

Caring for colleagues through debriefing

Coping with serious incidents is a reality for many mental health nurses. Support through debriefing can help lessen the toll these traumatic events take.

By Bernie Burns

Three years of undergraduate nursing study had prepared her for many clinical situations – but not this one. Just three months after graduation, this young nurse faced what even seasoned mental health nurses would consider a nightmare – being on duty when an inpatient committed suicide. The new graduate, who had nursed the patient frequently, was one of the first on the scene and had helped in the resuscitation attempts.

Critical incident stress debriefing (CISD) helped this young nurse deal with the intense emotions and thoughts that followed: *“The debriefing reassured me that what I was thinking and feeling was entirely normal in the circumstances. The realness and humanity shown by the group was very reassuring for me as a new grad.”*

A critical incident can be defined as an event that threatens to overwhelm a person’s ability to cope, or that produces unusually strong emotions, thoughts or behaviours in the person experiencing it.¹ It is often a powerful event that lies outside the range of usual human experience, which the person has little or no control over. Events classed as critical incidents in nursing can vary, depending on the specialty involved. Paediatric nurses rank sudden infant death syndrome as an event sufficient to warrant debriefing,² whereas emergency department nurses rate workplace violence and multi trauma as significant work stressors.³

According to Gabrielle Nolan, a duty nurse manager in specialist mental health services at Christchurch’s Hillmorton Hospital, attempted or completed suicides, serious deliberate self-harm and violence against staff make up the majority of critical incidents in mental health.

“The very nature of the work we do, can expose us to incidents that may be threatening, overwhelming, or potentially traumatising,” Nolan says. Coping responses are highly individualised – some “manage by shutting it

out, others by becoming clearly emotional”. Some bounce back quickly, while others become overwhelmed and struggle. What’s happening in a nurse’s personal life can also dovetail with the incident and influence coping responses, she says.

Mental health nurses have always had to cope with critical incidents. In the past, this coping often involved the use of spontaneous, informal debriefing sessions to support colleagues. A former American firefighter and paramedic, Jeffrey Mitchell, formalised debriefing when he developed a seven-step process, known as the Mitchell model (see diagram, below).⁴ Although originally designed for frontline emergency workers – such as police and firefighters – it is now used around the world, in a variety of health-care set-

tings.⁵ It is the model used by the 15 facilitators of the CISD team – 14 of whom are nurses – at Hillmorton Hospital.

CISD is an information-sharing and event-processing session, conducted as a conversation between people who have experienced the same incident.⁶ It is a structured intervention conducted by two trained facilitators who were not party to the critical incident. CISD is designed to relieve stress at an early stage, help people process their shared experiences and to form healthy attitudes about stress reactions.

In the Mitchell debriefing model, within one week of a critical incident, a group is led through seven straightforward, structured stages in a single session, lasting between one and three hours. It enables them to review facts, thoughts, impressions and reactions in a safe, confidential setting.⁷

In her 10 years as a facilitator on the Hillmorton CISD team, Nolan has learnt that no two debriefings are the same. As few as two people, or up to 25, can show up on the day. Some debriefings will stay on course and require minimum guidance, while others quickly de-rail and need concerted input to stay on track. Some participants “will dominate, while others will remain mute”, she says. Some will appear clearly emotionally affected, others not so. Some will come with impossible expectations, others with more realistic outlooks.

Some groups will relate easily to each other, while in others, the unwanted presence of one particular person “can powerfully silence others”. The two facilitators who jointly run each debriefing may work seamlessly together to achieve the necessary “tag-team” rhythm, or remain out of step with each other for the entire session.

Debriefing is not therapy, professional counselling or psychotherapy. Nor is it designed to resolve cumulative stress or to manage personal problems that existed before the incident. Researchers hold differing views on its value – some question its effectiveness,^{8,9,10,11,12} while other studies find many positive benefits.^{13,14,15,16,17,18}

Nolan’s advice to nurses interested in the facilitator role is to develop their people skills, and check their motivation for taking on the role. This

The seven phases of the Mitchell model⁴

1) Introduction

Introduce debriefing facilitators, explain process and set expectations.

2) Fact phase

Getting the picture. Describe the event from each person’s perspective on a cognitive level.

