Police Psychology Into the 21st Century

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In ordinary citizens, the occurrence of severe stress reactions, in the form of nightmares, flashbacks, sleep disturbances, and anxiety, after involvement in major disasters is well known (Frederick, 1977; MacHovec, 1984; van der Kolk, 1984). That similar reactions could occur in police officers involved in shootings or other highly disturbing situations was not widely recognized until recently. What prevented any recognition of the degree to which police officers were at risk for the development of severe stress reactions was the fact that two assumptions were made. The first was that, because they are trained to deal with emergency situations and do so on a more frequent basis than ordinary citizens, police officers are not vulnerable to the development of the kinds of stress responses seen in civilians. The second assumption was that if stress symptoms occurred, they did so in a limited number of individuals, and no special attention needed to be paid. Police officers were tough and, as Reiser and Geiger (1984) put it, “time would heal” (p. 317).

During the 1980s, it became clear that these assumptions were not valid. A number of authors described the occurrence in police officers of the same kinds of symptoms seen in civilians (e.g., nightmares, flashbacks, and anxiety) after those officers had been involved in crisis situations in which their lives or the lives of others had been threatened (Ayoob, 1982; Blak, 1986; Carson, 1982; Loo, 1986; McMains, 1986; Nielsen, 1986; Reiser & Geiger, 1984; Stratton, 1984). Furthermore, it was recognized that, if left untreated, these symptoms could, and did, have long-lasting effects. Officers involved
in shootings or other equally traumatic incidents developed posttraumatic stress disorder, displayed diminished work performance, left the force within a few years of a shooting, became involved in alcohol and other substance abuse, or even attempted suicide (Blak, 1986; Clements & Horn, 1986; Kroes, 1985; Perrier, 1984; Solomon & Horn, 1986).

Originally, attention was directed primarily to one particular situation as being sufficiently stressful to cause concern—an officer-involved shooting (Fishkin, 1988; McMains, 1986; Solomon & Horn, 1986)—but later it was recognized that a range of other situations also had the potential for being highly traumatic, and the concept of the critical incident was born (Gentz, 1991). By the end of the 1980s, the matter of critical incident stress responses in police officers was deemed of sufficient importance to merit a special conference on the topic, which was held at the FBI Academy (Reese, Horn, & Dunning, 1991). At the present time, far from being viewed as invincible, police are seen as individuals who, because of their repeated exposure to scenes of carnage and mayhem, may be especially at risk for the development of stress symptoms.

This chapter deals with professionally run critical incident debriefing for police. First some background material is presented. The critical incident is defined in detail, the nature of the reactions displayed by police officers is described, and the theoretical basis for professionally administered debriefing programs is explained. Second, a detailed account of the mandatory debriefing program used by the author with police in San Bernardino and Riverside Counties in California is presented, and the model is compared with the one developed by Mitchell for firefighters and other emergency personnel. Third, evidence is presented to show that the debriefing method achieves some measure of success. Fourth, some unresolved issues that merit further study are explored.

**BACKGROUND MATERIAL**

**What Is a Critical Incident?**

Various definitions have been offered of what constitutes a critical incident. According to Mitchell and Bray (1990), it is an event that has sufficient emotional power to overcome the usual coping abilities of the individual. According to Horn (1991), it is an event that is experienced on or off the job that is outside the realm of normal human experience and could be expected to produce significant emotional reactions in anyone. Nielsen (1986) stated that what characterizes the critical incident is that it is traumatic, unexpected, and a serious threat to the individual’s well-being; contains an element of loss; and involves disruption of the individual’s values or as-
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Assumptions about the environment. Mitchell (1991) similarly, said that a critical incident is one in which the officer's expectations of perfect performance suddenly are tempered by crude reality; the officer sees her or his own imperfections and experiences a loss of self-confidence.

McMains (1991) and Gentz (1991) offered the most comprehensive descriptions. According to McMains (1991), a critical incident is a situation that reminds the officer of her or his own limits and overwhelms the individual's capacity to cope. One thing that makes the incident traumatic is that it brings home to the officer that he or she is not in total control of every situation but rather is vulnerable. The officer cannot maintain the myth of omnipotence and immortality. Gentz (1991) presented a similar argument. He said that the police officer experiences an event that cannot be assimilated into her or his current life perspective. The individual comes up against the reality of death. If the officer is sick and trembling, then the old self-concept of being perfectly controlled is challenged. Like McMains, Gentz said that the officer has a disturbing sense of his or her own vulnerability because the individual's usual defense mechanisms did not work. Gentz (1991) also agreed with Nielsen (1991) with respect to the element of loss. A critical incident involves loss because there may be death or serious injury, loss of a physical ability, or loss in terms of a major assault on the officer's values or assumptions about his or her environment. An important point made by Gentz (1991) was that a critical incident should be defined not in terms of the event but rather in terms of the impact it has on the individual. That is, a critical incident is one that, by definition, requires the individual to make extraordinary adjustments.

