CHSAlliance
QUALITY. ACCOUNTABILITY. PEOPLE MANAGEMENT

The Debriefing Toolkit for Humanitarian Workers

Thirteenth Edition

Dr Debbie Hawker

Clinical Psychologist

www.resilientexpat.co.uk

Feedback received on the first edition of this manual

"I have carefully reviewed your publication. It is splendid! You write with unusual clarity. The coverage is thorough – just enough, not too much. The inserts highlight valuable pointers. It is the most practical manual I have seen in this area. The reference and resource list is up to date. Thank you for the list of websites! I also appreciated the handouts in the appendix … your ideas will be immensely useful."

(Prof. Clyde Austin, Professor of Psychology, Abilene Christian University, USA)

Author

Dr Debbie Hawker is a consultant clinical psychologist who worked for Oxford University Psychiatry Department for nine years, before working full-time with humanitarian organisations. She and her husband David have served short-term in many different parts of Africa, Asia, Latin America and Eastern Europe. They offer assessments, training, debriefing, consultations, supervision, mentoring and retreats, as well as conducting research and writing books and journal articles. Debbie chaired the working group which produced guidelines for good practice in member care (UK). Debbie is on the Executive Committee of the Global Member Care Network.

About this manual

The manual has been produced by the CHS Alliance and Dr Debbie Hawker. The handouts in the appendices may be photocopied for non-commercial use, citing this manual as the source. If further information is required, Debbie can be contacted through www.resilientexpat.co.uk. Considerable care has been taken to ensure this document is both accurate and relevant. However, the CHS Alliance is unable to provide any warranty concerning the accuracy, completeness or relevance to your organisation relating to any information contained herein.

This publication may be quoted by not-for-profit organisations, in any form (written, visual, electronic, or audio) without the express permission of the CHS Alliance, provided any and all references are fully attributed to the CHS Alliance and this publication.

All other requests for permission must be directed to and approved in writing by the CHS Alliance. You can contact the CHS Alliance by email on info@chsalliance.org.

All rights reserved.

CHSAlliance
QUALITY. ACCOUNTABILITY. PEOPLE MANAGEMENT

Table of Contents

1. Introduction **1**
2. Definitions **2**
3. Operational debriefing **3**
4. Exit interview **4**
5. Personal debriefing **6**
6. Does personal debriefing help? **8**
7. Structured vs. unstructured debriefing **17**
8. Who should be offered personal debriefing? **17**
9. Should debriefing be mandatory? **19**
10. Characteristics of the debriefer **20**
11. Recommended steps for becoming a debriefer **22**
12. The Critical Incident Debriefing (CID) procedure **23**
13. Theoretical framework for Critical Incident Debriefing **24**
14. Issues to consider **27**
15. What to avoid in the debriefing process **30**
16. The seven steps of Critical Incident Debriefing **31**
Step 1: Introductions 32
Step 2: The facts about the experience 32
Step 3: The thoughts during and after the experience 32
Step 4: The sensory impressions and emotions 32
Step 5: Information about normal signs of stress 33
Step 6: Discussing coping strategies, and future planning 35
Step 7: Ending the session 36
After everyone has left 36
Follow-up 37
17. Individual vs. group debriefing **38**
18. Routine personal debriefing (not CID) after returning 'home' **41**
(a) Routine end-of-assignment debriefing for individuals 42
(b) Routine end-of-assignment debriefing for groups 52
(c) Routine end-of-assignment debriefing for short-term teams 53
19. Cross-cultural issues and national staff **56**
(a) General issues 56
(b) Advice for working with interpreters 63
(c) Useful resources in languages other than English 64
20. Children **64**
(a) After a traumatic experience 64
(b) Routine debriefing for children on return 'home' 69
21. Debriefing media personnel **73**
22. Debriefing at a distance (e.g. by phone or internet) **74**
23. Care for the debriefer **77**
24. Conclusion **78**
References and resources **80**
(a) References 80
(b) Useful websites 90
(c) Training courses 91
Appendices **92**
Appendix 1: Coming Home (for humanitarian workers) – Handout 1 93
Appendix 2: Symptoms of stress or trauma – Handout 2 98
Appendix 3: Stress management strategies – Handout 3 106
Appendix 4: Symptoms of post-traumatic stress disorder (PTSD) – Handout 4 110
Appendix 5: When and where to obtain professional psychological or psychiatric help – Handout 5 112

©CHS Alliance 2018

CHSAlliance
QUALITY. ACCOUNTABILITY. PEOPLE MANAGEMENT

Appendix 6: Recommended self-help books – Handout 6 114
Appendix 7: Summary for Critical Incident Debriefing (for debriefers) – Handout 7 116
Appendix 8: Summary for Debriefing on Return Home (for debriefers) – Handout 8 117
Appendix 9: Helpful websites for media personnel (for debriefers & workers) – Handout 9 119
Evaluation Form 120

©CHS Alliance 2018

1. Introduction

This manual gives guidelines for those who offer debriefing to people who work as humanitarian workers, including staff working in a relief or development context, volunteers, missionaries, peacekeepers, consultants and trustees. The term 'humanitarian worker' is used here to refer to all such people, including both national and international staff. We recognize that humanitarian workers are a diverse group, and each person should be treated appropriately according to their individual characteristics. This includes respecting their gender, age, ethnicity, religion and sexuality.

Although the whole toolbox should be useful for both national and international staff, section 19 concentrates particularly on national staff and cross-cultural issues.

Most humanitarian workers report that, on the whole, their humanitarian work was a good experience, and they are glad they did it. Despite this, most humanitarian workers whose assignments last for at least six months (as well as many of those on shorter assignments) report that they find it helpful to receive a personal debriefing session afterwards. This is especially true of those who have had stressful experiences, and those who find it difficult to readjust to their home life afterwards. Personal debriefing sessions generally last two to three hours, and can have an extremely beneficial effect.

Anonymous feedback from a humanitarian worker about personal debriefing:
"I thought beforehand that it was going to be a waste of time, but I found that actually it was very helpful to be able to talk about everything, however small, that had happened."

Aid work can be extremely stressful. About 50% of humanitarian workers develop depression or another psychological difficulty during or shortly after their humanitarian work (Lovell, 1997; Paton & Purvis, 1995; Paton, 1992). Around 30% may develop significant symptoms of post-traumatic stress (Eriksson et al., 2001). Without debriefing, 18 months after returning home 25% still show significant symptoms of post-traumatic stress. With good debriefing, this can be reduced to 7% (Lovell, 1999b). Thus, it is extremely important that high-quality debriefing is offered to humanitarian workers.

"Organisations such as voluntary disaster charities typically involved in Third World disaster settings have not recognised that their personnel inevitably suffer from catastrophic stress syndromes as a direct result of their work and no measures have been taken by the majority of these organisations to ensure the psychological health of their workers." (Busuttil. 1995)

©CHS Alliance 2018

2. Definitions

'Debriefing' means different things to different people. We offer the following definitions of different types of debriefing:

Operational debriefing: Asking for information about the work performed and what was achieved. The aim is to learn what was done well, what could have been done better, and what changes should be made.

Personal debriefing: Asking how the experience was for the individual (What was best/worst? How is the readjustment process going?). Aims to help them integrate their experience into their life as a whole, perceive the experience more meaningfully, and bring a sense of closure.

Critical incident debriefing (CID), also known as critical incident stress debriefing (CISD): A highly structured form of personal debriefing, which can take place after a traumatic experience (such as a natural disaster, a violent incident, or a traffic accident). Goals are to educate about normal stress reactions and ways to cope with them, to promote the expression of thoughts and feelings about the incident, to bring a sense of closure, and to provide information about how to access further support or help if required.

©CHS Alliance 2018

3. Operational debriefing

Operational debriefing is a routine review of an assignment from a factual perspective. It is usually held shortly after a humanitarian worker has finished their assignment (although it may take place just before the end of assignment). People can be debriefed on their own or as a team.

Operational debriefing provides an opportunity to learn what happened (for the record and for future planning). In particular, there is an opportunity to learn from any mistakes, critical incidents or near misses. Whistle-blowing can be encouraged so that any concerns about colleagues or practices can be reported in a safe place.

Operational debriefing enables the debriefee to make suggestions, raise concerns and ask questions, as well as identify what remains to be done. The debriefee can be thanked for their work. Expectations can also be clarified (e.g. reports to be written, financial matters and future employment opportunities).

It is good practice to conduct operational debriefing before personal debriefing, and usually these should be conducted by different people. This helps the debriefee to understand that these two debriefings have different purposes. First, they discuss the work (operational debriefing). Then they are free to talk about how they felt personally, having already got work issues 'off their chest'. If strong emotions emerge during the operational debriefing, the debriefer should show empathy and sensitivity but promise that these issues can be dealt with during the personal debriefing which will follow. (If the personal debriefing comes first, the operational debriefer may feel unsure of how they should deal with any strong emotions).

The operational debrief is generally conducted by someone who has been involved in managing the project, such as a line manager or a member of the Human Resources team.

The issues discussed in operational debriefing will vary depending on what the organisation wants to learn from the assignment, but the following are typical areas to discuss:

- How did the work go? What did you achieve? How do you think you did?
- What did you do well?
- Any things that were done less well/any mistakes made?
- To what extent have the objectives been met?
- At what stage is the work now? What remains to be done? (If applicable: How did the handover go?)
- If more people are needed to continue the work, what skills do they need and what should they know?
- Any comments about colleagues, leaders or team dynamics which we should be aware of?
- Any concerns about particular people or practices, breaches of the code of conduct, or possible safeguarding issues? Point out that whistle-blowing is encouraged, and provide written information about how concerns can be raised at a later stage, or reported anonymously.
- How well did the actual job fit with the job description?
- What were the best/worst parts of the work?
- How would you rate the preparation/training you received? How could this have been improved?
- Any other suggestions for improvement (e.g. support, communication, work conditions)
- Any other suggestions you would like to make
- Is there anything else we should do? Anything you are concerned about?
- Lessons learned
- Any needs you have
- Would you like to stay involved with the organisation/project? How? (E.g. receiving updates; helping select or prepare new staff)

©CHS Alliance 2018

- Clarification about anything still to be done (e.g. written report – length and deadline).

It is normal practice for a written report to be required. This is useful for the organisation (as a record of the work and suggestions), and may be essential for funding. Workers are often keen to provide this written feedback, but it is important that they are given sufficient time to produce it, as they may feel exhausted after returning home and need a few weeks' break before writing it. A rushed report is of less use than a more thoughtful one. Moreover, a report is useless if nothing is acted upon. The organization has a duty to take feedback seriously, reflect on it, and take action or implement change if needed.

4. Exit interview

An **'exit interview'** usually refers to a combination of operational and personal debriefing, occurring at the end of a humanitarian assignment. It often occurs 1–2 weeks before the end of assignment – when the work is nearly complete, but allowing sufficient time in case the interview reveals anything that should be done before the worker leaves. Sometimes the exit interview takes place just after the assignment ends, and sometimes it takes place at a distance (e.g. over the internet). The debriefer is usually a team leader or manager.

The issues to be discussed may include those listed above under operational debriefing. In addition, the following issues may be included:

- How is the transition going (e.g. handing over to a colleague, or closing a project down)?
- What is needed to help the transition go well, and help end your time here well? (As well as work issues, this may include social matters e.g. arrangements for saying goodbye, parties, etc.)
- How do you evaluate your work here and your time here overall?
- Your views on the project, and any recommendations for change.
- How are you feeling about leaving?
- What arrangements have been made (e.g. help with removals or transport)? Anything we can do to help?
- Provide education about transition (see Handout 1).
- Reminder to make enough time to say goodbyes and take photos if appropriate etc. (as this can help readjustment).
- Recommend enough time off/ time to rest before resuming work.
- Discuss any ways to keep in touch with the project. (E.g. will updates be sent by email/ social media?)
- Future plans (for the individual and the project).
- Reminder of what the organisation expects when you return home (e.g. written report; attending operational and personal debriefing).
- Reminder of practical details (e.g. returning keys/equipment etc).
- Confirm when the final salary will be paid and whether untaken annual leave will be paid, and other financial matters.
- Confirm any matters related to medical checks or ongoing medical care, debriefing or counselling which might be offered.
- Ask whether there are any concerns about particular people or practices, breaches of the code of conduct, or possible safeguarding issues? Provide written information about the whistle-blowing and complaints mechanisms and about how concerns can be raised at a later stage, or reported anonymously. A postal /email address and phone number for concerns should be provided, as well as information about any independent agency where complaints or concerns can be directed (e.g. the Charity Commission in the UK, or Safe Call (https://www.safecall.co.uk).

©CHS Alliance 2018

- Make clear the organisation's policy on providing references e.g. who can provide references on behalf of the organisation?

The remainder of this manual will focus on personal debriefing and critical incident debriefing, as these require more training and skill than operational debriefing and exit interviews. Although most expatriate humanitarian workers experience an adequate *operational* debriefing at the end of their assignment, 48–78% report receiving no or inadequate *personal* debriefing (McConnon, 1992; Lopes Cardozo & Salama, 2002; Foyle, 2003). The situation is even worse among locally employed (national) staff, with less than 3% receiving personal debriefing after an assignment (Lopes Cardozo & Salama, 2002).

The CHS Alliance considers the needs of national staff to be as great, or perhaps even greater, than those of expatriates when considering debriefing. National staff often need to relocate within their country, and are not necessarily 'local'. Therefore the term 'local staff' can be misleading. National staff should be offered culturally appropriate debriefing procedures or other forms of support, adapted for their culture and situation (see section 19).

©CHS Alliance 2018

5. Personal debriefing

While *operational* debriefing is often conducted by the line manager, it is preferable if the person who conducts the *personal* debriefing is not involved in line management for the individual concerned. This is because it can be difficult to express emotions honestly to a line manager, especially if it is feared that this will have a negative impact on future employment prospects. See section 10 for a discussion of the characteristics of the person who conducts the personal debriefing.

