

Chapter 8

Critical Incident Interventions: Crisis Response and Debriefing

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ABSTRACT

Police officers are exposed to many critical incidents throughout their careers. This chapter discusses critical incident exposure and psychological sequelae in police officers, police culture, obstacles to mental health care, currently utilized early interventions, existing research for these approaches, alternative evidence-based early interventions, emerging models, and directions for future research. Given the frequency and potential impact of critical incidents, early intervention for exposed police officers is of central importance. One of the most commonly utilized group early interventions, Critical Incident Stress Debriefing (CISD), has limited empirical support, such that some departments are being advised against its use. That said, there are important challenges in identifying better, evidence-based alternatives.

INTRODUCTION

Police officers are exposed to many critical incidents throughout their careers (Carlier et al., 2000; Malcolm et al., 2005). A critical incident may be defined as, “A potentially traumatic event which may cause a given individual’s emotional resources to become over-taxed, resulting in a spectrum of reactions from exhaustion to increased and unrelenting mental health symptomology” (Maguen et al., 2009, p. 754). Critical incident exposure is one of the reasons some have considered policing to be the world’s most psychologically dangerous job (Marin, 2012).

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Given the frequency and potential impact of critical incidents, early intervention for exposed officers is of central importance. In practice, one of the most common formal interventions following a critical incident is an individual meeting with a mental health professional that has an in-depth understanding of the law enforcement culture (typically an in-house or contracted police psychologist). The goal of such meetings is to provide support and education, rather than to treat or prevent traumatic stress reactions (E. Dorian, personal communication, March 16, 2016). However, there is not yet a universally adopted approach or methodology for such contacts and there is no research evidence regarding their effects.

One of the most commonly utilized group early interventions, Critical Incident Stress Debriefing (CISD), has limited empirical support; evidence suggests it may not be helpful and may even be harmful to participants (Mitchell, 1983; Tuckey, 2007). Some organizations are being advised against its general use (Tuckey, 2007) and researchers have recommended that mandated group psychological debriefings should cease (Bisson, McFarlane, Rose, Ruzek, & Watson, 2009). However, there are important challenges to identifying a better, evidence-based alternative.

This chapter will discuss critical incident exposure and psychological sequelae in police officers, police culture and obstacles to mental health care, early interventions in current use, existing research on these approaches, alternative evidence-based early interventions, emerging models, and directions for future research.

Critical Incident Exposure / Sequelae

Police officers are faced with an array of critical incidents during their careers. These may include officer involved shootings, deaths involving children or gruesome scenes, traffic collisions, and line of duty deaths or injuries (Marin, 2012). Although the way critical incidents are defined and documented is not always clear, it has been estimated that a first-year police officer is exposed to an average of 12 critical incidents, and that the average 30-year police officer at the time of retirement has been exposed to an average of 250 critical incidents (Marin, 2012).

Psychological distress in police officers is common in the early weeks following a critical incident; risk factors and vulnerabilities, discussed below, appear to make chronic adjustment problems more likely. In a sample of 89 police officers recently exposed to a potentially traumatic stressor, the most commonly reported emotional reactions at the time of the incident, regardless of whether or not the officer went on to develop posttraumatic stress disorder (PTSD), included helplessness (80%), intense fear (59%), and horror (21%) (Marchand, Boyer, Nadeau, Beaulieu-Prevost, & Martin, 2015). In most cases, these emotions are transient and naturally resolve (Litz et al., 2002). Those whose reactions do not subside within approximately 3 months after an incident are more likely to experience chronic distress (Kessler et al., 1995). Approximately 6.8% of the general American population meets criteria for PTSD (Kearns et al., 2012). Prevalence rates of PTSD in police officers range from 7-19%, suggesting that approximately 135,000 police officers in the United States experience symptoms of PTSD (Komarovskaya et al., 2011; Marin, 2012; O'Hara, 2012).

Risk factors for the development of PTSD have been identified. In the general population, risk factors include prior trauma exposure, psychiatric history, poor social support, perceived life threat during the trauma, and distress during and immediately after the trauma (Kearns et al., 2012). Additionally, younger age and female gender are associated with greater likelihood of developing PTSD following a trauma (Litz et al., 2002).

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