As noted earlier, the original concept of postshooting trauma has been broadened. The only danger at present is of going to the other extreme and listing virtually every situation that a police officer encounters as constituting a critical incident. Listed here are some of the specific examples cited by recent authors (Ayoob, 1984; Havassy, 1991; Mitchell, 1991; Mitchell & Bray, 1990; Nielsen & Eskridge, 1982; Stratton, 1984):

- Death (including suicide).
- Serious injury of another officer.
- Wounding or killing a suspect.
- Being wounded or in extreme danger.
- Witnessing serious multiple casualties.
- Traumatic deaths or injuries of children.
- Events that attract a great deal of media coverage.
- Situations in which the victims are known to the officer or remind him or her of a loved one.
• Traffic accidents or homicides that are particularly bizarre or gruesome.
• A failed rescue.
• An accidental death caused by the officer.
• A situation involving hostages.

Reactions to a Critical Incident

Immediate responses to a critical incident are physiological—muscular tremors, nausea, hyperventilation, faintness, sweating, and perceptual distortions (e.g., time being slowed down). All of these responses represent the body’s attempt to mobilize for extreme stress. Subsequent reactions within minutes or hours of the episode include shock, fear, denial, anger, numbing, and a general feeling of unreality (Blak, 1986; Blum, 1987; Carson, 1982; Nielsen, 1986; Reiser & Geiger, 1984). These reactions have to do with the fact that the individual feels vulnerable; they represent an attempt to reestablish the control that was lacking during the incident (Horn, 1991).

Delayed reactions also can occur. Within several days or sometimes even weeks, the officer may experience grief, intrusive thoughts about the incident, flashbacks, nightmares, and other sleep disturbances. Although these reactions are especially troublesome to the individual (Ayoob, 1982; Blak, 1986; Carson, 1982; Hill, 1984; Mantell, 1986; Solomon & Horn, 1986; Stratton, 1984), they have some positive aspects. According to Gentz (1991), these symptoms are signs that the person is still attempting to adjust and to assimilate the experience, to find a new cognitive category into which it will fit. Additional delayed symptoms that may appear and that do not have such positive aspects are depression, emotional withdrawal, anxiety, guilt, paranoia about being watched, and sexual dysfunction (Carson, 1982; Fishkin, 1988; Hill, 1984; Loo, 1986; Mantell, 1986; Stratton, 1984). There may be delayed physiological symptoms as well, in the form of headaches and stomach aches. These represent anxiety in masked form. For the officer who is concerned about possible legal or other repercussions of the incident, it is easier to complain about headaches than about the worry itself.

Typically, the symptoms described in the preceding paragraphs are temporary. Within a few weeks or at most a few months of the critical incident, they gradually abate. However, in some cases—especially if no treatment was provided—the aftereffects of the critical incident are apparent many months later in the form of anger, hostility, irritability, problems about accepting authority, fatigue, inability to concentrate, loss of self-confidence, increased use of drugs and alcohol, and overindulgence in food (Ayoob, 1982; Blum, 1987; Carson, 1982; Fishkin, 1988; Loo, 1986; Mantell, 1986; Nielsen, 1986; Reiser & Geiger, 1984; Solomon & Horn, 1986; Stratton, 1984). Many of these long-term effects interfere with work performance and
threaten the stability of close personal relationships. Ultimately, they may be responsible for early retirement, burnout, and suicide in police officers.

Not all of the aftereffects are negative. One positive aftereffect is that the officer may take some major step that had long been contemplated but about which he or she was hesitant. Examples are: an officer who was unhappily married before the incident decides afterward to get a divorce; an officer who was thinking about buying a house actually does so; an officer who has no children decides to become a parent. All of these responses constitute realistic attempts by the individual to come to terms with her or his own mortality.

**Theoretical Basis for Treatment**

During the 1980s, at the same time that attention was being called to the problem of critical incident stress in police officers, a number of authors described treatment programs administered by mental health professionals that either were in place or that the authors wished to see instituted (Alkus & Padesky, 1983; Blak, 1986; Fishkin, 1988; Garrison, 1986; Hannigan, 1985; Hill, 1984; Lippert & Ferrara, 1981; Mantell, 1986; McMains, 1986; Mitchell, 1983b; Somodevilla, 1986; Stillman, 1986; Trapasso, 1981; Wagner, 1986). Despite some minor differences in specifics, all of these programs were similar and were based on a set of assumptions that derived from crisis theory (Aguilera & Messick, 1986; Titchener & Kapp, 1981). My treatment program, which is described in the next section, rests on the same theoretical foundation.