It is recommended that personal debriefing is offered to **all** humanitarian workers at the end of their assignment (and preferably on an annual basis, or when requested) because:

1. They generally appreciate such debriefing.
2. Those who are not offered a personal debriefing may feel that their efforts were not valued, and may feel unsupported as they transition after completing the assignment. Debriefing can help show that you and your organisation value them and care about their welfare.
3. It is common for humanitarian workers to feel isolated, especially after they have finished their assignment. Personal debriefing can help to reduce such isolation.
4. Debriefing can help reassure the individual that it is normal to experience minor difficulties while readjusting – so they do not worry about what they are going through.
5. Stress-related or trauma-related symptoms or adjustment difficulties can be picked up, and further help offered.
6. Practical information (e.g. about accommodation or financial matters) can be offered, and questions answered.
7. Debriefing may help to prevent depression or anxiety disorders from developing, and may prevent feelings of failure.
8. Debriefing can help to resolve issues, bring closure, provide a sense of meaning, and help people to move on.
9. People who receive debriefing may continue to support the organization (and might choose to work for them again).
10. Organisations can learn and make changes on the basis of what they hear during debriefing (although the primary goal of personal debriefing should always be to help the individual rather than to benefit the organisation).
11. The Core Humanitarian Standard on Quality and Accountability (CHS) includes a commitment that "policies are in place for the security and the well-being of staff" (Commitment 8.9). Organisations that offer debriefing are giving a clear and positive message to staff, volunteers and donors alike, and are likely to be viewed much more favourably than those who do not.

CHS Guidance Notes and Indicators (2015):
"Staff often work long hours in risky and stressful conditions. An agency's duty of care to its workers includes actions to promote well-being and avoid long-term exhaustion, burnout, injury or illness" (p.31).

Quotations from two returned humanitarian workers:
"My organisation offered no help when I returned. I felt I really needed help from people who really understand the pressures of 're-entry' and the symptoms of burn-out. How vital is support and debriefing in the period following return."
"Would like to see more counselling and debriefing services offered as a *normal* part of the returning home process."

©CHS Alliance 2018

Duty of Care International write:

"Employers' policies and procedures must reflect a Duty of Care relevant to the type of work and environment their employees work in and these will be used in a court or tribunal when assessing whether an employer has fulfilled its obligations towards its employees.

Responsibility to take care of your employees applies whether people work in high or low risk environments. It is likely a court will expect employers to take even further responsibility with those working in higher risk situations.

http://dutyofcareinternational.co.uk/about/#legal

6. Does personal debriefing help?

Many papers have been published showing that participants report finding personal debriefing very helpful (Mitchell & Everly, 1997). It is more difficult to assess whether people who receive debriefing are less likely to have symptoms of trauma afterwards. It is difficult to conduct research which involves randomly assigning people to either be debriefed or not, and following them up (such studies are known as 'randomised controlled trials'). Two influential reviews have been published of research on debriefing. These are known as the Cochrane review and the NICE guidelines. These reviews have influenced policies and practice around the world, so they will be discussed here in detail.

Rose, Bisson & Wessely (2003) published a Cochrane review of debriefing (a systematic review of the effectiveness of interventions). In this, they identified 11 randomised controlled trials, each of which involved a single session of critical incident debriefing for an individual adult. Three studies indicated that debriefing was associated with a positive outcome (in terms of reduced psychological distress when compared with the non-debriefed group). Six studies found no effect of debriefing, and two studies associated debriefing with a negative outcome. This Cochrane review concluded that, overall, debriefing has no effect on outcome.

The National Institute for Clinical Excellence (NICE) produced guidelines which recommend that single-session critical incident debriefing 'should *not* be routine practice' (NICE, 2005). NICE identified seven randomised controlled trials of debriefing, two of which report the same study. Of the six different studies, four found debriefing to have no effect on the measures used, and two suggested it might have a negative effect.

However, the Department of Health (2001) evidence-based practice guidelines have acknowledged concerns over the quality of the studies in the Cochrane and NICE reviews. They state that "many of the published studies showing negative results for critical incident debriefing do not assure the quality of the intervention" (p.24). Even Rose et al. (2003) acknowledge that the quality of the studies "was generally poor".

The recommendations of the Cochrane review and the NICE guidelines are essentially based on the same studies. We can learn important lessons from the studies which suggest that debriefing had no effect or a negative effect, as these teach us how *not* to do debriefing. The two studies which indicate that debriefing might be harmful involved people admitted to hospital after road traffic accidents (Mayou, Ehlers & Hobbs, 2000), and burns victims (Bisson, Jenkins, Alexander & Bannister, 1997). These studies are discussed below.

Debriefing may fail to help if the session is too short

One problem with these studies was that the debriefing was very short, lasting only 20–60 minutes. Many debriefing experts have found that adequate debriefing usually takes at least two hours, and can take much longer (Turnbull et al., 1997; Parkinson, 2001; Rick & Briner, 2000). Because of the lack of time, the full package of critical incident debriefing was generally not offered. For example, in the traffic accident study, debriefing "was relatively short and had limited internal structure. It contrasted in significant ways with the models of psychological debriefing described by Mitchell … and Dyregrov" (Mayou et al., 2000, p.592). Such rapid debriefing may be too rushed to be of benefit, and may in fact make matters worse.

In another review of studies of psychological debriefing, Arendt & Elklit (2001) considered the effect that the duration of a debriefing session may have on its effectiveness. They identified six studies in which debriefing had lasted one hour or less. In each case, debriefing was found to have either no effect or a negative effect. In contrast, five studies involved debriefing lasting more than one hour, and in each of these cases debriefing had a positive effect.

©CHS Alliance 2018

This is not indisputable proof that debriefings of longer than one hour are beneficial while shorter debriefings are not. The studies also differed in other respects – in particular, the longer debriefings tended to be with groups while the shorter ones were with individuals. However, taking the evidence as a whole, it appears that debriefings lasting at least an hour are more beneficial than shorter debriefings, and the shorter ones may be worse than nothing at all.

If spending at least an hour on each debriefing appears impossible due to limited staff capacity, possibilities include debriefing groups together or using an external debriefer. For more ideas, see: www.chsalliance.org/files/files/Resources/Case-Studies/Debriefing-building-staff-capacity.pdf.

Quotation from a returned humanitarian worker:
"My organisation offered a 45-minute debriefing appointment. I was conscious of the time limit right from the start. It made me feel 'unrelaxed' and all I could think of was 'how can I fit in all I'd like to tell someone?' To just explain all the things I was involved in overseas could take that long! I came out of it feeling like it was open heart surgery without time to be stitched back up, and I was left to pick up the pieces afterwards.

I was then very fortunate to be offered another debriefing through my church, and this was the complete opposite. From the beginning I felt that I could talk over the things that really mattered to me. To not have any time constraint helped and conveyed to me that this person put a priority on this time as well. To have to highlight a few positive and negative parts of my experience was very helpful indeed and helped to structure the debriefing. We talked for more than three hours.

If I was in the same situation again, I would prefer to not have a debriefing at all than to be debriefed in 45 minutes – it just is not possible."

Debriefing may fail to help if provided too soon after a traumatic event (especially where there is an injury), or while the trauma is ongoing

Another important consideration is when the debriefing is provided. The traffic accident patients were debriefed "within 24 hours of the accident or as soon as they were physically fit to be seen" (Mayou, Ehlers & Hobbs, 2000, p.589). However, it is generally recommended that debriefing should never occur within the first 24 hours following a traumatic incident, especially when someone has been physically injured. When someone is in severe pain, avoiding thinking about the trauma can be a healthy coping mechanism, and it can be better to provide painkillers and encourage distraction (or sleep) than to ask them to focus on the cause of their distress. Forcing someone to speak about the details of the trauma during those initial hours may actually encode it more vividly into their memory and impede recovery. In addition, it may be detrimental to encourage a traumatised person to 'vent' their feelings immediately after the trauma when they are struggling to regain composure and make sense of the chaos. Traumatic experiences lead to a sense of loss of control and powerlessness. Attempting to cope in their own way during the initial hours, and perhaps to control their emotions, may help them to regain a sense of control. Insisting on immediate debriefing may reinforce feelings of helplessness (Everstine & Everstine, 1993).

It is likely that the patients in the traffic accident study needed more time to recover from the physical injury before receiving a psychological intervention. Further evidence for this is provided by the study of burns victims. Here, the researchers observed that the sooner the debriefing was provided, the worse the outcome (Bisson et al., 1997). This is probably due to the reasons discussed above. Moreover, for burns patients the trauma generally continues for a considerable time after the injury has occurred. Severe pain often comes with dressing changes, grafting, surgery, physiotherapy etc., and progressive scarring after a burn may cause more problems than the burn itself. Therefore, "early

©CHS Alliance 2018

debriefing in the hospital may be timed too soon for most patients to benefit, in that their most traumatic experiences in relation to the burn may still be months down the road" (Kraus, 1997, p.583). One of the benefits of debriefing can be helping people to realise that the difficult experience is now over and they can start to move on. Debriefing while the trauma is continuing (as in the Bisson et al. study) is likely to be of less benefit. During the first few days after a trauma, people are often in shock. They may be highly aroused or they may be dissociating, but either way they find it difficult to concentrate and benefit from a debriefing session.

Everly & Mitchell (1999) recommend that debriefing should take place between 24 hours and 10 days after acute crisis (never in the first 24 hours), and where there is a major catastrophe, debriefing should take place only after 3–4 weeks have passed. Debriefings which occur later than this may still have a positive effect, but intervening too early may have a negative effect.

Debriefing is more likely to be effective if the debriefer is trained and experienced, and perceived as 'credible' by the debriefee

Dyregrov (1997) wrote:
"The background, training and personal qualities of the leaders are extremely important variables in making successful debriefings." (p.593)

Another problem with several of the research studies is that relatively inexperienced debriefers have been used. For example, in the traffic accident study:

"Regrettably, the experienced clinical nurse specialists and social workers who were recruited initially to undertake the interventions found that their primary clinical responsibilities in the emergency psychiatric service prevented their reaching many of the study patients before they were discharged. After the first ten subjects, the interventions were undertaken instead by the research assistant." (Hobbs & Adshead, 1997, p.166–167)

It has been reported that the debriefers in the burns victim study received only half a day's training in debriefing methods (Parkinson, 2001, commenting on Bisson et al., 1997). This is an insufficient time to be properly trained, let alone develop the skills through practice and experience. During the study, 25 patients were debriefed by five nurses, meaning that on average each nurse conducted five debriefings. This is not enough to become highly experienced.

A study which found debriefing to have no effect for women who had experienced early miscarriage used a debriefer who had 'limited medical knowledge' (Lee et al., 1996, p.51). The participants in this study felt it was very important to have an explanation for their miscarriage, and rated the limited knowledge of the debriefer as a negative aspect of the intervention.

Research suggests that debriefing tends to be more beneficial when led by a trained, experienced debriefer (Arendt & Elklit, 2001). The debriefer should ideally be able to answer questions related to the experience which they are debriefing, or else know who else can answer such questions. Both Dyregrov (1999) and Mitchell & Everly (1993) have stressed the importance of having the right debriefer, but some of the research studies have instead used the most convenient person to provide debriefing. In the study of patients with burns, many of the debriefings were undertaken by nurses who were also involved in painful procedures such as changing dressings. This may have influenced the patients' perceptions of the debriefer and their willingness to talk freely with them.

©CHS Alliance 2018

As well as being trained, it is also important that the debriefer can demonstrate that they have some understanding of what the person is talking about. This has been referred to as 'cultural competence' or 'credibility'. People want to know that the debriefer understands without them having to explain everything. Ideally, they want to get the sense that the debriefer has been through something similar (although not necessarily exactly the same experience) and has come out the other side. Many emergency workers prefer to be debriefed by trained colleagues than by mental health professionals. People who have suffered a traumatic incident often talk more readily to other people who have experienced similar (or the same) incidents than to professionals (see Watts, 2000; Orner, 2003; Alexander & Wells, 1991).

When humanitarian workers were asked about the qualities they would want in a debriefer (Lovell, 1999b), the three qualities which they judged to be the most important were:

1. They have some training and a lot of experience using CID
2. They would give debriefing individually
3. They have been involved with humanitarian work.

Less important but still desired were:

1. They are the same gender as debriefee
2. They have had similar experiences to debriefee
3. They would give debriefing with partner or family
4. They have the same nationality as debriefee.

On the whole, the humanitarian workers were fairly neutral about whether or not the debriefer was from their organisation, and whether or not they had been trained as a mental health professional. They generally did not want someone who would give them debriefing in a group with other humanitarian workers, preferring individual debriefing.

Fawcett (1999) states:
"Debriefer credibility is an important issue. Credibility may be a function of several factors. Probably the most important is the 'me too' factor – the notion that the debriefer knows what is being talked about because of their own personal experience. Two other factors also seem important. The first is the ability of the debriefer to hear what is being said accurately and without overly condoning or condemning the speaker. The second is the perceived ability of the debriefer to influence future events. In other words clients often hope that the debriefer will either be able to encourage current good practice where it exists or discourage bad practice where it exists." (p.63)

People generally want to be debriefed by someone who can either answer their questions or point them to where they can get the answers. Studies using inexperienced research assistants may fail to provide a 'credible' debriefer. The ideal debriefer for humanitarian workers is a trained and experienced debriefer who has done humanitarian work themselves, and knows how to take action or find out more information if the debriefee wants this.

Obviously, the debriefer also needs to be someone who can cope with hearing about traumatic incidents. If they appear extremely shocked or upset by what they hear, the debriefee may feel unable to continue talking about their experiences as they may feel a need to 'protect' the debriefer.

Quote from someone who received debriefing:
"She was well-meaning but obviously had no idea of what I was talking about. She kept squirming and saying 'ooh that sounds awful'. She said 'I don't know why you want to go back to that job anyway'! She couldn't help me at all, as she didn't understand the sort of job I do."

People who have more severe injuries are likely to have more difficulty adjusting

In the two studies which reported an adverse effect of debriefing (Mayou, Ehlers & Hobbs, 2000; Bisson et al, 1997), the people who were randomised to be debriefed had more severe injuries than those who were not debriefed. In addition, in the Bisson et al. (1997) study, almost twice as many of the debriefed group had suffered from previous significant trauma. Thus it is not surprising that the more severely injured group had more distress at follow-up. Bisson et al. (1997) observed that initial distress was a far stronger predictor of poor outcome than the presence or absence of debriefing. In other words, although the group who were debriefed reported more difficulties when they were followed up, this was not necessarily because debriefing was unhelpful, but it may have been because they were more severely injured and more distressed in the first place.