3) Thoughts phase

Allow participants to describe cognitive reactions and to transition to emotional reactions.

4) Reaction phase

Identify the most difficult aspect of the event for the participants and their emotional reactions to it.

5) Symptoms phase

Identify personal symptoms (physical, cognitive, emotional) of distress.

6) Teaching phase

Educate about normal reactions and adaptive coping mechanisms (ie stress management).

7) Re-entry phase

Clarify ambiguities and prepare for termination.

will help flush out any hidden or conflicting agendas they may have. Her colleague, staff nurse and veteran debriefer Graham Kerstens, says facilitators must be “comfortable responding to people in heightened emotional states”. These emotions can range through frustration, anger, grief, despair, hopelessness and distancing.

Kerstens knows coping with a completed suicide may be the most difficult task a mental health nurse will face in their career. He also knows from experience that critical incidents involving serious assault on a staff member can have a ripple effect on the entire nursing team. A long lead-in period to an assault is not uncommon, which intensifies the emotions expressed at the debriefing. “This is because of the prolonged cumulative stress involved. The actual pathway to the assault may have involved nurses being on high alert for many days.”

Hopelessness and resignation are common when nurses are repetitively exposed to abuse and threats. “They can’t see things ever getting better because of the ongoing nature of the abuse . . . One-off incidents are easier to cope with than ongoing/repetitive exposure,” he says.

Facilitators must be watchful for participants who are withdrawn and uncommunicative, he says. They must also be attentive listeners and have a tactful and respectful manner. “You need to strike a balance between being empathic and avoiding enmeshment.” An understanding of the work environment where the incident occurred is also helpful.

Kerstens says it is also important to be self-aware and able to make personal adjustments. “For example, I have a loud voice so have to make a conscious effort to speak quietly.” A skilled facilitator guides the session rather than lectures, and allows flexibility within the intervention model.

Debriefings go well, he says, when participants feel comfortable with others in the group, show support and feel safe to contribute honestly. “They are often reassured to see others having similar reactions to themselves.”

Less positive behaviour that can arise in a session includes defensiveness, blaming, domineering behaviour by one person and preoccupation with the clinical aspects of the incident. If those closest to the incident are not present, this can have an effect on the debriefing – “it leaves major gaps in informa-

tion-sharing”.

In Kerstens’ view, attendance at sessions should always be voluntary. “Mandatory participation would increase the reactions already felt and negative attitudes can undermine the process for others.”

Having two facilitators is a big advantage. “We sit at right angles to each other so as not to miss anything. Having different styles of communication is helpful – the group may respond better to one style over the other. It

only making eye contact and saying a few words.” She says shock can cause people to retreat, reactions may not be picked up, and it is easy for an individual to get overlooked later. “It’s common for people to say directly after a major event that they’re fine – adrenaline plays a role in this.”

A common theme in the feedback she receives about debriefing – either through anonymous evaluation forms or informally – is how it provides a complete picture of the inci-



Hillmorton staff at a debriefing – sessions go well when participants feel comfortable with others in the group.

also enables us to reflect back on the session and share our different perspectives on what went well, what didn’t, and who may need further follow-up,” he says.

EAP and ‘defusing’

Nolan says debriefing is not the only intervention available after a critical incident. One-to-one counselling is easily accessed through the employee assistance programme (EAP). “This is a big step for some nurses, as many view it as them not coping.”

Also, as a duty nurse manager, she has learnt the value of “defusing” – a short, informal team discussion, immediately after the incident, before people go back to their duties or go home. It helps those involved stabilise their immediate emotions, mobilise coping resources and identify immediate needs. “It can be as brief as two minutes or up to 30, if time allows.”

While group participation is best for defusing, because of the context it affords, this may not always be practical. In those instances, experience has taught Nolan the benefits of “individually approaching those directly or peripherally involved. Even if it’s

dent. “It helps fit the missing parts of the jigsaw together – what led up to the event and what actually happened during it. Everybody has a small piece of information that, when shared, will provide the big picture. Those who have doubted themselves – whether they had done the right thing – find this particularly helpful.”