Three very important assumptions are made. The first is that the individual being treated was functioning adequately and was free of serious psychological problems before the incident. The second, and related assumption, is that any symptoms displayed are not signs of serious disturbance; rather, the symptoms are those that would occur in anyone who had been exposed to a similar level of trauma. The third assumption is that any problems experienced are temporary. Because the intent is not to produce major alterations in personality or to deal with long-standing personal problems, treatment can be brief; often, it is confined to only a single debriefing. In such a setting, the mental health professional necessarily functions in a more directive way than would usually be the case. In addition to facilitating the expression of emotion about the incident, the professional provides support and reassurance. To the extent that specific information is provided about the normalcy of the officer’s responses to the incident, the professional also functions as an educator. The goals of treatment are: (a) to alleviate the painful effects of the incident, (b) to prevent the subsequent development of a posttraumatic stress disorder, and (c) to restore the individual to the preincident level of functioning as quickly as possible (Mitchell & Everly,
1993). To accomplish the latter goal, it is important that treatment be administered relatively soon after the event, before the officer has time to see it in a maladaptive and self-critical way (McMains, 1991). Ideally, debriefing occurs within 24 hours of the incident.

THE BOHL LAW ENFORCEMENT MODEL

The debriefing technique I use with police officers derived originally from the pioneering work of Mitchell, a professional who, in a series of books and papers that date from 1982, has provided detailed accounts of how to carry out critical incident debriefings (Mitchell, 1982, 1983a, 1983b, 1984, 1986a, 1986b, 1986c, 1991; Mitchell & Bray, 1990; Mitchell & Everly, 1993). Although Mitchell’s model provided a basis, I found, after continued work with police officers over the years, that his approach—which was developed to treat firefighters and other disaster workers—needed to be modified in a number of significant ways when the individuals being treated were police officers. In the description that follows, both similarities to, and differences from, Mitchell’s technique are noted (all comparisons are based on Mitchell’s most recent descriptions of his technique in Mitchell & Bray, 1990; Mitchell & Everly, 1993).

When Is a Debriefing Carried Out?

In my work with police in Riverside and San Bernardino Counties, California, the debriefing always is done as soon after the critical incident as possible. The facilitator interviews the officer or officers immediately after the incident and makes an assessment about what would be the most beneficial approach to follow. Frequently, the debriefing is conducted then. Sometimes, though, it is clear that an individual is too exhausted or hungry or that the individual simply feels unable to talk. Officers may say that they need to exercise, to see their families, or just get away from the scene. If that is the case, a debriefing is scheduled for some time within the next few days. If a group is involved, it is possible for different people to elect to do different things. Some may stay for an immediate debriefing, and others may elect to meet at a later time. The schedule, then, is flexible, with the paramount concern being how best to meet the needs of individual officers. The only limitation is that, if the debriefing is postponed, the delay period is not allowed to exceed 3 days. Also, it is made plain that the debriefing is mandatory.

My approach differs from the one described by Mitchell. Because he deals with disaster teams, Mitchell’s assumption is that a fairly large group of individuals will be involved, and he outlines a whole hierarchy of interventions. These range from a large-scale demobilization of an entire disaster unit, to a smaller scale defusing, to a still smaller scale debriefing. In Mitchell’s scheme, the debriefing is the most time consuming and intense of the three
interventions. It is the only one that requires the presence of a mental health professional, but it is not used routinely. Rather, it is used when the other, shorter interventions have been tried and found to be ineffective. Consequently, it may be attempted as much as 3 weeks or more after the event, even though Mitchell acknowledges that a debriefing is best done between 24 and 72 hours after the critical event.

The Number of Participants at a Debriefing

In my work with police officers, it is not uncommon for the debriefing to involve only a single participant. That is because many situations—for example, an officer-involved shooting—involves only a single individual. Even if a group was involved in the incident, individual debriefings may be held first, within 24 hours of the incident; and then, within 1 week, the group will be brought together for another debriefing, the major purpose of which is to encourage bonding. The reason for this approach is that police officers who work on the street seem to do better in a one-on-one debriefing than in a group debriefing. Often, if several officers were involved in a single incident, they do not know each other and are reluctant to participate in a group debriefing. Special Weapons and Tactics (SWAT) teams, on the other hand, have a strong sense of group solidarity. They want to be seen in a group, and they are not embarrassed about talking about an emotional event before their peers. The situation that Mitchell described with emergency personnel is different. In his case, it is usual for a large group (20 or more) to be involved in a debriefing. These individuals, like police SWAT teams, probably functioned as a unit before and during the incident. Consequently, the maintenance of cohesiveness is a more important issue for them than for law enforcement personnel.