The latest research

In an online update to their Cochrane review, Rose, Bisson, Churchill & Wessely (2006) identified four randomised trials of psychological debriefing which had become available since their earlier review. The results are in keeping with the 11 previous trials. One study (Litz et al., 2004) is unpublished and not publicly available, and so little can currently be said about it – it concluded that debriefing had no effect.

Two published studies found no significant differences between people who were debriefed and those who were not. These studies used short sessions (15 minutes to 1 hour), and the debriefers had little experience of debriefing, so it is not surprising that no effect was found.

The fourth study (Campfield & Hills, 2001) used a debriefer who had four years of experience doing debriefing. Debriefing lasted 1–2 hours. Immediate debriefing (within 10 hours of a non-injurious robbery) appeared to hasten recovery from symptoms.

The recent findings are in keeping with the earlier studies which indicate that debriefing might not help if the session is too short, or is provided by a debriefer who has little experience. Early debriefing may be helpful if there has been no injury, but debriefing should be delayed if the person is still in physical pain.

Since the publication of the Cochrane review, a randomised controlled trial of volunteer fire-fighters has found that group Critical Incident Stress Debriefing (CISD) was associated with significantly less alcohol use when compared with the group who received no intervention. CISD was also related to significantly better quality of life at follow-up than receiving only education about trauma (Tuckey & Scott, 2014). Thus this more recent study showed benefits of group CISD for emergency workers.

What about humanitarian workers – might they be different from the people debriefed in the studies?

Debriefing may be more effective for people who have been selected ('resilient, psychologically strong' people), 'briefed' and know they may experience stress as part of their work

Critical Incident Stress Debriefing was originally devised for *emergency workers* (e.g. members of the ambulance, police and fire services) who had experienced critical incident *stress* as part of their job. Debriefing was not devised for *members of the public* who, without warning, experience *trauma (*unexpected, disaster-type events). It has been said that people cannot be 'debriefed' if they have not already been 'briefed'. That is, debriefing is aimed to help people who experience stress during the course of their work, and who know in advance that this might happen. Humanitarian workers have much in common with the emergency workers for whom debriefing was designed. The people selected for humanitarian work tend to be psychologically robust and prepar to encounter stress. In their review of the studies on debriefing, Arendt & Elklit (2001) found that personal debriefing generally has a beneficial effect when the people being debriefed are professional helpers, but is insufficient when used with members of the public who unexpectedly experience trauma. Jacobs, Horne-Moyer and Jones (2004) reached a similar conclusion in their review: "CISD is an effective method of reducing risks for PTSD-related symptoms in emergency service personnel. However, when debriefings are conducted with primary victims of traumatic events … the results are much less promising." (p.5)

Everly, Boyle & Latling (1999) conducted a meta-analysis of ten studies, involving a total of 698 people, the majority of whom were emergency workers or soldiers. They report that group psychological debriefing was effective in alleviating the effects of vicarious psychological distress in emergency care providers. (They also included some studies with other sample groups, so that their main conclusion was that group debriefing was effective.)

Rose, Bisson, Churchill & Wessely (2006) admit that the studies in the Cochrane review may not be relevant for emergency workers, and state that research on "the efficacy of debriefing in emergency workers" is "a particular priority" (p.15). As mentioned above, a study published since the Cochrane review has found that group CISD appears helpful for fire-fighters, as it was associated with significantly less alcohol use and better quality of life at follow-up than was found in non-debriefed control groups (Tuckey & Scott, 2014).

Promising results have also been found among soldiers when an adaptation of CID has been used to review a period of military service, rather than a single traumatic incident (Adler, Castro and McGurk, 2008; Adler et al., 2009). This 'battlemind psychological debriefing' includes discussion of return to life at home. It has found to be associated with fewer post-traumatic stress symptoms, depression symptoms and sleep problems when compared with standard stress education, among soldiers who have high levels of combat exposure.

Debriefing may be especially helpful for humanitarian workers, who may otherwise feel isolated and have difficulty finding people to talk to about their experiences

The 11 studies reported in the Cochrane review of 2003 used participants who had suffered recent miscarriages; complications giving birth; road traffic accidents; dog bites; burns; violent crimes; or who were the relatives of trauma victims. This is very different from the population of humanitarian workers or emergency service workers, who are generally healthy, resilient people with strong coping skills who have some expectations that they may encounter stress and trauma in the course of their work, and so who are partially prepared to cope with this. Humanitarian workers are more likely to face ongoing stress or several incidents than one-off traumatic incidents, and personal debriefing may

©CHS Alliance 2018

focus on a number of stressors rather than an individual event. Thus the Cochrane review is of less relevance than research on debriefing specifically for humanitarian workers.

Most people who suffer from incidents such as a miscarriage, traffic accident or a burn are able to talk to medics and their family and friends (or other patients on a hospital ward) about their experience. They are quite likely to come across other people who have experienced something similar. In contrast, many humanitarian workers feel that there is no-one who can understand their experiences or who is interested enough to listen. Some humanitarian workers report that are expected to be able to cope with difficulties themselves, and people only want to hear their positive stories. Many feel isolated and say they do not have anyone they can confide in who would understand their feelings. Some humanitarian workers who have experienced significant trauma (e.g. violent incidents, or being aware of extreme suffering or acts of gross cruelty) do not want to tell even their spouse or closest friend. They are afraid that the person they tell might be traumatised or worried about their safety. Some long to talk to someone who is outside the situation and can bring another perspective and yet understand, but they do not know where to find such a person. Debriefing may be the only opportunity for them to talk in detail about the difficult parts of their humanitarian work.

Quotation from a humanitarian worker who observed horrific human rights abuses during the Balkans crisis:
"I haven't been able to talk to anyone about this. I can't tell my wife, because then she would feel traumatised too. I couldn't tell my colleagues, because they had all seen similar atrocities and were already coping with too much. The thing which kept me going was knowing I would be able to talk about it during this debriefing. That saved me from going under."

Quotation from a humanitarian worker:
"I was desperate to talk to someone who I knew would be able to handle extremely traumatic experiences. I had shared some of it with others, but most people could not cope, which left me worse off."

The need to talk
"There appears to be a fundamental need that many, if not all, humans have, namely to share frightening and distressing experiences with others who have at least some understanding of what has been experienced and who feel some caring or concern that this has occurred."
(Robinson, 2000, p.104)

Greenberg et al. (2003) studied 1,202 peacekeepers on return from deployment. About two thirds reported that they had spoken about their experiences, mainly with peers and family members. Speaking about experiences was associated with less psychological distress than not speaking to anyone. Two thirds of the sample were in favour of a formal psychological debriefing on return from deployment. Those who did not speak to anybody, perhaps because of a lack of opportunity or social skills, were the most in favour of formal debriefing.

Lovell (1999b) conducted a study of personal debriefing for humanitarian workers, avoiding the problems of previous research listed above. Trained debriefers who had themselves worked in the humanitarian sector conducted individual debriefing sessions which lasted on average two hours.

Debriefing occurred around 1–3 weeks after the individual had completed their assignment. Personal debriefing was found to be highly beneficial for this group. Of the 33 humanitarian workers who had received personal debriefing (because all staff in their organisation received debriefing), it was found that only 7% reported having intrusive thoughts of a clinical severity when they were followed up (using anonymous questionnaires) approximately 14 months after the debriefing. This compares with 24% of workers from other humanitarian organisations who received no personal debriefing. Likewise, only 7% of debriefed personnel reported clinically significant levels of avoidance, compared with 25% of the non-debriefed group. Only 3 of the debriefed personnel reported that the debriefing was not helpful (these 3 feeling that they had no need for it). Those who found it helpful made comments such as, "I thought beforehand it was going to be a waste of time, but I found that actually it was very helpful to be able to talk about everything, however small, that had happened".

Forty percent of those debriefed reported that there had been a positive change following debriefing (e.g. fewer flashbacks afterwards, or "it gave me permission to feel the way I was feeling – a sense of release and relief"). No one reported a negative change.

In another major study of 600 missionary agencies across 22 countries, debriefing during home assignment correlated with retention (Hay et al., 2007).

Debriefing may have various benefits which have not been considered in most of the research

Debriefing may also have positive benefits in domains which have been overlooked by most studies. For instance, Deahl et al. (2001) conducted a randomised controlled trial of group debriefing amongst British soldiers returning from peacekeeping operations in Bosnia. Debriefing was associated with a significant reduction of alcohol misuse. Debriefing has also been associated with improved coping skills, increased morale and staff retention, reduced sick leave and compensation payments, and less use of mental health services in the 12 months after the incident (Mitchell & Everly, 1997; Robinson et al., 1995). The vast majority of people who receive debriefing report that they find it beneficial (Mitchell & Everly, 1997). Even if questionnaires cannot always demonstrate a benefit of debriefing, the fact that people report finding it helpful should not be ignored.

> "A growing suicide problem at the New York Police Department in the 1990s was addressed by police officers training themselves in the principles of crisis intervention (including Critical Incident Stress Debriefing) and making themselves available to colleagues affected by harrowing incidents … it was such police officers who provided the main body of support for their colleagues in New York after September 11th 2001. As a guest psychologist, I was witness to the positive transformation of mood and attitude amongst officers undergoing Critical Incident Stress Debriefing several months after the terrorist attacks. Despite the suicide problem that preceded 9/11, no suicide occurred in the department in the year after 9/11. By comparison, aware of the critical studies on debriefing undertaken in the UK, the fire department in New York elected to abandon crisis intervention … The mass resignation, increased incapacity due to stress and suicides that have occurred at the fire department make a sharp contrast with New York City's police officers." (John Durkin, psychologist and former fire-fighter)

©CHS Alliance 2018

In summary of the above discussion:

1. The studies which suggested that debriefing may be ineffective or harmful have methodological flaws, including offering debriefing which is too short, too soon (when the person is still suffering physically), or uses an inexperienced debriefer. These studies also have other limitations not listed above, including small sample sizes and inadequate statistical analyses. The study of road traffic accident patients (Mayou, Ehlers & Hobbs, 2000) is rated as being particularly poor quality, including excluding people without any psychological symptoms and having a high attrition rate (Rose, Bisson, Churchill & Wessely, 2006). Therefore, it is surprising that so much attention has been paid to the findings.

2. These studies are in any case of less relevance to us than studies of humanitarian workers or similar groups such as peacekeepers or emergency service workers. Debriefing was originally devised for such groups and not for the general public. It appears to be beneficial for these groups. A report by Hawker, Durkin & Hawker (2011) discusses the problems with the previous studies, and some evidence in favour of offering debriefing to humanitarian workers and missionaries.

> Skilled debriefing by experienced debriefers is likely to be of benefit to humanitarian workers, as long as the debriefing session is not too short and occurs at a suitable time and not when the person is still in severe physical pain.

©CHS Alliance 2018

7. Structured vs. unstructured debriefing

Some debriefers use a structured format, while others prefer an unstructured approach. Either of these may be effective, but for people who are not trained as mental health professionals a **structured approach** is recommended because:

- It provides a starting place, so that people do not say "I've got nothing to talk about".
- It ensures that the most important aspects are discussed.
- It prevents deeper issues (from the past) becoming the main focus.
- It stops the session from becoming a counselling session.
- It provides people with a sense of security, as the clear structure is explained at the outset, so they know what to expect.
- It allows for a gentle 'step down' into discussion of the more emotional aspects, and then 'climbing back up' so that the session ends by thinking about support and the future.
- It allows two debriefers to work together, knowing that they are going in the same direction.
- It works for groups as well as individuals.
- Structured debriefings can be conducted by people who are not mental health professionals.
- The debriefers are perceived as being professional, and this helps them and the person being debriefed to feel confident with the process.
- The debriefer is less likely to become over-involved or feel lost or feel out of their depth or think that they said 'the wrong thing' if there is a clear structure to follow.
- The structure is flexible enough to allow for discussion of longer-term stresses as well as one-off incidents. The question "is there anything else that was important for you that you would like to discuss" can be asked to ensure that the structure does not prevent discussion of any aspect.
- Research indicates that people like the structure, and it is beneficial.
- Randomised controlled trials have been conducted on structured critical incident debriefings, but not on unstructured, general debriefings – so there is a better base of literature and research for the structured approach.

One humanitarian worker told us he had gone to a debriefing session where he was told "this time is yours to use as you want it. Talk about anything you want to, related to your time overseas". He did not know where to start – so much had happened, and without a structure he did not know how to talk about it. He ended up talking about trivial issues, like coffee. He soon ran out of things to say and left thinking the debriefing was a waste of time. Knowing that he still needed an opportunity to process his experiences, he then asked to receive a structured debriefing session. He spent three hours talking about his experiences and said that this was very helpful.

Anonymous feedback from two debriefed humanitarian workers:
"It was structured. I knew what I wanted to talk about. The structure filled in the gaps of what I hadn't thought about."
"The structure was fine – basically I felt free to talk, although the skilled questioning in fact guided us along very well and thoroughly."

8. Who should be offered personal debriefing?

Many people say that they did not realise that they would benefit from debriefing until after they had received it (Lovell, 1999b). Nearly everyone can benefit from having a skilled listener to help them

©CHS Alliance 2018

explore their experiences and reactions. Ideally, personal debriefing should be offered to every humanitarian worker (national or international). There are two reasons why it should not be offered just to those who are known to have experienced a ‘traumatic incident’. Firstly, the organisation is often not aware when there has been an incident which the individual regards as traumatic. Secondly, the whole humanitarian experience and transition afterwards can be regarded as a ‘critical incident’ which involves change and stress. Nearly all humanitarian workers who have been working for more than six months (and also many who have been on shorter assignments) report that there were some stressful parts of the experience, and the majority also report some difficulties readjusting afterwards (Lovell, 1997).