She knows debriefing is not for everyone: “Some nurses never get value out of it. Some attend under pressure – either from themselves or from colleagues. A sense of duty motivates others because they don’t want to minimise the event in the eyes of their colleagues.” Nolan says some attend out of a misguided idea of what debriefing can do, eg that it can change managerial responses or influence future clinical decisions – debriefing is the wrong forum for these issues, which would be better taken to a meeting with managers or a union.

Diverse views

Nurses, who wished to be anonymous, shared their views and experiences of debriefing for this article. Some described what informal debriefing looked like in an earlier era, before the introduction of the Mitchell model: “Hav-

ing a school of nursing on site was fantastic. Classmates were of outstanding support as we all went through different experiences together, we learned how to cope from each other. Sporting teams and social events were encouraged, hospital social clubs provided a regular venue for informally discussing important issues and making valuable friendships. Support after a big incident was automatic. Charge nurses were ward-based, and instrumental in quickly addressing issues before they became problematic. Leadership was visible and directly accessible.”

This collegial support has, in other nurses’ opinions, been seriously diluted over time: “Nursing was a community, but these days we barely know each other. Student nurses are often scattered, having to find placements in different parts of the country. The introduction of casual, pool and bureau nurses has resulted in the fragmentation of teams. Often, unfamiliar nurses are left to flounder, as regular nurses are in survival mode themselves. Charge nurses are often located in offices removed from day-to-day management of the ward, so critical leadership is absent. The shift from a collective nursing focus to an individual one has resulted in a sense of powerlessness and isolation, automatic and immediate support is no longer engrained into the infrastructure of nursing.”

Many described how formal, structured debriefing helped them cope after major incidents. One said: “Over 40 years of nursing has seen me involved in many major incidents. I find debriefings useful and always attend. Reflecting back on the incident puts the bigger picture of the event together and clarifies things for me. That helps with the self-doubt and gives a sense of closure I guess. Being a pool nurse means I am not part of a permanent team, so debriefings are particularly beneficial in that regard.”

Another nurse said: “The incident involved somebody in the throes of a psychotic fuelled rage, going on a violent rampage on the ward. It was horrendous, TVs were ripped from walls, furniture was smashed and doors kicked in. It was an afternoon shift, so we only had minimum staffing numbers. We barricaded ourselves in the office and called the police, who took up to 45 minutes to arrive. In the meantime, the destruction continued – we fully expected the office walls to cave in with all the bombarding they were getting. The confidential aspect of the debriefing was helpful, I was able to talk freely about the incident. For me, it was a forum to be heard. The input from the facilitators was highly supportive. Unfortunately, it didn’t happen until about six weeks after the incident – now that was way too late.”

Another commented: “Debriefings have kept



Veteran debriefing facilitators Graham Kerstens and Gabrielle Nolan – facilitators run debriefing sessions in pairs, and afterwards can discuss what went right and wrong and who might need follow-up.

me emotionally healthy during my 40 years of nursing. When the actual major incident is happening, you have to repress a lot and remain professional. You are not able to say how terrified you actually are. Being able to talk later to those who’ve been through the same experience, and hearing their different slants, is really helpful for me. It’s a safe, confidential and supportive place.”

Some nurses, however, don’t find debriefing helpful, for a variety of reasons: “I got put

be open and vulnerable at a debriefing when I don’t trust the others present?”

How does a facilitator cope with the stress associated with the role over the long term? Kerstens says easy access to other members of the debriefing team and taking regular supervision helps. Also, having the workload spread across the entire team “means everyone gets a turn”. He never debriefs his own immediate work colleagues or accepts a debriefing if he has a prior connection to a patient involved.

His solid belief in the merits of debriefing also helps, while the specialist education provided – an intensive introductory week, subsequent modules and yearly group reflections, reviews and updates – equip him well for the role.

The Mitchell model of CISD has been used at Hillmorton Hospital for nearly 20 years now, and many nurses have found the structured debriefing sessions both constructive and supportive. Not all nurses process stress and trauma the same way, however, and not all find debriefing helpful – the facilitators themselves insist that attendance should never be mandatory. For the new graduate at the start of this article, debriefing was a choice offered to her, which helped her come to terms with a shocking event: “We all shared similar emotions. The follow-up calls I got after the debriefing were so helpful. I felt supported, more at peace. I worried less.” •

* This article was reviewed by Auckland University senior nursing lecturer Anthony O’Brien and by the co-editors.