Who Conducts the Debriefing

The number of individuals on the debriefing team is variable. If peers or clergy are available, they are included, but it is possible for there to be only a single individual, the mental health professional. In Mitchell’s system, where typically a large number of participants are involved, this approach is not feasible. A debriefing is led by a team of at least four individuals—a mental health professional, several peer support personnel, and perhaps a member of the clergy; and each member of the team has a designated role (e.g., leader, coleader, and doorkeeper) to play.

Duration of an Intervention

The duration of a debriefing varies according to the number of individuals involved. If only a single officer is seen, it may last for 45 minutes to 1 hour. If a small group is involved, the average time is 1½ to 2 hours. For larger
groups, the time may extend to 3 or even 4 hours. The major determinant is that there be sufficient time for individuals in the group to ventilate feelings and to obtain support and reassurance. Mitchell's debriefings, which typically involve larger groups, necessarily last for longer, with 3 hours being an average duration.

**Preparation for an Intervention**

To prepare for the debriefing, I often walk through the scene of the incident. For example, if the debriefing involves an officer-related shooting, the shooting team that did the investigation will be interviewed to ascertain what happened. Useful background information is obtained. The commander may mention that he or she is worried about a particular individual who was involved in prior shootings or who is otherwise stressed (e.g., by being involved in a divorce).

In Mitchell's model, a more elaborate preparation is involved, but that is because, typically, his debriefings occur days or weeks after the event. He reported that members of the debriefing team meet first to review published reports of the incident and to engage in preliminary planning of the strategy to be followed at the debriefing. Afterward, there is a period of informal talk with the participants. Then, the team retires to a separate room to engage in more planning of strategy. Finally, they enter the debriefing room to conduct the debriefing.

**Steps in the Debriefing**

**Phase 1.** The first phase is the introduction, the purpose of which is to make clear to participants the nature of the process and who will be involved. The facilitator begins by telling the participants about herself and, if there is a peer counselor present, then he or she is introduced as well. Participants are told not only what the debriefing involves but also what it does not involve. Specifically, they are told that the purpose of the debriefing is to aid in recovery, and they are assured that information obtained during the debriefing will be confidential; also they are told that the debriefing is not a form of group therapy.

This phase is similar to the introduction phase employed by Mitchell. However, there is a one important difference. Mitchell makes clear to participants, at this time, that no one who does not wish to speak will be forced to do so; and he reports that, indeed, some unspecified proportion of firefighters and emergency personnel elect to remain silent during his debriefings. In my experience with police officers, that caution has been found to be unnecessary. Failure to take part in a debriefing is an extremely rare event and occurs in less than 5% of the cases. Generally, police officers are
eager to say what happened, especially during the fact phase. There may
be reluctance later to describe the feelings elicited by the incident; but, as
discussed later, the experienced facilitator should be able to deal successfully
with that reluctance.

The difference between Mitchell's experiences and mine may have to do
with fact that, as already noted, the groups I see during a debriefing are
considerably smaller than those seen by Mitchell. However, there is still a
major theoretical difference between the two approaches. In my view, the
explicit statement about not speaking may be counterproductive. If an officer
is truly unwilling to speak, then the sensitive facilitator will respect that
need. Nonetheless, every effort should be made by the facilitator to make
individuals who take part in a debriefing feel sufficiently comfortable so
that they are willing to participate fully in the debriefing process.

**Phase 2.** In my model, the second phase is a fact phase, during which
participants tell what happened during the incident. The facilitator asks
questions like the following: Where were you during the incident? Tell me
about the experience. What was your role? Sometimes, it is helpful to ask
a participant to go through the experience frame by frame, like a movie.
When the facilitator listens to the accounts, she picks out issues to which
she will return later during the feelings or reaction phase.

In Mitchell's system, the second phase also is one in which factual infor-
mation is obtained about what happened during the incident. However,
Mitchell discourages an early show of emotion at this time because he feels
that such emotion makes participants feel anxious and like the debriefing
is out of control. In my experience, the attempted distinction between phases
of the debriefing that are cognitive and phases that are emotional is not
meaningful. Consider a concrete example. Suppose that an officer is asked
to state a fact but begins to express emotion. There is nothing to be gained
by telling the participant to wait until later in the debriefing. The critical
thing here is to be flexible. It is more important to respond empathically to
the needs expressed by the individuals who attend the debriefing than to
follow a rigid and arbitrary set of rules.