When debriefing a team, it is best if everybody in the team attends. If a team were caught up in a difficult incident and some members were elsewhere at the time, it is wise to invite the members who were absent to join the rest of the group for debriefing. It will be helpful for them to hear about what happened. They may have felt guilty about not being there to help, or they may have experienced other strong feelings which they can share with the group. This will help to avoid the team dividing into two separate groups (those who were there and those who were not).

Whenever possible, it is good to debrief partners (e.g. spouses/couples) together. This can help them understand and support each other better. It is sometimes appropriate also to offer them each an individual debriefing, in case there are things which they do not want to say in front of their partner – especially if they are having relationship difficulties. Even if only one partner was involved with humanitarian work and the other remained at home, it can be worth inviting the ‘stay-at-home’ partner to attend the debriefing, to help them understand their partner’s experiences and know how to support them.

Quotation from a humanitarian worker who had been on assignment with her husband:
“Although my husband did not think *he* needed a debrief, he was willing to be debriefed with me and we both learnt a lot from it. For the first time we heard each other express what had been the hardest experiences, and we had time to reflect on them. So much had happened and life was so busy overseas that there had been no time to reflect on how our experiences had affected us.”

Quotation from a returned humanitarian worker who had (several times) worked for a few months while his wife remained at home:
“I consider debriefing with wife is essential. It helps them also to identify with your experience.”

The needs of national staff as well as those of expatriate staff should be considered after traumatic incidents and at the end of assignments. Debriefing for national staff will be considered later in the manual (section 19).

©CHS Alliance 2018

9. Should debriefing be mandatory?

We have just indicated that personal debriefing should be *offered* to every humanitarian worker, if possible. If it is not actively encouraged but only available to those who request it, most people will fail to request it, either because they think that they do not 'need' it (although after debriefing they might realise that they did), or because they believe that requesting debriefing is a sign of weakness.

This does not mean that debriefing should be mandatory. People have different ways of coping with stress. Orner (2003) found that while talking about traumatic events was important for 80% of emergency service workers, 20% used other coping strategies. Likewise, Martin & Doka (2000) observe that people work through grief in different ways, and not everybody needs to talk in detail about it. As well as personality differences, there are also cultural differences in what people find helpful (see section 19).

Our recommendation is that all humanitarian workers are encouraged to attend debriefing after assignments of six months or longer, or after shorter assignments to high security settings. They should be given the opportunity to decline the debriefing if they want to, but it should be offered on an 'opt-out' rather than an 'opt-in' basis. Some organisations require those who 'opt out' to sign a disclaimer form, stating that they were offered debriefing but declined to accept it. This illustrates how seriously the organisation takes debriefing. Having an 'opt-out' policy helps to ensure that the maximum number of people benefit from debriefing and removes any stigma which might be attached to requesting debriefing, while not forcing anyone to accept debriefing.

In addition, short-term workers to lower security settings should be allowed to request debriefing if they want it – as even short-term workers can encounter stress and benefit from debriefing. Frequent travellers (e.g. workers or consultants who make several work-related trips every year) should be offered debriefing on an annual basis, and encouraged to request it sooner if they have experienced a stressful trip.

©CHS Alliance 2018

10. Characteristics of the debriefer

Before describing the process further, it is appropriate to say a little about the debriefer. (See also the section on debriefer credibility and experience, p.10–12.) Debriefers do not need to be mental health professionals, but they should be people who are trusted and respected in terms of professional integrity and competence (Lazovik, 1995). What is important is that they have adequate training in the skills of debriefing, have good listening skills, and are warm, non-judgmental, affirming and able to empathise. They must be able to maintain confidentiality. They should be comfortable with silence, as sometimes debriefees require time to reflect before speaking. They should also be able to sit with people who are showing strong emotion (e.g. crying or feeling angry). Debriefers need to recognise their own limitations, and be willing to refer people on for further help if necessary. They should receive supervision. Debriefers can suffer from 'secondary trauma' (that is, they may feel traumatised by the things which they are hearing) unless they are able to be adequately 'debriefed' and supported themselves. Hughes (2002) cautions that "it would not be appropriate for anyone who has themselves experienced a recent trauma or who is experiencing major life events or changes to take part in a debriefing training or to facilitate a debriefing" (p. 26–27).

Some people prefer to be debriefed by someone within their organisation who is familiar with the way the organisation works, as then 'jargon' and procedures need not be explained. Others prefer an external debriefer, who is seen as 'neutral' and can be told issues which the person does not wish to disclose to anyone in the organisation. It can be easier to talk about problems involving team members or the organisation if the debriefer does not know the people involved. If possible, it is best to ask the person who is going to be debriefed whether they have a preference for an internal or external debriefer, and whether they prefer a debriefer who is the same gender as them. As discussed previously, it is preferable if the person who conducts the personal debriefing is not involved in line management for the individual concerned. The debriefer should also not be a personal friend of the person being debriefed.

Sometimes two debriefers work together. This is especially helpful when debriefing a couple or group, or when one debriefer has limited experience. Debriefers should be aware of any potential role conflicts (e.g. if they also know the person they are debriefing in another capacity, or if they may be involved in assessing them for a future post). It is helpful if the debriefer has some knowledge of the culture the participant was based in, even if this was only gleaned through reading an information sheet. People find it discouraging and off-putting if the debriefer displays complete ignorance about the country, e.g. asking "where is Azerbaijan?" It is preferable if the debriefer has worked in the humanitarian sector themselves, and so is perceived as having 'cultural competence' and 'credibility'.

It is preferable for no other observers to be present during a debriefing. People tend to feel inhibited if someone has been invited to 'come and observe'.

Debriefers should not come across as cold and uncaring, but should appear sensitive and caring.

Quotation from a returned humanitarian worker:
"I have been debriefed twice. The first time was less than helpful. I had no reaction from the debriefer, felt unaffirmed, felt the debriefer had no concept of the depth and confusion of my struggles. I left feeling more of a failure than I had come. The second time, six months later, with a different person, was *excellent* … we were *not* rushed and spent all day talking. The debriefer acknowledged the depth of pain and confusion and showed great empathy in his response to us and his gentle questions… Lots of respect and understanding around."
(Lovell, 1999b, p. 11)

Quotation from a returned humanitarian worker:

"When I arrived in Goma the only word I could find to describe it was: Hell … a lot of dead bodies everywhere; 500,000 refugees from Rwanda; cholera, dysentery, shigellosis. I began work immediately … Then I became ill. On my last day, en route home, I was stopped by the military and threatened by a 9 mm gun when a soldier argued that I was a terrorist … That was enough … I went to [the organisation's] headquarters for what proved to be a very short – three hours – and cold debriefing. It seemed to me that nobody there knew what was happening in Zaire. 'Thanks for everything, Marc. You look a bit tired … You should rest. Thanks again for everything.'

I don't know why people were so cold at [the organisation's] headquarters ... And, anyway, what was I to talk about? When you cut yourself and are bleeding it is obvious that something has happened and people are looking at you. But when something happens inside your head, how do you know what to do?

What is hardest for me to take? Goma, or the way [the organisation] treated me?

When you go into the field, you believe that the people back at headquarters are professionals who will take care of you if something happens to you. In reality, you feel like a lemon, squeezed and thrown away when they do not need you anymore."

(Danieli, 2002, p. 186 – 187)

©CHS Alliance 2018

11. Recommended steps for becoming a debriefer

1. Find out more about what debriefing involves (e.g. by reading this manual), and check whether you have the qualities mentioned in the previous section.
2. If you have never received training in basic listening skills, attend a short course (e.g. a one-day course) to learn these skills.
3. Attend a debriefing training course, preferably one specialising in debriefing for returned humanitarian workers (contact www.resilientexpat.co.uk to ask about our training courses).
4. Read an account of the experiences of a humanitarian worker (e.g. Stratton, 2003; Bilinda, 1996; Bilinda, 2006; French Baker, 2007; or the case-studies in Danieli, 2002). If you prefer a novel, try McKay, 2007. Alternatively, spend time meeting with people who have been involved with this type of work, so that you can gain an understanding of the issues involved. If you have been involved with this type of work yourself, this step may be less necessary for you.
5. Role-play a debriefing session, following the recommended structure, to practise the skills of debriefing and become familiar with the model. It is good to do this a few times, so that you become familiar with the structure.
6. Act as 'co-debriefer' in a debriefing session alongside a more experienced colleague. Learn from them. Decide in advance who will do what. For example, you might decide that they will take the lead in step 1 of the debriefing, you in step 2, and then alternate throughout the session. Perhaps agree that if you feel 'stuck' and want them to take over, you will ask them, "is there anything you want to say at this point" which can be translated as "help – I don't know what to say next!"
7. After several joint debriefings, you may feel confident enough to offer debriefing on your own. Always remember to stick to the structure, and refer the person on for further help if necessary. Seek support and supervision after debriefing, and occasionally attend further training courses to refresh and enhance your skills. Re-read this manual from time to time, to remind yourself of the procedure (as it is easy to slip into bad habits). Read some of the references to increase your knowledge and understanding. Remember to take care of yourself too.

©CHS Alliance 2018

12. The Critical Incident Debriefing (CID) procedure

The structure of CID was originally described by Mitchell (1983) and Dyregrov (1989). It was initially designed to be used with a group of emergency workers who had experienced a 'critical incident' (traumatic event) together during the course of their work. It was devised to help them cope with symptoms of stress and to help speed up normal recovery. Thus, it is not a 'treatment' for people who have already developed difficulties, but rather a preventative measure. The CID process has been used with innumerable different groups of people worldwide.

A typical CID lasts between two and three hours (although it may last much longer, especially with a large group). The process should not be rushed. Participants should leave a CID knowing where they can get further help should further difficulties develop. **CID is not counselling.** The process should be **non-judgmental**, not looking to see whether correct procedures were followed, or who was 'right' and who was 'wrong'.

©CHS Alliance 2018

13. Theoretical framework for Critical Incident Debriefing

Most people believe that the world is basically a good and meaningful place, and that "I am a worthwhile person". A traumatic event can shatter these basic assumptions (Janoff-Bulman, 1992). For example, after surviving a disaster, an individual may think, "the world is evil and I'm not safe", "the world is meaningless and random", or "I'm a terrible person" (because I did not save others or because I was raped etc.). Such conclusions produce a sense of ongoing threat. This is associated with increased risk of PTSD (Ehlers & Clark, 2000).

One theory (see Horowitz, 1975; Janoff-Bulman, 1992) suggests that it is difficult to store a traumatic event in long-term memory, because it does not fit in with pre-existing beliefs about the world. The brain cannot make sense of what has happened, and so the traumatic experience is kept in the 'active memory' instead of being stored away. Some people try to avoid thinking about what happened, but because the brain is still trying to process the information, intrusive thoughts and images keep coming into their mind. They may have nightmares, or 'flashbacks' (pictures of what happened, and a feeling that it is happening again), or they may find themselves thinking back to the incident again and again. Such intrusive thoughts are a symptom of post-traumatic stress. Trying not to think about the event, or feeling 'numb', is also a symptom of post-traumatic stress (known as 'avoidance').

The CID process encourages the individual to talk about the incident instead of avoiding thinking about it. This helps them to process it and store it in longer-term memory. If you have told your story to someone, your brain no longer needs to keep holding it in active memory waiting for the information to be 'sorted through and filed'. An analogy might be a librarian cataloguing new books. Before the information is catalogued, it sits in a messy pile on the desk, getting in the way when the librarian tries to do other work. Once catalogued, it can be retrieved when you want to retrieve it, but the rest of the time it is out of the way so you can get on with other things. Telling your story helps to organise it and give it meaning – and to 'catalogue' it in your mind.

By describing everything that happened, the brain begins to make some sense of it, and can store it in long-term memory. This promotes a more rapid recovery. Once the story has been told in detail, the symptoms of avoidance and intrusive thoughts are likely to decrease. The incident can be placed in the context of the rest of the person's life, instead of taking over their whole life. Thoughts such as "the world is not safe" or "I am bad" can be re-appraised within this context. For example, "usually I am safe but accidents occasionally happen"; "I did what was normal in the situation and tried to save my life – that does not make me a bad person".

Ehlers and Clark (2000) report that, "It is assumed that, unlike individuals who recover naturally, individuals with persistent PTSD are unable to see the trauma as a time-limited event that does not have global negative implications for their future" (p. 320). Critical Incident Debriefing can provide a sense of 'closure', which may help prevent the development of PTSD. The event is over, the person is no longer under threat, and they can start to move on.

Describing details of the traumatic experience may also help individuals to make connections and be aware of things which might trigger them to remember the trauma in the future. For example, if a woman was raped while lying looking at a ceiling with a distinctive crack in it, seeing similar cracks in the future might trigger a flashback of the rape. As she does not know why the memory has been triggered, she may feel that she is still in danger. However, if she has spoken about the crack and thus brought it to conscious awareness, when she next sees a similar crack it is likely to lead to a memory in context ("that's like the crack I was looking at as I was raped"), rather than an automatic flashback. As she understands the trigger and knows that she is no longer in danger, the memory is less likely to cause distress. CID does not aim to take away the memory of the event, but it can stop the flashbacks – and flashbacks tend to be perceived as much more distressing than normal memories, because people feel that they are re-living the trauma and that they have no control over this, and they might not know what has triggered this.

When people try to avoid thinking about a traumatic event, or only focus on certain aspects rather than the whole context of the event, they may be more prone to persistent PTSD. Describing the whole experience from start to finish, so that it is all linked together in an autobiographical memory base, appears to reduce the likelihood that isolated stimuli which are associated with the memory (such as a crack, or a distinct sound or smell) will trigger a recollection of the event. Thus, putting the memory in context may reduce the likelihood of developing persistent PTSD (see Ehlers & Clark, 2000).

Smyth et al. (2002) found that people who had been displaced from their homes as a result of a hurricane and subsequent flooding were experiencing less negative affect at follow-up if they had been asked to write about their "deepest thoughts and feelings about the experience", than a comparison group who were asked to write only a factual description about how their schedules had been disrupted by the events. This is in keeping with much other research indicating the benefits of expressing thoughts and feelings.

