Letters To The Editor

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Critical Incident Stress Debriefing: Helpful, Harmful, or Neither?

Dear Editor:

Critical incident stress debriefing (CISD) was developed as a therapeutic technique to be used with first responders after exposure to an excessively stressful or horrific critical incident (CI), the primary goal being to facilitate adaptive coping mechanisms following the CI. Although CISD has a long history and is used in many settings, research studies examining its effectiveness have not supported its continued use. Knowing this, I was particularly concerned after reading "Pediatric emergency department staff preferences for a critical incident stress debriefing" by Clark et al.[1]

The authors infer in their introduction that research evidence supports the use of CISD for health care providers to decrease negative effects of exposure to a CI. However, research evidence does not support this position. In fact, most researchers have determined that CISD is, at minimum, not helpful. In addition, authors of a meta-analysis, 2 systematic reviews, and a comprehensive literature review on the effectiveness of CISD in preventing negative symptoms following a CI reached the same conclusion: CISD does not improve recovery from exposure to a CI.[2-5] Furthermore, the authors of the systematic review and literature review also agree that evidence exists that CISD may actually increase the risk for developing posttraumatic stress disorder.[3-5] It is for these reasons that the World Health Organization recommends that "Psychological debriefing should not be used for people exposed recently to a traumatic event as an intervention to reduce the risk of posttraumatic stress, anxiety or depressive symptoms."[5] These important and high-strength studies were lacking from the article by Clark et al.[1] Unfortunately, much of Clark and colleagues' review of the literature relies on lower-strength research and nonscientific literature that supports the use of CISD.

Most research on the effectiveness of CISD is quite old by research and publishing standards, an issue not addressed by Clark et al. Regardless, existing meta-analyses, systematic reviews, and literature reviews need to be addressed in the manuscript when more recent studies are not available, especially when they refute the presupposition of the study. Certainly, more high-quality and rigorous research on this topic needs to be conducted and published. In addition, research has been conducted since the referenced review articles were published, yet none of these are cited in the text.[6,7] I believe it is important to note that authors of a soon-to-be-published quasi-experimental study, "Impact of crisis intervention on the mental health status of emergency responders following the Berlin terrorist attack in 2016," found that those first responders who participated in CISD following their response to a terrorist attack had lower scores on measures of quality of life and higher scores on depressive symptoms.[8] Although this study would not have been available to Clark et al for their study, it is 1 more piece of evidence showing that CISD is not helpful and may be harmful.

Those recommending or using CISD in emergency departments need to be fully aware of the evidence refuting the use of CISD and the harm it may do. It was my hope that Clark et al would have addressed the evidence suggesting that CISD is not effective and why it continues to be used, but the article instead appears heavily biased in favor of CISD. CISD may be a sacred cow that needs to be put out to pasture.—*Christian N. Burchill, PhD, MSN, RN, CEN, Nurse Scientist II, Office of Nursing Research and Innovation, Cleveland Clinic, Cleveland, OH; E-mail: burchic@ccf.org*

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Response to Burchill Letter

Dear Editor:

Thank you for this opportunity to reply to the letter, "Critical incident stress debriefing: Helpful, harmful, or neither?" based on our manuscript, "Pediatric emergency department staff preferences for a critical incident stress debriefing."[1] We are grateful to the author of this letter for their valuable feedback.

We were approached by the management of this particular site to assist emergency nurses and staff in dealing with tremendous stress after a critical event such as a pediatric death or severe injury and illness. To provide nurses and staff relief from deep psychological pain and to prevent attrition after these critical events, we proposed a post–critical event debriefing. Surveys of emergency nurses indicate debriefings are desired by nurses and could be beneficial,[2,3] could reduce turnover,[2] and must follow or use debriefing guidelines or tools.[4] Research articles indicate debriefings after critical incidents could improve retention and need to be tailored to institutional needs,[5] are desired,[6] and should not include those who feel debriefing is not needed.[7]

For a variety of reasons outlined in our manuscript, we arrived at an "à la carte" debriefing process that did not include the seven steps of formal critical incident stress debriefing (CISD) proposed by Mitchell[8] but did include ways for staff to decompress or discuss team and individual performance. Staff participation in the proposed process is voluntary, and counseling resources from the facility's Employee Assistance Program were offered.[1] The literature indicated that CISD might provide a framework that could be adopted to achieve our goals. We used qualitative methods to arrive at staff preferences for a debriefing that might use the CISD framework. We did not specifically intend to reduce or prevent the incidence of posttraumatic stress disorder (a CISD outcome) nor to undertake psychological debriefing. Our participants notably indicated that they did not want psychological debriefing, in terms of discussing their feelings surrounding the event, so that they can maintain their professional ability to care for subsequent patients.[1]

We would not support CISD as outlined by Mitchell and Everly[8] as the exclusive method for debriefing nurses and staff. Data generated from this study are novel and support both the case for debriefing as a coping mechanism for emergency nurses and other staff when they help develop guidelines for their own debriefing process as well as the options presented in the "à la carte" debriefing template. Debriefing includes allowing staff access to broader resources such as counseling offered by Employee Assistance Programs.—*Paul Clark, PhD, MA, RN, University of Louisville School of Nursing and Norton Healthcare Institute for Nursing, Louisville, KY, E-mail: prclar01@louisville.edu; and Barbara Polivka, PhD, RN, FAAN, University of Louisville School of Nursing and Norton Healthcare Institute for Nursing, Louisville, KY.*

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