**Phase 3.** In my model, Phase 3, the thought phase, is one in which
participants describe their thoughts during the stressful event. This phase is
like the thought phase employed by Mitchell, except that participants are
asked about all of their thoughts and not necessarily what occurred to them
first, as in Mitchell's model. A further difference has to with the previously
mentioned distinction that Mitchell attempts to make between cognitive and
emotional domains. According to Mitchell, the thought phase is a transition
from the earlier, more cognitive domain to an emotional domain. In my
experience, the two domains are not so readily and neatly separated.
That even Mitchell finds the distinction difficult to maintain is shown by his statement that a debriefing can become intense during the thought phase. In their recent book, Mitchell and Everly (1993) reported that people sometimes walk out at this point and need to be brought back by a specially designated member of the debriefing team called a doorkeeper. In my experience with police officers, the problem of people walking out of a debriefing does not arise. On a few rare occasions, an officer who was in tears has left the room to compose herself or himself. In that case, the facilitator or some other member of the team went outside to make sure that the person was alright and told the officer to come back when he or she was feeling better. However, it is important to stress that, on these rare occasions, the officer came back voluntarily.

The difference between Mitchell’s experiences with firefighters and emergency personnel and my experiences with police may be due to the fact that they are different populations. Police are more autonomous than firefighters and emergency personnel, and they are less used to working as part of a team. They would not tolerate a doorkeeper. However, again, there is a theoretical difference with respect to approach. In my view, it is intrusive to force people to attend a debriefing if they are too upset to be there. Also, if the debriefing is properly handled, people should not want to leave and there should then be no necessity to force them to return.

**Phase 4.** In my model, Phase 4 is the feelings or reaction phase, the purpose of which is to allow participants to express the emotions associated with the critical incident. At this time, the facilitator goes back to the factual statements made earlier by participants about their actions during the critical event. They are asked about what their feelings were while they were carrying out the actions they described earlier. For example, a participant might be asked: What did you feel when you realized that you had shot the suspect? What did you feel when you thought your partner had been shot?

What is helpful for participants is not the mere expression of emotions but rather the opportunity to validate feelings. Often, it is a revelation to discover that peers had similar feelings. Some emotions, it must be noted, are difficult to validate. For example, there is not much that even the facilitator can say to an individual who is experiencing strong guilt. In that particular situation, the guilt may be appropriate. Certainly, it is not helpful for the facilitator to say, “Well, you should not feel that way.” In the debriefing situation, there are no “shoulds.” An appropriate response by the facilitator is, “Okay, you feel guilty. What are you going to do with that guilt?”

Sometimes, police officers who were eager to speak during the fact phase do not want to describe their feelings at this point in the debriefing. An officer may say, “I felt just like he did” (indicating a neighbor who has just spoken). At that point, the facilitator may need to encourage the individual
to speak by asking: What was the worst part of the experience for you? It is also possible for the reverse to occur. An officer may do little or no speaking during the fact phase and simply agree that the facts presented by his or her neighbors are correct. Yet, during the reaction phase, that same officer may voice emotions that are quite different from his or her neighbors.

In Mitchell's system, as in mine, the fourth phase is a feelings or reaction phase, during which the facilitator encourages participants to ventilate emotions. The major difference between the two approaches, however, is that I try to get at feelings by using information the participant already has provided. In contrast, Mitchell tries to get at feelings by asking: What was the worst thing about the event? What caused you the most pain? In my view, these are not the best questions to ask. For a police officer who was involved in a shooting, everything about the experience was bad. Consequently, questions of this type are not asked routinely. As noted earlier, they are used only if the individual is not otherwise responding.

**Phase 5.** In my model, Phase 5, the symptom phase, is one in which participants describe what they experienced at the time and are still experiencing. Most of the symptoms that participants talk about are immediate physiological responses like nausea and time slowing down. The facilitator tries to validate the participants' experiences. For example, if someone says, "I felt sick to my stomach," then the facilitator validates by saying that anyone would feel sick in that situation. However, it is important for others in the group to validate as well. The officer needs to know that her or his coworkers had the same reactions.

In Mitchell's model, symptoms are dealt with in two separate phases rather than one. First, participants are asked to describe what they experienced at the time, a few days later, and are still experiencing. The debriefing team may mention specific symptoms and ask if anyone has had those symptoms. During this phase, there is presumably a return to cognitions, as distinct from emotions. Then, there is a separate phase, the teaching phase, during which the facilitator tells participants that their stress responses are normal, and they are assured that the responses will subside. This phase, too, presumably is cognitive rather than emotional. Coping strategies, such as, diet, rest, exercise, and talking to the family are discussed.