Research has indicated that writing or speaking about personally stressful events can have physical benefits (in terms of improving immune response) as well as psychological benefits (Pennebaker, Kiecolt-Glaser & Glaser, 1988; Pennebaker & O'Heeron, 1984; Petrie, Booth, Pennebaker, Davidson & Thomas, 1995). Disclosing both the facts and one's feelings about a stressful event appears to have more physical and psychological health benefits that disclosing just the facts or just the feelings (Pennebaker & Beall, 1986; see also Foa & Kozak, 1986; Pennebaker, 1989). Although it is beneficial to write about one's reactions to stressful events, it appears to be even more beneficial to talk about them (Esterling, Antoni, Fletcher, Margulies & Schneiderman, 1994; Murray, Lamnin & Carver, 1989). Bereaved parents have also been found to benefit from an opportunity to talk at length (on average 2.5 hours) about their experience "from beginning to end" (K. Dyregrov, 2004).

In stressful situations, people often experience a sense of being out of control. Recovery is associated with regaining a sense of control. Education about normal stress reactions and how to cope with them can help in this regard, as people know what to expect and that their reactions are normal. It can also be helpful to allow people to have a say in when their debriefing takes place, as this helps to reduce feelings of powerlessness.

Teaching people that their reactions are normal (a procedure known as 'normalising') is also important for another reason. After a traumatic event, most people have some symptoms of stress (e.g. nightmares, flashbacks, intrusive thoughts about the event, tearfulness, outbursts of anger, concentration problems, tiredness etc.) Some people worry that this is a sign that they are 'not coping', 'losing it', 'going crazy' etc. They draw negative conclusions about themselves such as "I'm a weak person", "I'm mentally ill" or "I should be able to cope better – I'm a humanitarian worker". People with religious beliefs may think that their problems indicate a lack of faith, and they may feel guilty. These thoughts put them at risk of becoming depressed about the fact that they are feeling depressed, or anxious about being anxious. If this happens, normal, short-lived responses can turn into more serious, longer-term problems. Research has indicated that one of the best ways of predicting which workers will develop psychological problems is whether or not they 'invalidate their feelings' (in other words think, "I shouldn't be feeling this way, it's a sign that I'm not coping"). Those who do this are much more likely to develop problems than those who think "it's normal to feel like this in such circumstances. I'll take a break and look after myself, and talk to someone about how I'm feeling" (Lovell, 1997). Research has also shown that negative appraisals of symptoms of stress after a traumatic event predict the development of post-traumatic stress disorder (Ehlers et al., 1998).

In the light of this, one of the important roles of debriefing is to let people know that symptoms of stress which they are experiencing are normal and common after a difficult event. Humanitarian work can be classed as a 'difficult event'. Even when nothing particularly traumatic happened, lots of change will have taken place and change is tiring and stressful. The worker can be reassured that it is normal to feel very tired after an assignment, and perhaps to feel low or have other symptoms of stress. They

can be informed that such symptoms tend to naturally reduce over time, although for some people it can take about 18 months to feel completely 'back to normal'. People generally feel relieved when they discover that their symptoms are normal and will resolve over time. The debriefer can provide information about ways to cope with the symptoms of stress. Towards the end of a debriefing, people are encouraged to identify sources of ongoing social support (e.g. family members or friends they can talk to). A lack of social support increases the risk of psychological problems developing, and so it is important to encourage the debriefee to find people who can support them. Information is also given about further help which is available if they desire it.

Quotation from a humanitarian worker:
"It was an opportunity to explain how I felt – and the process of debriefing gave me the permission to feel the way I was feeling. It was OK to feel sad, guilty, angry etc."

14. Issues to consider

Timing:

During the first 24 hours after a traumatic event people may be in too much shock or physical pain to benefit from a CID, and debriefing during this period may even be detrimental (see page 9). Everly & Mitchell (1999) recommend that debriefing should take between 24 hours and 10 days after an acute crisis, and 3–4 weeks after a major catastrophe. It is useful to provide CID before people draw firm conclusions such as "I should have done more" or "I'm not coping" and develop difficulties. However, debriefings which occur much later (even months later) can still be helpful (Chemtob, 2000; Stallard, 2000; Raphael, 1977; Chemtob et al., 1997) and may in many cases be more beneficial than early debriefing. It is better to wait until a person is ready for debriefing than to force them to attend an immediate debriefing when they may be hostile to it or unable to concentrate.

When to debrief – an example
A humanitarian organisation phoned me to ask for advice after two of their personnel were present during a terrorist attack. The organisation wanted them to attend a critical incident debriefing session immediately (as they had read that it should take place within the first 72 hours after an incident). However, the men involved were resistant to this, stating that they first wanted to see

Quotations from humanitarian workers:

"They initially wanted to do debriefing within 36 hours of arrival home. I found the thought of that very difficult as it was too much at once. Moved to two weeks later."

"Debriefing should *not* be on the day of return as is often the case. People need time to settle back a little bit and mull things over before talking them through. But we shouldn't wait *too* long."

(D. Hawker)

"Common sense should overrule procedural dogma regarding timing."
(Stuhlmiller & Dunning, 2000, p.314)

Before debriefing humanitarian workers who have just completed their assignment, they need some time to recover from travel/tiredness, to see people they want to see, to sort out practical matters and to begin to readjust to their home environment. **Personal debriefing 1–3 weeks after the assignment is optimal**, although if this is not possible, debriefing at another point is still useful. A follow-up contact about two weeks later may be beneficial (e.g. by e-mail or phone, to check how things are).

Group versus individual debriefing:

There are pros and cons of each, which are considered in section 17.

Venue:

©CHS Alliance 2018

Debriefing should take place in a comfortable, quiet, well-lit room where there will be no interruptions (including phone calls). Glasses of water and tissues should be available. Should debriefing be 'in the field', or back at 'home'? When there has been a traumatic incident on the field, debriefing near the site has advantages if it is practical. After the end of assignment, it is good to offer debriefing in the home region, as re-entry issues can be addressed as well as issues related to the humanitarian work. If this is not possible, remote debriefing can be considered (see section 22).

It is vital to choose a venue that is as safe as possible. Personnel should be briefed regarding any security risks.

Example of the need to consider safety and security of the debriefing location:
A humanitarian worker in Somalia was in a convoy which was attacked. He was flown to Nairobi for debriefing. He was not briefed about security issues in Nairobi. He was shot while in Nairobi. Thankfully, he lived to tell the story.

Children:

See section on children later in this manual (section 20).

Confidentiality:

If you do not offer confidentiality, debriefees are unlikely to be completely honest with you, and the debriefing will not be as beneficial for them. Remember that personal debriefing is *for their benefit*. If you want to assess whether they should be offered another humanitarian position, this should be done in a different setting e.g. a job interview or a psychological assessment. For information about psychological assessments, see *Supporting staff responding to disasters: Recruitment, briefing and on-going care* (Lovell-Hawker, 2011), available at www.chsalliance.org/files/files/Resources/Tools-and-guidance/Supporting-staff-responding-to-disasters-recruitment-briefing-and-on-going-care.pdf.

Work out what your policy on confidentiality is, and make this clear to the debriefee before you start. For instance, you might promise that everything they say will be confidential unless you think there is a risk of serious harm to themselves or someone else (including an act of terrorism), or if they disclose abuse – in which case you are legally or morally required to tell someone. Some debriefers also state that they may need to pass on information if there has been a breach of the organisation's code of practice (a disciplinary offence such as corruption).

Ensure you know who to contact if there is a reason to over-rule confidentiality. For example, allegations of abuse should be reported to the organisation's Safeguarding Coordinator. All staff should know who the Safeguarding Coordinator in their organisation is. Independent debriefers should find out who the relevant authorities in their area are.

Some debriefers worry that the organisation will miss out on learning if confidentiality is promised. This might be true on some occasions, but often this does not happen because:

1. Debriefers ask debriefees what they want to do about any problems which should be reported to the organisation. When asked this, many debriefees are willing to provide feedback themselves (anonymously or under their name), or give permission for the debriefer to pass on important information anonymously. Many people give permission as they want change to take place. If they give consent this is not breaking confidentiality.

©CHS Alliance 2018

2. Sometimes trends emerge over the course of several debriefings. Such trends can be fed back without it being possible to identify any particular person as the informant.

For further discussion on the balance between maintaining confidentiality and organisational feedback, see www.chsalliance.org/files/files/Resources/Case-Studies/Finding-the-right-balance-between-confidentiality-and-organisational-feedback.pdf

Using handouts:

Many debriefers find it helpful to have a reminder of the steps of debriefing visible during the session (e.g. on a table to one side of them). This can help them feel confident and less anxious, and ensures that they stick to the structure and do not miss any steps out. It is recommended that debriefers do this, at least until they are so familiar with the structure that they do not need a reminder. Debriefees do not mind a piece of paper being visible – but it is helpful if it is kept to a minimum (e.g. one page) and only looked at when needed, as it should not distract from giving the debriefee full attention. Having a manual on the table and turning over pages or stopping to read the next section can be distracting and make the debriefer appear less experienced. Handouts 7 and 8 give example 'prompts' for critical incident debriefing and routine 're-entry' debriefing. These handouts can be printed and used during debriefing sessions.

Some debriefers like to give debriefees handouts on symptoms of stress/ trauma, and suggestions of ways to cope with these. Other debriefers prefer to give the information verbally. This is a matter of personal preference. Some debriefees like to have handouts while others feel overwhelmed by having too much paper and will not read them. Handouts 1–3 and Handouts 6 and 9 can be given to debriefees if this seems useful.

Writing notes:

Note-taking should generally be minimal, as it can give the impression that a report will be written, and make the session feel more like an interview or 'information gathering' exercise.

Having said this, it is sometimes useful to jot down a few words. For example, when the debriefee is identifying which issues to talk about, these can be quickly written down to ensure that none of them get forgotten. The debriefer should explain the reason he/she is writing notes ("I'm just going to write these down so that we leave enough time to talk about them all and don't forget any of them"). Ideally the writing should be visible to the debriefee (so that they know what has been written and don't need to worry about what has been recorded). At the end of the session any unnecessary notes can be shredded in front of the debriefee, so that they know no record has been kept.

Debriefers with poor memories may also want to jot down any unfamiliar names of important people or places mentioned, to assist them if they want to refer to them during the session. Again, the writing should be kept to a minimum and if necessary they should explain why they are writing. After the session, the debriefer may wish to write a few notes to refer to when making a follow-up contact later. These should be kept in a secure place where no one else can have access to them, and should comply with data protection legislation (e.g. GDPR).

If the debriefee discloses an issue of abuse, harm or another matter which needs to be reported, or an issue which they would like the debriefer to take action on, detailed notes should be taken about that issue.

15. What to avoid in the debriefing process

Personal debriefing generally has a beneficial effect. However, it may have a harmful effect if any of the following occur, and so the following should be avoided:

1. Breaching confidentiality, unless this is necessary for legal or moral reasons e.g. if the person is likely to seriously injure themselves or someone else, or if they disclose abuse. (In such instances steps need to be taken to protect those are risk – and the debriefee should be informed about this).
2. Causing the debriefee to 'relive' a traumatic experience in the debriefing session (e.g. asking them to describe their experiences in such vivid detail that they feel they are going through the trauma again). Debriefees tend to mention the important details without needing much prompting. Questions such as "what did you see or hear?" are adequate. There is no need to ask for vivid details (although if these are offered without prompting, that is OK).
3. Providing debriefing too soon after a traumatic event (e.g. in the first 24 hours, or while there is still significant pain from physical injuries).
4. Being a poor listener or appearing emotionally cold.
5. Rushing the debriefing instead of allowing adequate time (generally at least two hours for an individual debriefing, and longer for a couple or group).

©CHS Alliance 2018

16. The seven steps of Critical Incident Debriefing

The CID process involves seven steps, as outlined below. These allow for a gentle 'step down' into discussion of the more emotional aspects, and then 'climb back up' so that the session ends positively by thinking about support and the future. Different people have used different terms for the steps – see Kinchin, 2007, for a discussion of different models of debriefing. The following outline is adapted from Mitchell (1983) and Dyregrov (1989).

Step 1: Introductions

Step 2: The facts about the experience

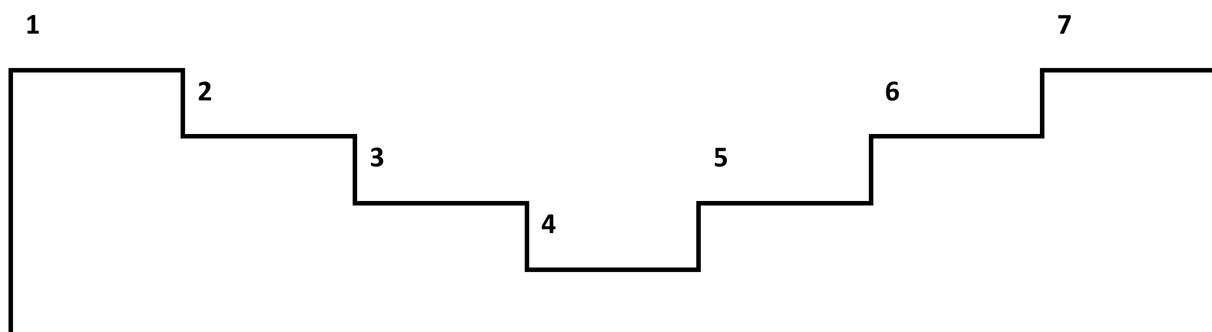
Step 3: The thoughts during and after the experience

Step 4: The sensory impressions and emotions

Step 5: Information about normal signs of stress

Step 6: Discussing coping strategies, and future planning

Step 7: Ending the session



The guidelines for the debriefer are as follows. **These are the steps to use when debriefing has been requested because there has been a traumatic incident.** (For more detail, see Parkinson, 1997.) As mentioned above, those who wish to use critical incident debriefing are strongly advised to attend a training course in this procedure, and then to work alongside an experienced debriefer before attempting to work independently (with ongoing supervision).

