and its rules, so that it may progress optimally. Open the conversation by defining its goals:

To talk about the event the team participated in, so that a shared and coherent picture of the event will evolve, draw the conclusions whether there should have been alternative decisions and interventions made so that future functioning will improve, enable everyone to express thoughts and feelings about the event.

The Rules. Ask all participants to speak for themselves. Invite those who want to continue speaking to do so. Put the event in a time and place context: clarify which event/events are about to be discussed and say the length of the discussion in advance.

The Discussion Phase of the Event

The purpose of this stage is to create the team's complete picture of the event. This is important, as when there are gaps in the information, participants tend to fill them with rumors and personal interpretations and distortions. This stage allows the members who are interested to relate their thoughts and feelings during the event and after it to other team members.

Next, begin the actual team talk. Tell the participants to tell the group what happened during the event from their perspective. Ask the medics questions such as: What injuries did you see? Which injuries did you treat? What is your understanding of what happened during the event from your perspective?

For instance, ask questions such as: is this the first time you have come into contact with such an injury (especially if the injuries are disturbing to the senses)? Do not encourage elaboration of the emotional reactions, but if the team member mentions a feeling that was connected to the event, react toward it naturally, and say, for example, "Such a reaction, feeling is completely natural." If the member is still feeling that way, one can say, "I am sure you'll get over it, it'll pass."

Do not allow any team members to avoid telling their story. Those unwilling to talk should be asked to at least state their role and function in the unit and their location in different phases of the event. Do not allow arguments while the participants are describing the event. It is reasonable to surmise that there will be gaps and differences in the perceptions of the team members regarding what happened during the event. It is important that no accusations or criticism of the functioning of team members be made, but through encouragement, the group should form the understanding that it is everyone's right to tell their story from their personal viewpoints. When differences occur with the varying versions told that do not allow continuation of the discussion, intercede and say that differing perceptions among participants are to be expected and that there is no "one truth."

If the members relate their mistakes while functioning during the event, try to elicit from them the more appropriate treatment. Speak of the possibility of more appropriate treatment, but do not be categorical.

At the end of the discussion, describe your version of the event—if you participated in it. Repeat the main facts raised by the team members and if differing versions arose, mention them and try to resolve them logically.

Gathering of Strength Stage and Summing Up

The goal of this stage is to prepare the team for the following period of activity while processing this event in a positive light.

Gathering of Strength Stage. Go from one participant to another and ask: What is the important thing or things that you did for the injured (or the team) during the event? If the team members do not find such a thing, give them your reaction based on your knowledge of their role and functioning. In this manner, you will be able to give each member a feeling of importance and change their perspective on the event into a more positive one.

If during a previous stage or during this stage there arose varying ways of emotionally coping with the event, do not ignore them. If it seems to be a positive way of coping, reinforce it positively. For coping that seems inappropriate, you may choose to overlook it or you may react and say, "This is one way of reacting, one should weigh when it is appropriate." Close with the important things that you and the team members did as a team for the injured.

Before summing up, allow the members to ask questions or propose answering questions after the meeting. Screen for team members whose behavior or reactions seem unusual or worrying. Offer to continue talking with them and give them an appointment that includes both time and place of meeting. If it seems that the reaction is a development of acute stress reaction, you may decide to refer the member to a mental health officer for consultation/treatment depending on the severity of the dysfunctioning. If many team members develop acute stress symptoms, consider inviting a mental health professional for a group intervention.

Summing-Up Stage. In this stage, direct the participants' attention toward the future. Detail as much as possible the operative plans of the unit, while emphasizing the planned actions of the medical team. Concentrate on what lies ahead in the near future for the team and emphasize the norms and values expected in future activities. Bring positive examples of the team's actions during the event while talking about the operational readiness expected from everyone in the following period.

Discussion

The psychological guidelines proposed for the medical team debriefing after a stressful event, as described here, make use of accepted treatment interventions, namely, crisis intervention and group therapy. According to crisis-intervention principles, the focus of the intervention is always the current crisis and not personal developmental events from the past.¹⁹ The three main principles that evolved from treating acute stress casualties from the World War I by American psychiatrist Salmon,²⁰ and later by Spiegel and Kardiner,²¹ are: proximity, immediacy, and expectancy. The medical team debriefing that takes place as soon as possible in time and place to the event, while expressing expectancy of continued appropriate functioning, makes use of these three principles.

Group therapy also developed in a military background, in the British army during World War II,²² making use of the military unit as a strongly supportive environment. Being part of a fighting unit creates clear boundaries between the unit and the external world, promoting a sense of belonging, security, and power. Effective command, cohesiveness, motivation, discipline, and proficiency in handling operational equipment are all factors in preventing development of acute stress reactions and creating the unit's emotional resilience (²³). These principles were the basis of the guidelines developed.

In research of group members exposed to traumas, conversations with other group members were evaluated as most important by those investigated, even more than conversations with partners or psychologists.^{24,25} Apart from actual support from group members, another element that has a calming effect is the knowledge that other group members experience the same stress reactions. This factor, termed "universalization" in group therapy, allows the group members to realize that they are healthy ("normal") people reacting toward a stressful situation (an "abnormal" event).

It is evident that unit physicians have a prominent role as commanders who are responsible for acute stress prevention in their units. In conducting the debriefing, they have a number of functions, including enhancing the personal sense of security and professional ability of their soldiers, increasing the soldiers' belief in the leadership of the unit physician as a commander and as their professional leader, and screening those soldiers who need further encouragement or psychiatric referral. Being a commander who is also a physician enables greater professional understanding than other unit commanders involved in traumatic situations. Furthermore, the doctor can evaluate at the end of the debriefing and later on, if there is need for further preventive group therapy, with mental health professionals.

Our intervention differs from CISD by not being trauma focused. Emotional processing is done through the "back door," interweaving it with the professional analysis of the unit's functioning. There is a focus on positive reframing of the events with little emphasis on the educational component of debriefing.

These guidelines are appropriate for professional debriefing of medical teams and rescue teams after stressful events. For such teams in the army, police, red cross, fire brigade, etc., the concept of debriefing/psychological debriefing is an accurate description of the intervention. Relative resilience of these professional teams toward stress may be achieved by previous preparations, such as long-term training, and specific preparations geared to address certain events, including detailed briefing before an event.

The use of the same terminology (debriefing, psychological debriefing) describing preventive therapeutic interventions, usually implemented by mental health workers toward casualties of stressful events, can cause confusion. In contrast to medical teams, those suffering from stressful events usually have not been prepared for the event. They often are not members of a cohesive group and may have lost family, close friends, and other supporting elements because of the traumatic event. Whereas the members of professional teams are usually healthy individuals, some of the stress-related casualties have a psychiatric history. This is the reason that it is not advisable to force all

those encountering traumatic events to go through the intervention and to respect the wish of those opposed to participating in the group process.

There may be variations in the time, place, method of intervention, and the professional experience of the therapists leading the interventions. These factors may explain the conflicting results documented in the preventive therapeutic interventions aimed at casualties of stressful events.

In summary, the psychological guidelines presented here for a medical team debriefing after a stressful event seem appropriate for managing an enquiry in medical units and may set an example for stress prevention in medical and other similar professional teams. The guidelines have become a fundamental element in the IDF Medical Corps comprehensive program for the prevention of medical team members' PTSD.²⁶ Further research is needed to evaluate the overall effectiveness of this prevention effort, since there is still a debate regarding the correct management of CISD for emergency service workers and the military.²⁷⁻³⁰

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