In my experience with police officers, the separation into two phases was not found to be useful. Consequently, symptoms are dealt with in one phase that includes both the participants' statements about their symptoms and assurances by the facilitator that the symptoms are normal and they will subside. In contrast to Mitchell's experience, I have found that this part of the debriefing frequently has a strong emotional component. Participants are relieved when others share their symptoms. They no longer feel isolated. Most important, they know that they are not crazy.
Phase 6. Phase 6 of my model, the unfinished business phase, is one in which participants are asked: What in the present situation reminds you of a past experience? Do you want to talk about these other situations? There is no comparable phase in Mitchell's model. The unfinished business phase was added because experience showed that the incident for which the current debriefing was being conducted often acted as a catalyst. Participants were reminded of prior events, not all of which had involved a formal debriefing. When asked about these prior events, participants have a chance to talk about incidents about which they have strong and unresolved feelings. The debriefing ends with a greater sense of relief and closure than would otherwise be the case.

Phase 7. Phase 7 of my model is an educational or teaching phase. Participants are told about how to deal with their families and their children. For police, a special problem is the fact that a child may have heard that the officer killed someone. Another possibility is that family members may experience vicarious symptoms. Therefore, it is important to educate participants not only about what they have experienced so far but also about what they may experience after the debriefing. So, for example, participants are told: You may not be able to sleep tonight. You may find yourself arguing with your spouse a lot during the next few days. As in the symptoms phase, participants are reassured that their symptoms are normal and will go away. Feedback from police officers who have been debriefed makes it plain that they appreciate this attempt to prepare them, in a practical way, for the immediate future.

In Mitchell's system, there is also a teaching phase, as noted earlier, in which stress symptoms, both those already experienced and those that may be experienced later, are described, reassurance is provided about the normalcy of the responses, and coping strategies are discussed. Where the two models are different is that, at the end of Mitchell's teaching phase, participants are asked whether they can see anything positive or hopeful in the incident. The rationale is that the individual should try to see the incident as part of a growth experience. In my work with police officers, this approach has not proved to be useful. Officers who have seen their partners shot or killed or who have had to deal with cases of child abuse find it difficult to find anything hopeful or positive in the experience, no matter how well they handled the situation. If officers make spontaneous attempts to talk about positive aspects, they are not discouraged. However, this line of discussion is not followed routinely, as is done by Mitchell.

Phase 8. Phase 8 of my model, the wrap-up, is a time when questions are answered and participants are asked about whether there is any information they want passed on to their supervisors. In Mitchell's system, this
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Phase 9 is the final one; during it, the facilitator not only answers questions but also verbalizes feelings that were not openly expressed and sums up what has been said in the debriefing. This kind of verbalization of feelings is best done earlier. There is another difference from Mitchell’s model. During this final phase, he has all team members make statements in which they indicate their support and offer encouragement. In my experience, such statements, however well intended, overpower participants. What works better for police is to have expressions of encouragement and support come from members of the peer group who were present at the debriefing.

**Phase 9.** Phase 9 of my model is a round robin. Each person is instructed to say anything that he or she wants to say. The remark can be addressed to anyone, but because others cannot respond directly, participants have a feeling of safety. The facilitator also contributes something at this time. This phase is not part of Mitchell’s system. It was added because experience showed that it has a powerful effect on participants. Again, the theoretical difference between my approach and that of Mitchell needs to be noted. According to Mitchell, by the final phase, the debriefing should be back on solid cognitive rather than emotional ground. The round robin phase, on the other hand, constitutes an emotional ending. However, it is important to note that the emotions expressed are positive. The possibility exists for negative emotions to be expressed, but that never happens. For example, one police officer may say to another one, “I want you to know that I am glad you are my partner” or “I want you to know that Michael (a dead officer) loved you.” A remark addressed to the facilitator might be “I am glad we did this.” Thus, the debriefing ends on an upbeat note, with hugs, handshakes and a show of relief. Participants seem to experience a strong sense of bonding.

**Afterward.** Typically, participants do not leave but stay to talk informally with the facilitator, other members of the debriefing team, and each other. Before they leave, they receive handouts describing the initial symptoms experienced, symptoms they may experience later, ways to cope (e.g., exercise, meditation, talking to family members), and unsuccessful coping mechanisms to avoid (e.g., reliance on alcohol and drugs). For police officers in San Bernardino and Riverside Counties, the mandatory debriefing with a mental health professional is the first, but not necessarily the only, intervention after a critical incident. The officer has the option of requesting additional debriefings with a mental health professional, a peer support group, or a member of the clergy. Debriefings with nonprofessionals are extremely valuable because they provide a different kind of support than that provided by the professional.
DO THE TREATMENTS WORK?