Later in the manual we will explain how these steps can be adapted for routine personal debriefing after a humanitarian assignment. In general, CID is best delivered by people with experience of working with trauma. More routine debriefing at the end of assignments can be carried out by good listeners who have received debriefing training. It is advised that all potential debriefers familiarise themselves with CID by reading the steps below, even if they only plan to offer routine debriefing (not CID), as routine debriefing is an adaptation of CID.

The steps should flow naturally from one to the next, so that the session runs smoothly. Debriefers should use their own words, speaking in the way which comes naturally to them. Any example wording given is purely a guideline. It is not necessary to say everything which is listed here or to ask every question – these are just examples.

Handout 7 provides a summary of the 7-step process. The handout can be used as a prompt during debriefing sections, so that debriefers do not feel they have to remember all the steps.

Step 1: Introductions

Introduce yourself. To help establish credibility, it can be helpful to refer to your experience as a debriefer, and any experience you have of humanitarian work. Ask any others who are present to introduce themselves. **Explain the purpose** of the CID (which is to help prevent or reduce stress-related problems, and help them discuss the traumatic event and move on from it). **Discuss confidentiality** (see section 14). Check that any mobile phones have been turned off. Discuss how much time there is available (e.g. "It's hard to say how long this debriefing will last. Usually we take about three hours, but we can be flexible. I don't have anything else booked today. Is there a time that you will have to leave by?").

Explain that you will be using a structure which has been proved to be useful. If debriefing more than one person, explain that everyone will have an opportunity to answer each question if they want to – people will take turns to answer and should not interrupt anyone else. Point out that it is not an interrogation, and if they do not want to answer a question that is fine. Ask if there are any questions at this point.

Step 2: The facts about the experience

Rather than beginning with an emotional description of the events, participants are eased in gently. Explain that first you would like to hear the facts about what happened. This is especially useful with people who find it difficult to talk about their feelings. It also encourages people to tell the full story, which helps them to process their experiences. **Ask them to describe what was happening immediately before the crisis, and then to describe the traumatic incident from beginning to end, and then to outline what has been happening since until this point**. Prompt with further questions if necessary (e.g. "Where were you? What were you doing? How did you first know something was wrong? What happened next?"). Only move on to the next step when the whole story has been told, from start to finish.

Step 3: The thoughts during and after the experience

Ask questions such as "what was your first thought when you realised something was wrong? What did you expect? **What went through your mind** during the incident? Was there any point at which you thought you (or a family member or friend) were going to die? What were your thoughts and impressions afterwards?" People often begin to reinterpret their experience simply by talking in this way, and they may start to get rid of negative beliefs. This is often a very short step, sometimes with just a couple of these questions.

Step 4: The sensory impressions and emotions

Only now, when people feel more comfortable, are they asked about any particularly memorable sensations from the experience, and about their feelings. The purpose is not to make them recall the incident so vividly that they re-experience it during the debriefing. In fact, there is some research that suggests that asking people to keep going over a traumatic event in great detail may have a negative effect, especially if this happens very soon after the event. It may cause them to encode the memory in such vivid detail that it will keep coming back to their mind in a distressing manner (see Ehlers, 1998).

Therefore, it is best not to probe for *lots* of details. Rather, **ask general questions such as "were there any sights, sounds or smells that were especially vivid or memorable?"** Verbalising anything which

stands out may help them make connections which will prevent flashbacks later. If the individual chooses to talk about lots of details, they should be allowed to do so, as that indicates that the memories are already very vivid. Otherwise, keep the questions more general.

Next, **ask about the feelings** they had during the event. If they need prompting, pick up on any emotions which they have already mentioned, or choose a few which you think they might have experienced and ask about those – e.g. "Did you feel any anger/guilt/fear/helplessness?" Ask **"what was the worst part** for you?" When they have answered this, add, "what were your feelings then?" You might also ask whether they cried at any point, and how they have been feeling about the incident since it happened.

Step 5: Information about normal signs of stress and trauma

After step 4, people are helped to move forward. By this time they may have mentioned some symptoms of stress which they experienced during the incident or shortly afterwards, and perhaps some of these still remain. These might be physical symptoms, emotions, behaviours, thoughts or beliefs. In step 5, **provide information about normal signs of stress/ trauma** (see Handout 2). This is important, because people who think that the symptoms which they are experiencing are a sign of weakness or inadequacy are more likely to develop further problems.

Signs of ACUTE stress

- Increased adrenaline (preparing body for 'fight or flight')
- Increased cortisol (raises blood sugar and blood pressure)
- 'Unnecessary' activities are switched off (e.g. digestion; sex drive; sleep)

Signs of CHRONIC stress (result of high cortisol level longer term)

- Insomnia (due to high cortisol level at night)
- Chronic fatigue (it is exhausting to constantly 'run on adrenaline' and lack sleep)
- Reduced immune system (wounds take longer to heal; less resistance to catching infections; skin problems; acne; itchiness)
- Memory loss
- High blood pressure; risk of heart disease or stroke
- Fat remains in blood longer (as metabolism slowed) – can lead to high cholesterol levels/heart problems
- Depression
- Headaches
- Slowed digestion; diarrhoea or constipation; stomach ulcers; irritable bowel syndrome
- Comfort eating (leading to weight gain) OR loss of appetite (leading to weight loss)

People who feel depressed about the fact that they are feeling depressed, or anxious about the fact that they feel anxious, are likely to add to their problems. Those who think "I must be going mad" or "I will never get over it" when they have intrusive memories of a traumatic event are more likely to have symptoms of PTSD one year after the event (Ehlers, Mayou & Bryant, 1998). Among humanitarian workers, one of the best ways of predicting who will go on to develop problems is to find out which people tend to think that they are 'over-reacting' – these are the people who are likely to develop difficulties (Lovell, 1997). In contrast, people who know that it is 'normal' to feel tearful, or have sleeping problems, or get very tired after a period of stress are likely to be kinder to themselves and adjust well.

Step 5 involves explaining that symptoms of stress/ trauma are normal after a major change or a traumatic event. It may be useful to provide a list of common symptoms of stress / trauma (such as Handout 2, *Symptoms of stress or trauma*, which is available in English, Spanish and French), and ask whether they have experienced any of these symptoms (either during the incident or since then). Point out that some people do not experience any of these symptoms, and that is OK, but many people experience at least a few of these after a time of stress. These symptoms are normal, and usually they disappear by themselves as time passes. If the individual has intrusive recollections about an experience, they do not need to try to push such thoughts out of their mind (as that tends to cause more intrusive thoughts). It is better to just let the thoughts come and go, without worrying about them or trying to fight them.

Saying “that’s normal” to someone who is talking about their signs of stress might sometimes seem to be minimising their experience. Using a term such as “that’s natural” or “that quite often happens” might be more appropriate.

In some cases, it is useful to ask general questions to help the person talk about changes which they have noticed in their life. For example you might ask, “How do you think the experience has affected you? Has your life changed in any way since the incident?” If their partner or family were also involved in the incident, it may be appropriate also to ask how they have been affected.

Some people appear embarrassed if they admit that they have been crying. It is worth reminding people that crying is normal in times of stress or grief. Crying is healthy, and people tend to feel better after crying. Researchers have analysed tears and found that emotional tears are chemically different from the tears cried when there is dust in the eye or when peeling an onion. Emotional tears contain hormones including adrenocorticotropic hormone (ACTH), which has been shown to be one of the most sensitive indicators of stress. Crying, by eliminating the excess ACTH, may relieve stress. Emotional tears also contain significantly more of the hormone prolactin than irritant tears. Abnormally high levels of prolactin have been found in people with high levels of anxiety and depression. It has been reported that crying may help eliminate excess prolactin, which may help stave off anxiety and depression (see Lutz, 1999). Others suggest that while crying is generally helpful, if people feel ashamed or embarrassed about crying, it might actually make them feel worse (Rottenberg et al., 2008).

While the exact benefits of crying may be disputed, there is little doubt that it can help people feel better. It can be worth telling debriefees that it is normal and helpful to cry and they do not need to feel embarrassed or ashamed about their tears. One of the advantages of debriefing is giving people permission to show their feelings, without feeling that they are ‘going crazy’.

“Crying is better than laughing. It blotches the face but it scours the heart.”
(The Bible, Ecclesiastes 7:3, ‘The Message’ version)

“It is a relief to weep; grief is satisfied and carried off by tears.”
(Ovid, 43 BC–17 AD. Cited in Lutz, 1999, p.118)

Sometimes it becomes apparent that the person being debriefed feels guilty about the way they behaved. For example, they may have run away from a crisis instead of helping other people, or they might feel that their mistake caused other people to suffer. It can be appropriate during this teaching stage to point out that in times of stress, people often respond automatically and in ways that are out of character. In a crisis, we are unable to think as we usually would. Trying to save oneself can be an

©CHS Alliance 2018

automatic instinct, and people often make mistakes or act out of character when under stress. You may be able to reassure them that what they did is completely understandable. If there are major issues of guilt, it may be appropriate to recommend that they receive counselling.

In most cases, the debriefer is able to reassure the debriefee that their symptoms of stress are normal. Occasionally, however, a debriefee discloses symptoms that are more severe than normal reactions. If the debriefer feels any concern, they should encourage the debriefee to seek professional help. If they appear to require immediate help (e.g. if they are contemplating suicide), arrange professional help (e.g. from their doctor, or take them to hospital if risk seems imminent). Ensure that someone remains with them in the meantime.

See appendix 5 for a list of indications that professional help should be sought, and information about where to find such help. Sometimes a few sessions of counselling are enough to help the debriefee feel much better. The debriefee can be informed that requesting counselling or therapy should not be seen as a sign of weakness – it is a healthy way of looking after themselves and making them stronger to deal with stress in the future. A positive debriefing session can help people be more receptive to counselling than they might otherwise have been.

Relevant self-help books can also be recommended, especially for mild problems or where there is a waiting list for treatment (see Handout 6).

Step 6: Discussing coping strategies, and future planning

After discussing symptoms of stress, the next step is to **discuss strategies for coping** with these. Ask what usually helps them to relax, and what they have found helpful in the past. Encourage them to do things which help reduce stress reactions. You may choose to give them Handout 3, *Stress management strategies*, which is available in English and Spanish.

This step is also the place to **discuss the support which is available** to them. Ask about their personal support. Who can they talk to, especially about their feelings? Do they have understanding friends or family members they can contact – even if this needs to be by phone or internet due to distance? They may find it helpful to be able to contact others who have been through a similar experience, or who at least have a good understanding of such experiences. For instance, if the trauma involved kidnapping, they could contact www.hostageuk.org. For bereavement care, see www.cruse.org.uk.

Some people find it hard to move on after a stressful experience. They may stop going out. They may avoid meeting people or getting involved in activities, because they feel they do not have the energy. If this persists for a number of weeks, they are at risk of becoming depressed. It can be helpful to gently encourage them to start doing some of the things which they previously enjoyed, and to build up more social contacts – perhaps by joining a club (e.g. one where they might meet people from the region where they have been working, or a local justice group or fair-trade group). Some people find support through a religious group, and others meet friends by joining a sports club. This can be done gradually, as they will also need time to rest, but some progress should be encouraged so that they feel they are moving on. Moderate activity (such as walking or swimming) may help to reduce tension, depression, and fatigue.

> "I like long walks, especially when they are taken by people who annoy me."
> (Noel Coward)

They should be asked about **their plans for the future**. Although it is unwise to make important decisions immediately after a stressful experience, it is still useful to ask about future plans. After a traumatic experience, some people lack hope and fulfillment. Asking what they would like to do in the

©CHS Alliance 2018

future may help to dismantle this sense of hopelessness and help them to set new goals. If they do not feel hopeless, they may still appreciate having someone to help them think about their plans.

If the debriefing takes place following an evacuation, there is likely to be discussion about whether the person will return to the place they were evacuated from (either long-term or just to say goodbye). Evacuations are especially difficult because there is little time to prepare or say goodbye, and it is often helpful if a return visit is possible, in order to collect belongings and have a proper 'ending'. Evacuees may want to talk about the friends and possessions they had to leave behind.

It is sometimes difficult to tell whether the humanitarian worker is experiencing normal symptoms of stress which will resolve naturally, or whether their symptoms are more severe. Stress-related symptoms usually subside over a period of a few weeks. They should be advised to seek professional help if significant symptoms persist beyond this or become worse or are significantly interfering with their life, work or relationships. Tell them who they can contact (e.g. a named person at the organisation, or their doctor) if they want help or counselling at any point in the future. Sometimes difficulties emerge months or years later.

Ask whether they have any questions or anything else they want to say. Occasionally debriefees may ask if you would provide some general feedback to the organisation based on their experiences, or make a concern known. If this is requested it can be very useful, although you should be careful about issues of confidentiality.

Step 7: Ending the session

The debriefing has focused on the negative aspects of the experience, but there are sometimes also positive aspects. If it does not seem inappropriate (e.g. if no one has died or been abused), it is good to give an opportunity to reflect on these, by **asking if anything positive has come out of this incident**, or if they have learned anything from it. For example, some people state that surviving a difficult experience has given them a stronger sense of gratitude, or a greater determination to enjoy every day. Some people report a deeper appreciation of their family, or a sense of achievement and self-confidence, or spiritual growth.

Ask if they have **any other comments or questions**. If you have planned to follow up the debriefing by contacting them again, mention the details at this point. (We recommend a follow-up contact about 2–4 weeks later, or sooner than this if there are concerns.)

To close, **summarise** the debriefing (perhaps by reminding them that symptoms of stress are normal, and by encouraging them to try out strategies for dealing with their stress). Ask how they are feeling now. If appropriate, say that it is not unusual for some people to feel worse at the end of a debriefing, since memories of the trauma will have been brought to mind. This is helpful in the long term, and part of the recovery process.

If you can genuinely do so, you may want to let them know that you think they have coped well and you expect them to continue doing well. Thank them for sharing their experiences, and end the session.

After everyone has left

Evaluate the session, and think about any lessons you have learned. Then find someone who you can talk with about any emotions the session evoked for you.

©CHS Alliance 2018

Follow-up

It is good practice to arrange a follow-up contact about two weeks later (in person or by phone or internet), even if they seem to be coping well. The follow-up may be earlier if that seems more appropriate (e.g. if they seem to be having a lot of difficulties).