References for this article are on p42.

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off with the amount of people present who had very little to do with the incident itself. The staff closely involved were well outnumbered by those not. I thought there was an unhealthy voyeuristic aspect to it.” Others found it difficult to attend because of work commitments: “I was on edge, stressed, unable to concentrate, knowing I was [going] back to an intense work-load.”

Sometimes debriefing can work against a nurse’s natural way of coping: “I’ve been involved in multiple critical incidents over the years: suicides, a hostage-taking scenario, severe deliberate self-harm by slashing/burning/cutting, and violence where people’s lives were at risk. The hyper-vigilance that comes with near-misses can be equally stressful. I’ve developed my own way of compartmentalising things as they happen – suppression and repression works well for me. I don’t find it helpful reliving the incident again at a debriefing.”

Attendance, for some, is influenced by how much they trust their colleagues: “How can I

Accessing electronic records leads to practice suspension

Balvinder Toor, RN

A REGISTERED nurse who inappropriately accessed the electronic records of 34 individual patients on 173 occasions during October 2012 has been found guilty of professional misconduct, censured and suspended from practice for four months.

Balvinder Toor, who worked for the MidCentral District Health Board from October 2007 to her dismissal in March 2013, has since returned to her home country, India.

A Health Practitioners Disciplinary Tribunal hearing in Wellington in May this year heard that an audit in November 2012, by the nurse director of emergency services at Palmerston North Hospital, established that from October 1-30, 2012, Toor had accessed electronic records of patients she was not providing care for. She was dismissed in March 2013.

Toor admitted the charge brought by a Professional Conduct Committee (PCC), that she had accessed and/

or viewed the electronic record of patients and colleagues in an electronic reporting system, when she knew she had no authority to do so. The tribunal found Toor guilty of professional misconduct likely to bring discredit on the

The Health Practitioners Disciplinary Tribunal has the power to discipline all nurses and to request that all its decisions be published in *Kai Tiaki Nursing New Zealand* and other relevant publications. The full decisions are on the tribunal's website.

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nursing profession.

In considering the penalty, the tribunal said the mitigating factors in the case included there was no suggestion of poor clinical judgement or lack of professional standards by Toor; no harm had been done to any patients whose records had been accessed; Toor had not passed on any information she had received; and she had cooperated with the PCC and the tribunal. As a result of the misconduct, she had lost her job and was said to have had no personal income and very little financial support since then. The consequences of her misconduct were such, according to submissions, that Toor "is reminded daily of the shame she

'As a result of the misconduct, she had lost her job and was said to have had no personal income and very little financial support since then.'

has brought on her family and of the ruined chance of a better life [in New Zealand]".

There ap-

peared to be little risk of re-offending.

Toor had no explanation for her actions, nor any specific reason to access the records. Her counsel described this as "naïve and mindless curiosity". The tribunal stated this was both a

mitigating and aggravating factor.

Other aggravating factors were the time over which the offending occurred and the number of patients and times of access to the records.

The tribunal, in its decision in June, rejected non-publication of Toor's name. In her affidavit, Toor expressed concerns about the impact of the publication of her name on her father, husband and two daughters. The tribunal noted the concerns but said there was nothing in the information provided "sufficient to persuade it that there are significant interests for Toor or her family members which outweigh the public interest in identifying the practitioner in the context of the charges that have been found". There were also questions of impugning other practitioners if she was not named, and all the family members Toor mentioned were not resident in New Zealand.

Education on privacy

As well as the censure and four-month suspension from practice (effective from one month after the tribunal's decision of June 2, 2016), the tribunal ordered Toor to pay \$3400 in costs. Should she recommence practice in New Zealand, she must have undertaken or be willing to undertake education, fixed by the Nursing Council, on patient privacy and confidentiality and on the appropriate statutory, regulatory and ethics provisions of the Privacy Act 1993 and the Health Information Privacy Code 1994.

The tribunal directed that a copy and summary of its decision be published on its website (www.hpdt.org.nz) and a notice stating the effect of the decision be published in *Kai Tiaki Nursing New Zealand* and the Nursing Council's newsletter *News Update*. The decision number is 818Nur16/339P. •

Caring for colleagues through debriefing (pp12-14) – references

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