It is unrealistic to think that a single debriefing will resolve all problems, so that the individual does not feel anything afterward or think about the incident. The major purpose of the debriefing is to prevent the occurrence of more serious problems weeks or months later. The question is: Does the debriefing accomplish that purpose?

According to McMains (1991) and Mitchell and Everly (1993), there are fewer resignations in departments that have critical incident stress debriefing programs than in departments that do not have such programs. There are several unpublished studies (cited in Mitchell, 1991; Mitchell & Everly, 1993) in which benefits were claimed, but because a treated group was not compared with an untreated control group, the findings of these studies are not conclusive. As noted by Mitchell and Everly (1993), the most convincing case would be made by a piece of research in which a true experimental design was involved, meaning that a comparison was made between individuals who had experienced critical incident debriefing and individuals who had not experienced critical incident debriefing.

To my knowledge, the only study of this type carried out to date was the one by Bohl (1991). Participants were male police officers drawn from the Inland Empire area of southern California, all of whom had been involved in a critical incident. The treated group \((N = 40)\) came from departments that had mandatory debriefing programs, and the untreated group \((N = 31)\) came from departments that did not have such programs. Members of the treated group received a 1½-hour group debriefing (with my technique) by a mental health professional within 24 hours after the critical incident. Three months later, each participant took three formal psychological tests, the State-Trait Anxiety Inventory, the Beck Depression Inventory, and the Novaco Provocation Inventory (a measure of anger). A fourth test, devised by Bohl, assessed the frequency of occurrence during the preceding week of six common stress symptoms—nightmares, flashbacks, difficulty falling asleep, difficulty staying asleep, loss of appetite, and excessive hunger. Although the two groups did not differ significantly on the measure of anxiety, they differed in the expected direction on the other three measures. By comparison with the untreated group, the treated group was significantly less angry and depressed; they also had fewer and less severe stress symptoms. Overall, then, the treatment seemed to be successful in reducing the distress caused by involvement in a critical incident.

A possible weakness in the study was that, due to the necessity to comply with regulations imposed by the participating departments, it was not possible to assign participants to the treated and untreated groups on a random basis. That lack meant that the results might have been due to pre-existing differences between the two groups. However, Bohl (1991) presented considerable
evidence against such an interpretation. The treated and untreated groups did not differ with respect to the number of critical incidents in which they had been involved, age, marital status, or number of years on the job. The departments from which treated and untreated participants were drawn were essentially similar with respect to geographic location, size, philosophy, hiring practices, and socioeconomic level of the populace served. Further, the departments from which untreated participants were obtained had instituted mandatory debriefing programs by the time the study was over. Thus, even though the Bohl (1991) study did not meet all of the criteria for a true experimental design, it nevertheless presented the best evidence currently available that debriefing programs for police are beneficial.

**UNRESOLVED ISSUES**

There are two issues about which further research are needed: (a) Why do the treatments work? (b) Why do some people cope better with critical incidents than others? Current views on both of these topics are now considered.

**Why Do the Treatments Work?**

There are four commonly cited reasons for why the interventions work (Blak, 1991; Havassy, 1991; Mitchell & Everly, 1993). The first has to do with promptness. They are applied early, before the person becomes isolated and begins to utilize maladaptive coping mechanisms (such as withdrawal) that effectively isolate him or her from help. The second has to do with emotions. The debriefing interview offers an opportunity for emotional catharsis. The third has to do with cognitive factors. The individual has an opportunity to make sense out of what happened. The fourth has to do with the provision of peer support and group acceptance. Common themes emerge during the debriefing—anger, fear of repetition of the event, powerlessness, guilt, depression, distress about having behaved aggressively, questioning of the career choice, and reaffirmation of efficacy and competence.

Havassy (1991) suggested another reason that is worth considering in detail, which is that the debriefing works because it functions as a social ritual. She pointed out that rituals or prescribed ways of behaving have been used in all cultures as a way to deal with the emotions aroused by death and loss. Rituals are healing because they provide the participant with a sense of closure about the event. People outside of the police who have been involved in disasters can find support groups. Police need to find support groups within their own setting because they feel isolated from the public and also are committed to the maintenance of an image of control.
Debriefing is an ideal ritual because it is culturally sanctioned within the police culture; in many cases it is mandatory. The individual who is upset does not have to think about what to do. Also, the debriefing is shared by individuals from the same background. In the course of the debriefing, as in other rituals that involve loss, the individual’s feelings are validated, and the result is that the person feels less isolated. He or she has participated in a shared social event within the community.