The follow-up contact provides an opportunity to check how the person is getting on and allows the debriefee to raise anything which did not come up at the debriefing. Most debriefees report that they are starting to feel better by the time of the follow-up, and the follow-up generally takes little time.

Questions to ask during the follow-up might include:

- How have things been since we met for your debriefing?
- Have you thought of anything else you would like us to talk about, or any more questions you wish to ask?
- You mentioned that you were experiencing (*list any symptoms of stress they mentioned e.g. difficulty sleeping or concentrating; irritability; low mood; extreme tiredness).* Has that got any better or worse since we met? Have you noticed any other changes?
- You said that you were going to (*remind them of the things they intended to try to reduce stress e.g. exercise more; take a holiday; contact friends; explain to your boss why you have less energy; write down your feelings; listen to relaxing music).* Have you managed to do that yet? How has that gone?

If they are feeling worse or symptoms are persisting and getting in the way of normal life, they should be encouraged to seek further help (e.g. from their doctor). They should be informed that these difficulties are treatable, and the sooner they get help, the sooner they will feel much better. People can be given hope - depression, post-traumatic stress disorder and other problems are treatable. There should be no stigma attached to seeking help. These are conditions with a biochemical component, and one should be no more embarrassed about asking for help for these difficulties than for a medical condition such as diabetes. They are not a sign of weakness. Getting treatment is wise and enables one to continue working well and enjoying life.

If things seem to be going OK, remind them how they can contact you or get help if they want to in the future.

©CHS Alliance 2018

17. Individual vs. group debriefing

CID in groups

The CID procedure was originally designed to be used with groups. The group should be seated in a circle. If possible, there should be two debriefers for group debriefing, and they should sit at opposite sides of the circle, so that between them they have a clear view of everyone. Sitting together encourages people to look at and address the debriefers throughout the session, whereas sitting apart encourages people to address the whole group. Although very large groups are sometimes debriefed together, it is generally advisable to try to keep the group to a maximum of 12 people. Participants are more likely to feel able to express their opinions and feelings when the group is smaller (Armstrong et al., 1998; Armstrong, 2000).

When debriefing a group (even a group of two), it should be explained that each person will have the opportunity to respond to every question if they want to, although no-one will be forced to speak. At each step, they can choose not to say anything if they do not want to speak. Some people may say little but still benefit from hearing what is said, and still contribute to the group by supporting the others. Everyone should be asked not to interrupt when anyone else is speaking. If someone does interrupt, they should be gently reminded not to. Only the debriefer has the right to interrupt, and can do so if one person is talking too much so that others do not have enough time, or if someone is going off-track.

In group debriefing, everyone should be asked to introduce themselves in the introductions stage (unless of course everyone has met previously). They should also have an opportunity to mention their work position or role in the incident. When outlining the need for confidentiality, it should be explained that group members are free to tell other people what *they* said during the debriefing, but they should respect the confidentiality of other people present and not disclose what anyone else has said.

In the second step, the debriefer might ask for a volunteer to tell their story of the facts about what happened to them. After they have finished, the debriefer can point out that it is helpful for everyone to tell their story, as each person will have a different account, and people can bring different perspectives and add pieces of information which others might value. The floor is then open for others to add their stories.

Everyone should be given an opportunity to add to the facts. After this, the debriefer should ask about thoughts, and again each person should have the chance to speak. The debriefing should continue in this manner, with each person having the opportunity to respond to every question before moving on. The debriefer should be careful to ensure that everyone's contribution receives some recognition (e.g. by saying "thank you", making a comment or nodding after they have spoken). It is important that one or two people do not dominate the session. Sometimes it is worth asking a quieter group member "do you want to add anything?" without putting pressure on them if they do not wish to speak.

When asking about feelings (step 4), when one person mentions a symptom of stress the debriefer can ask "has anyone else experienced something similar?" When people nod, this helps the group to 'normalise' the symptoms for each other. It can be very reassuring for a participant to see that they are not the only one experiencing these sorts of symptoms – many others are too. In step 5 the debriefer provides information for the whole group. In step 6, different people can share ideas about things that they have found helpful in coping with stress, so that the group can learn from each other as well as from the debriefer.

©CHS Alliance 2018

CID with an individual

The CID procedure has been modified for use with individuals. When used individually, the debriefee should have the chance to say as much as they want to at every step before moving on to the next step. When discussing confidentiality, the individual should be told that they can tell others what happened during the debriefing if they want to, but the debriefer will not disclose what they said (apart from any exceptions to confidentiality such as abuse, as discussed earlier).

In individual debriefings, the debriefer will need to provide more information about symptoms of stress and ways of coping, which would otherwise have arisen from the group discussion. Handouts may be helpful in this regard, as a way of illustrating that other people have these symptoms too.

Comparing group with individual debriefing

An advantage of the group format is that group members have the opportunity to discover that other people are experiencing similar reactions. This helps them realise that they are not ‘weak’, but merely experiencing normal symptoms following an abnormal event. Groups of people with shared experience of trauma can be very supportive. Each person learns that they are not alone, and this can facilitate recovery.

A group debriefing can also help people to piece together what has happened, as they gain extra information from others who were present. This may help to dismantle negative beliefs such as “the problems were all my fault”. Group debriefing is much less time-consuming for the debriefer than conducting separate debriefing with each individual. In general, group debriefing can work well for teams who have worked closely together or people who were all involved with the same critical incident. Routine end-of-assignment debriefing can also be effectively conducted with a group (see below, section 18b and 18c). Even if the people have served in different parts of the world and with different organisations, there is usually a strong sense of connection when they meet with other people who have been doing humanitarian work . See Fawcett, 1999, for further insights concerning group debriefing.

There are also many situations when it is preferable to debrief an individual or a couple or family rather than a larger group. Sometimes a traumatic event was only experienced by one person. A humanitarian worker who has lef their assignment might want to receive debriefing related to an incident which took place, and this might only be possible as an individual debriefing. Some people feel uncomfortable speaking about personal matters in a group setting. If the members of a group do not trust each other or feel safe with each other, or if there are conflicts and problems within the group (including blaming and scape-goating or problems with the group leader), group debriefing may not be effective.

During an individual debriefing, there is more time available for discussion tailored to the needs of that one person, without them thinking that they should curtail their responses to allow time for everyone else to speak. Group debriefing can be harmful if participants feel traumatised by hearing disturbing details which they were not aware of, or if others in the group are overly negative and this is not addressed by the debriefer.

> “You know, I didn’t start feeling bad till we went over it in the group … I thought we had done a good job … should be proud. Now I guess I was wrong, and that bothers me a lot … I wish I hadn’t gone.”
> (Koval, 1987, cited in Armstrong, 2000)

©CHS Alliance 2018

When debriefing takes place in a group format, it is advisable to say at the end that individual debriefing is available for anyone who would like to receive it. While for many people group debriefing is sufficient, there are some for whom it is not adequate and an individual session is necessary.

Quotations from three returned aid workers:
"I found it difficult having the CID with the rest of the team and at the beginning I found it awkward and wasn't completely honest. By the end of the CID I perfectly understood why we did it as a team and saw the benefits of that – but would have valued just a small part of the time on my own."
"I didn't find my group experience helpful because although we had all been in the same general experience, we had not had the same experiences."
"I certainly appreciated (and preferred) the individual debrief – because one feels one can be more honest than with other relief team members."

©CHS Alliance 2018

18. Routine personal debriefing (not CID) after returning 'home'

Some humanitarian workers receive an 'exit interview' before they leave their assignment, and an operational debriefing afterwards. This gives them an opportunity to reflect both on their work and on how they feel about their experiences. This can be a useful way of ending off the assignment, but this should be in addition to structured personal debriefing (which is a much more thorough procedure), and not a replacement for it.

'Over-debriefing' people can reduce the value of debriefing as people can get fed up if they are debriefed too often. Some organisations expect staff to have an exit interview on the field, personal debriefing at the international headquarters and again at the national headquarters, an external personal debriefing with a psychologist and then debriefing from a supporting church or group! Such 'over-kill' should be avoided! One effective operational debriefing and one effective personal debriefing session (with follow-up as required) is sufficient and preferable to five 'debriefings' from well-meaning but untrained people. On the other hand, if someone has had an unhelpful debriefing session, they can be offered an additional session with a more experienced debriefer. The debriefer should know what type of debriefing has already taken place, and the humanitarian worker should be clear about the purpose of each debriefing session (e.g. exit interview, operational debriefing or personal debriefing). Excessive repetition and overlap should be avoided.

Most agencies which offer personal debriefing do so at their own headquarters, as this is where trained debriefers usually are. Personal debriefing includes discussion of how the humanitarian worker is readjusting after completing the assignment, and their future plans. Ideally, personal debriefing should take place between one and three weeks after completing the assignment. If this timing is not possible, personal debriefing can still be very helpful at another time point. If an assignment lasts over a year, an annual debriefing or debriefing on request should be offered.

It is possible to consider the whole humanitarian experience as a 'critical incident', and to use a modification of the CID structure for routine debriefing of returned humanitarian workers (see Armstrong, Lund, Townsend McWright & Tichenor, 1995 and Armstrong et al., 1998 on 'multiple stressor debriefing'). The focus should not only be on traumatic episodes. Day-to-day stresses should also be considered. A number of humanitarian workers have said that they found it a great relief to learn that their whole experience could be considered as a 'critical incident'. This helped them to understand why they developed stress-related symptoms (such as nightmares) although they had not experienced any particular 'traumatic incident'.

The following section should be read AFTER studying the above section on critical incident debriefing, as it is an adaptation and extension of the CID structure. The following section is not meant to stand on its own – much of the detail has been covered in the CID section and will not be repeated here. Handout 8 provides a summary of the following 10-step process. The handout can be used as a prompt during debriefing sections, so that debriefers do not feel they have to remember all the steps.

©CHS Alliance 2018

(a) Routine end-of-assignment debriefing for individuals

We recommend adapting the CID structure as follows for routine debriefing:

1. Introductions

Introduce yourself (and mention any relevant experience e.g. any humanitarian work); purpose of debriefing (to reflect on their experiences and say whatever they would like – this has been found to help prevent stress problems later); debriefing usually lasts about 3 hours – check what time they need to leave by. No report is written and it is **confidential** (with certain exceptions, see section 14).

Ask for some basic details about their humanitarian work, if you do not already know these – e.g. where they were, how long they were away for, what they were doing, and when they finished. (Ideally the debriefer should acquire this information prior to the debriefing.) Then invite them to give an overview of their time, by describing their experiences (in brief), and ask them to tell you if there is anything in particular which they would like to talk about during this debriefing.

2. Identifying what was most troubling

Some debriefers begin debriefing by asking about the positive aspects and then move on to the negatives. This is generally the wrong order, for a number of reasons. Firstly, for people who have had a difficult time, it can seem insensitive to ask about the positives. They may conclude that you will not understand the difficulties they experienced, and so decide not to talk about the difficult aspects. They may feel that their problems are belittled by you being overly positive. If, on the other hand, someone has had a generally positive experience, they are unlikely to mind if you explain that you will start by discussing any difficulties and then come on to the positive aspects. Another reason is that it is good to end the debriefing on a positive note, and so to leave discussion of the positives until nearer the end of the session.

So, step 2 involves identifying the most negative parts of the assignment. If the debriefee mentioned particular issues or difficulties or stressful experiences during the overview in step 1, say that you would like to spend time talking about each of these. Ask if there is anything else that they would like to talk about in more detail as well.

If no particular difficulties emerged during the overview, say something like, “As you look back on the whole experience, what was worst or most stressful or challenging for you – either specific events, or stressful parts of the experience? Can you just give me the headings and they we can talk about each of these aspects? ” Encourage them to pick out about three or four issues. If they say “on the whole it was a good time”, say that you are pleased to hear that and that you definitely want to hear about the positives, but that most people find it useful first to talk over the parts which were most challenging. If they seem uncertain, you can give examples such as: “It could be a particular incident or a disturbing sight which sticks in your mind. Or it might be that there was a relationship or communication difficulty. Or something to do with the job or the agency. For some people the main problem is overwork, and for other people it is boredom, or being expected to do things which weren’t on the job description or which you don’t feel equipped to do. Or it might be something to do with the culture or the living conditions. Or being so far away from friends and family. Or a health problem. Or something you regret.” In 15 years of debriefing, I have never come across anyone who did not have some negative aspects to talk about – providing that the question is posed in this way.

Be aware that even if they experienced a traumatic incident, this might not have been one of the worst parts of the experience for them. Many people can cope with occasional traumatic incidents

©CHS Alliance 2018

– humanitarian workers tend to be prepared for these. Often, the more stressful experiences are the ongoing, more personal problems such as a difficult relationship, deadlines, or overwork (see Lovell, 1997; Alexander & Wells, 1991). The table below shows the results of an anonymous survey in which 145 former humanitarian workers were asked the open question, “what was the worst part of the experience for you?” and the results were then categorised (Lovell, 1997).

Worst part of the humanitarian work experience

	% of respondents
Cultural frustrations	21.4
Relationship problems	17.9
Dissatisfaction with agency or work/ overwork	17.2
Missing home/problems at home	11.7
Traumatic incidents	7.6
Living conditions/health	6.2
Isolation	4.8
Returning home	4.8
Everything/no response	8.3

The category ‘dissatisfaction with agency or work’ includes issues relating to overwork. This is a common problem, and it is useful to ask specifically about this.

Quotation from a former humanitarian worker:
“I felt as if my life had ended and I just had to do things for other people, and I couldn’t do enough for them.”

Quotation from the blog of a humanitarian worker’s wife:
“We live in a street with no name, on the top floor of a villa with no number. We have no landline, no letter box, we live out of the city centre. I am sure, to a Westerner, not being assaulted by the phone ringing would be bliss, not having unwelcome callers would be nice, for a while. But picture day in day out being like that. It can get quite lonely. The phone never rings, no mail plops into our non-existent letter box, people don’t pop in when just passing. I can say ‘hello’ and ‘how are you?’ in Albanian but that’s about it with my neighbours.”
(www.paradiselostintranslation.blogspot.com)

‘Isolation’ covers issues to do with being single and alone, as well as general loneliness.