**Why Do Some People Cope Better Than Others?**

One factor in ability to cope may be the sheer number of incidents in which the individual has been involved. The effect of such involvement appears to be cumulative. There may be, finally, just one horrifying incident too many for a police officer who was functioning adequately before the incident (Blak, 1986; Clements & Horn, 1986; Perrier, 1984). On the other hand, prior experience need not be a negative factor. Nielsen (1991) pointed out that if the individual has been involved in prior episodes in which he or she coped successfully, then the sense of mastery is increased, and the likelihood of a favorable outcome is greater than if the individual was experiencing the first critical incident.

Previous training in how to cope also may be helpful. Ideally, what such training should do is to prepare the individual. If he or she feels adequate and possessed of the necessary skills to cope successfully, it is less likely that the critical incident will be perceived as threatening and potentially overwhelming (Mitchell, 1991).

Another factor to consider is the degree of concurrent stress. The critical incident needs to be seen in context as just one of many events in the officer’s life (Nielsen, 1991). There is also the matter of the degree to which the officer was blamed for the event. As van der Kolk (1991) noted, the prognosis is better if the individual was not blamed for the incident.

Personality is yet another factor. Individuals with a strong sense of self should feel less threatened by failure to perform perfectly and so should do better than those with a weak sense of self (Nielsen, 1991; van der Kolk, 1991). Also, individuals who are able to ventilate their feelings and who try, afterward, to integrate the traumatic event into their total life experience (Horowitz, 1986) should cope more successfully than individuals who rationalize, deny, or ignore the experience.

**SUMMARY AND CONCLUSIONS**

The importance of dealing with critical incident stress in police officers now is widely recognized. Stress symptoms can occur after a variety of traumatic experiences, of which an officer-involved shooting is only one. Some reac-
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Reactions are immediate and represent mobilization for stress and attempts to re-establish cognitive control. Other reactions occur within days or sometimes even weeks of the incident and represent concealed anxiety, as well as continued attempts to assimilate the experience cognitively. Long-lasting responses may occur, especially if no treatment was provided.

The theoretical basis for treatment derives from crisis theory. It is assumed that the individual was free of serious psychological disturbance before the incident and that the symptoms are temporary. Treatment is brief, immediate, and directed toward alleviation of present symptoms, prevention of future symptoms, and restoration of an earlier level of functioning.

The treatment model developed by Bohl for police officers was described. Officers can be seen alone or in groups, immediately after an incident or within a few days; treatment can involve a team or only a single mental health professional; and, depending on the size and needs of the group, it can last anywhere from 45 minutes to 3 to 4 hours. There are nine phases.

In the introduction, participants are told what the debriefing is about. In the fact phase, participants are asked to describe their roles during the incident. In the thought phase, participants are asked about their thoughts during the incident. In the feelings or reaction phase, participants are asked about what their feelings were while they carried out the actions described earlier during the fact phase. During the symptoms phase, participants describe what they experienced during the incident and afterward, and they are assured by the facilitator that their responses are normal and will subside. In the unfinished business phase, participants are asked about other prior situations that were similar. During the education or teaching phase, participants are told about symptoms that may be experienced later. In the wrap-up, questions are answered, and participants tell the facilitator anything they wish to have passed on to their supervisors. In the round robin phase, each person, including the facilitator, makes one statement that can be addressed to anyone and to which others cannot respond directly. Afterward, participants are told about how they can request additional help, and they are given useful handouts about how to cope.

The Bohl Law Enforcement model was developed specifically for police officers, and it differs, both in method and in philosophy, from the treatment model developed by Mitchell for firefighters and other emergency personnel. The many differences were pointed out in detail earlier and are only briefly mentioned here. The model for police is less structured and formal, and there is no sharp distinction between cognitive and emotional phases of the debriefing. Some procedures used by Mitchell have been found not to work with police (e.g., routinely asking what was the worst aspect of the experience and asking participants to see something positive in the experience). Some aspects of Mitchell's technique have been found to be unnecessary with police (e.g., forcibly returning unwilling participants to a debriefing).
Two of Mitchell's phases have been combined, and two new phases have been added (unfinished business and round robin).

Experimental evidence was reviewed to show that critical incident debriefing for police actually is beneficial. Finally, two unresolved issues were considered: Why do the treatments work? Why do some people cope better with critical incidents than others? Current views were described, but it is plain that more research is needed.

REFERENCES


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