3. Facts, thoughts and feelings

Say that you would like to talk through each of the issues/stressful experiences which they have just identified. Ask them which one they would like to start with. Take this issue, and ask about the facts (“Could you tell me more about this? What are the details?”). Don’t rush – allow plenty of time to discuss the issue. This is the main part of the debriefing session. When they have discussed the facts

©CHS Alliance 2018

in full, ask what their thoughts have been about this issue. Then ask about their feelings about this – both during their assignment, and now.

Then do the same with each of the other issues. Don't rush!

4. Any other aspect you want to talk about?

After discussing all of the identified topics, ask if there is anything else that the individual would like to speak about. Give an opportunity to talk about issues which might not fit into the structure so well – e.g. problems with the organisation; unmet expectations; the fact that they were bereaved during the assignment, or any other factor. Sometimes people hold back the most important issues until they have 'tested the debriefer out' and found that they are a good listener, caring and non-judgmental. It may be only after building up a good relationship through talking about minor issues that they are able to disclose a more serious problem (such as their fear that they might be HIV positive, or a relationship they have had, or some other issue). It is important always to ask, "is there anything else that you wanted to talk about?" so that there is an opportunity to raise such issues.

Some people may choose to talk about spiritual or philosophical issues. Humanitarian work often raises questions about spirituality, world view, and the meaning of life. The debriefer does not need to provide answers, but can help by simply listening. In some cases, the debriefer might want to suggest that the debriefee finds someone else who they can meet with to continue exploring these issues.

5. Symptoms

Ask whether they experienced any stress-related symptoms at any point during or since their assignment. Give examples of such symptoms, e.g. tiredness; sleeping problems; nightmares; irritability; depressed mood; appetite changes; nausea; concentration or memory difficulties; flashbacks or finding themselves repeatedly thinking about what happened; trying to avoid thinking about their experiences; a change in their view of the world; guilt; sense of meaninglessness; anger; inability to relax; difficulty making decisions; tearful or unable to cry etc. (Use Handout 2 if you wish, *Symptoms of stress or trauma*. This handout is available in English, Spanish and French.)

6. Normalising and teaching

State that symptoms of stress are normal during humanitarian work and shortly afterwards and do not mean that they are over-reacting. Talk about coping strategies and ways to help reduce stress (e.g. allowing sufficient time to rest; exercise; doing things they find relaxing or enjoyable. See Handout 3, *Stress management strategies*; available in English and Spanish).

Some people feel guilty that they have not been able to cry, despite seeing people suffering. It is helpful to tell people that they do not need to feel guilty if they did not cry. At times of grief, people respond in different ways. Some cry, while others become very active and work out their grief by *doing* things (Martin & Doka, 2000). Neither response is better or worse than the other. Some people feel too upset to cry. When surrounded by poverty or suffering, some people become 'numb' to it and do not have any feelings towards the people who are suffering. This can be a healthy coping mechanism, as getting over-emotional can prevent one from being able to carry out the job.

Where there have been multiple stressors, they might not finish processing all of these during the debriefing. Encourage them to continue to process their experiences after the debriefing, and talk about how they can do this, and who they might talk with. Ask what support is available to them (e.g. friends, family). If they report medical concerns, recommend that they contact a doctor or a travel medicine clinic. They should make sure that they say where they have been working, as otherwise the doctor may not test for relevant tropical illnesses etc.

Case study: Why to use a doctor familiar with tropical illnesses
A student swam in Lake Malawi during a short-term mission overseas. On her return home, she went to her GP and said, 'I swam in Lake Malawi and now I'm worried about bilharzia'.
Her GP replied, 'Bill who?'.

Travel clinics such as Healthlink360 in Scotland (www.healthlink360.org) can provide expertise on tropical illnesses.

6. Return 'home'

Miss out this section if they are not returning 'home', e.g. local staff based near their home, or people debriefed mid-assignment

Quotations from two returned aid workers:
"The feeling of hollowness and absolutely gutted loss when returning to UK just doesn't bear thinking about. Quite literally the worst experiences of my life were leaving India."
"For some of us it is not a home-coming but the beginning of exile. We become displaced persons."

Examples of some of the frustrations associated with returning to the UK:
"A British computer engineer returning with his teenage daughters said: 'One of our biggest frustrations was being considered of no fixed abode by banks and anyone seeking credit ratings. The Royal Bank of Scotland was the only group who would take our French bank statements and offer a mortgage on the basis of them. It has taken a year before people start to consider us anything other than fly-by-nights.'
"A single lady who spent 30 years in various parts of North Africa and the Middle East as a radiographer complained: 'At the age of fifty-four, I couldn't prove my identity when I tried to hire a video'".
(Knell, 2007, p.47–48)

Ask how the return 'home' has been – but be aware that this may not feel like 'home' now. The following table shows the results of an anonymous survey in which 145 international humanitarian workers were asked to report their predominant feeling during the first few weeks after returning to their home country (Lovell, 1997).

	% of respondents
NEGATIVE FEELINGS	

©CHS Alliance 2018

Disoriented/confused/scared/strange	18.6
Devastated/bereaved/worst time in life	14.3
Difficulty readjusting	7.9
'Reverse culture shock'	5.0
Isolated	4.3
Frustrated with materialism	2.9
Like a fish out of water	2.9
Guilty	1.4
Sense of unreality	1.4
Exhausted and cold	1.4
POSITIVE FEELINGS	
Good/relieved	15.0
MIXED FEELINGS	
Mixed feelings	14.3
It was easier than expected	1.4
NO STRONG FEELINGS	
No strong feelings	9.3

It can be seen that about 60% of international humantarian workers report primarily negative feelings on return to their home country. Therefore, if the debriefee reports finding it difficult to adjust to being back home, they can be reassured that this is normal.

If they have not had many previous experiences of re-entry, discuss 'reverse culture shock' and readjustment processes. Prepare them for the fact that some people might not be interested in their experiences. Suggest that they may want to think of a short story to tell people who ask, "How was it?" More detailed responses can be saved for people who seem genuinely interested. (This is similar to the advice which soldiers are given during 'battlemind training' – Adler et al., 2009).

A handout about re-entry may be helpful (see Handout 1, *Coming home*).

> **Quote from a returned aid worker**
> "On returning home, you go from being a celebrity alien to just an alien."

Many people find it reassuring to learn that their responses are natural. Reading about other people's experiences of re-entry can be reassuring. For example, see the blog www.repatriatingtransitions.blogspot.com, or the books and websites at the end of Appendix 1.

©CHS Alliance 2018

You may also be able to direct them to other resources and useful information (e.g. in areas of finance and employment).

Ask about any current worries or questions. Many humanitarian workers who have been away for a period of years report feeling 'stupid' on their return home because they do not understand terminology or technology which has changed while they have been on assignment. For instance, humanitarian workers have told me about their puzzlement when asked "do you want cashback?" by a shop assistant, or when they read "must have experience with IT" in a job advertisement (referring to information technology). Some people who return to England find it helpful to watch soap operas such as 'Eastenders' to help them find out about current affairs! Others find such programmes irritating.

Example of finding returning to the home country puzzling:
"One person who came home to retire after thirty years overseas said to me: 'I came home to find that I had to get my electricity from the gas supplier, my phone from the television company, and my banking from the supermarket.'"
(Knell, 2007, p.153)

Some people have questions about how to sort out benefits or other financial matters, while others want to know how to find a National Health Service dentist in the UK. The debriefer does not need to know the answer to every question, but it is very useful if they can suggest someone who might be able to help, if they offer to find out an answer and let them know.

Returnees who dislike the amount that is wasted in their home country may appreciate information about ways to recycle items. For example, they may not have heard about schemes such as Freecycle which are becoming increasingly popular as a way to offer unwanted items to others in the local area, through an internet forum. Moreover, the former humanitarian worker can also use such schemes to request items. Many towns in the UK have thousands of active members in these schemes, and people regularly offer and receive items ranging from clothing to furniture, electrical equipment and plants. In 2018, the Freecycle network had over 9,290,000 members around the world. See https://www.freecycle.org/ for further information.

Some humanitarian workers value meeting up with other people who have also been humanitarian workers. They can be informed about any opportunities to do this. For example, some organisations arrange weekends for their returned volunteers. For information about free returned development workers' weekends for those returning to Ireland, see www.comhlamh.org.

For Christian workers returning to the UK, see www.penhurst.org.uk (look for 'new directions') or www.oscar.org.uk/service/training/reentry.

8. Positive or meaningful aspects

Debriefing has sometimes been criticised for focussing on negatives and 'pathologising' the experience. It is important to avoid this, and it is good to help the debriefee integrate the good and the bad parts of their experience by discussing both. After difficult experiences some people experience "post-traumatic growth" (Tedeschi et al., 1998) – that is, they come out even stronger and aware of the positives which have arisen through difficulties. Encouraging discussion of positive aspects can help to enhance this. Moreover, people who say that nothing positive has come out of the experience are at risk of developing depression (Lovell, 1997). Encouraging them to think of some of the positives may reduce the risk of later depression. In one study, over 70% of emergency workers reported that thinking about the positive aspects of their work had helped them to cope with

distressing and stressful work experiences (Alexander & Wells, 1991). A stressful and unpleasant assignment can be translated into a meaningful one (Lazarus & Folkman, 1984).

Ask whether there was anything positive about their experience, keeping this as an open question rather than "what was positive?" in case they feel that nothing was. Most humanitarian workers easily report positive aspects of their experience. These may already have emerged during the overview, in which case you could ask more about them, and ask what was best. Other questions which may be relevant are: "Was anything learned? Did you make any new friends? Were there ways (however small) in which you feel you helped someone or made a difference? Are you glad you accepted the assignment?"

It might be worth suggesting that they could write down (later) the aspects which they felt were positive or meaningful and the things they learned from their deployment.

If they appear to think that their humanitarian assignment was meaningless (which is rare), try to explore whether there were any positive or meaningful aspects at all (e.g. lessons the organisation has learned, or recommendations that could be made to help people in the future). Even after traumatic events people often report positive effects, such as the discovery that they are strong enough to cope with difficulties; closer relationships with people who have supported them, or realising the value of life and a desire to make every day count. Some people report spiritual growth and feeling close to God. Helping them to re-frame the experience as a meaningful one may assist in preventing future depression. If they remain entirely negative, professional help should be recommended.

> "What is significant … is that resilience can be cultivated, that the group can influence the individual, and that 'good company' can change the course of individual reaction from traumatic decline to traumatic growth."
> (Stuhlmiller & Dunning, 2000, p.317)

Good debriefing or counselling can be the 'good company' that helps change decline into growth. Debriefing can also encourage the debriefee to seek out other supportive people who will further enhance growth.

For information of how people generally respond to the question, "what was the best part of the humanitarian work experience for you?" the following table shows the results of an anonymous survey in which 145 returned humanitarian workers were asked this open question, and the results were then categorised (Lovell, 1997). Twenty-four percent of this sample reported that they were doing this work for reasons related to their faith (a 'call of God'), which may help explain the response 'being in God's will/seeing God work'.

Best part of the humanitarian work experience

©CHS Alliance 2018

	% of respondents
People; friends made	40.7
Work satisfaction	29.7
New culture and conditions	7.6
Personal development	4.8
The place/climate/simplicity	4.8
Being in God's will/seeing God work	4.8
Seeing my wife	0.7
Everything/no response	7.6

It may also be appropriate to ask people if anything has been positive about ending their assignment and, where relevant, returning 'home'. Asking if there is anything which they are grateful for can also be beneficial. People often talk about a new sense of gratitude for things they used to take for granted. They might be grateful for clean water from the tap; hot showers; having friends and family nearby; new friends made; meaningful work, and their health. Research suggests that there are many benefits in cultivating a sense of gratitude, so it can be worth asking the debriefee to reflect on whether there is anything which they are thankful for.

Reported benefits of gratitude
Stress resilience
More alert and enthusiastic
More energetic and optimistic
More progress towards goals
More exercise and better sleep
More forgiving and helpful to others
Better immune system/ less illness
Closer family ties
See Emmons, 2007

9. The future

Ask about future plans. Some humanitarian workers greatly value discussing their plans with someone who can bring an outside perspective. For example, they may feel under pressure to return to work immediately, or start a course, or to accept another assignment very quickly. This is especially the case if people keep asking "what are you going to do next", or if the organisation puts pressure on them to accept another position. They might value reassurance that they need time to rest before taking on further demands or making big decisions. Those who feel guilty about having some time off should be told that rest is strongly recommended after a humanitarian assignment.

It is normal to feel exhausted after completing a humanitarian assignment, especially if one tended to overwork. Failure to rest adequately can lead to significant health problems. My prescription is that, if possible, they should take at least two weeks' holiday for every six months spent in humanitarian work. So, after three years people should have three months off. It may not be financially possible,

especially for national staff, but giving permission to take a break can help them feel better about having at least a few days off! We would like organisations to consider funding this recovery time.

If they want careers advice, you may be able to tell them how they can access such advice – for example, see the following table.

Some career resources:

www.devnetjobs.org	DevNetJobs lists international development jobs
www.charityjob.co.uk	A charity job website, generally listing over 2000 vacancies
www.jobrapido.com	Collects jobs from hundreds of different sources. Includes search facilities for many countries around the world.
www.oscar.org.uk and www.christianvocations.org	These two sites list hundreds of mission vacancies, in the UK and around the world
www.chsalliance.org/files/files/Resources/Tools-and-guidance/career-development-management-resource-sheet.pdf	A list of career resources, from the CHS Alliance
www.devex.com	International development careers

Many people who have completed a humanitarian or mission assignment intend to stay involved in some way after leaving. The debriefing session can be a good opportunity to ask about such intentions, for example asking, "Do you intend to stay involved with the project, the people, organisation or the issues?" If they do, you can ask "How might you do that?" The aim is to help them turn good intentions into reality, and so continue to feel positive about the results of their assignment. There are many possibilities for staying involved, for example:

- Talking or writing about it and motivating others
- Keeping in touch with people they met
- Receiving updates about the project or place
- Reading communications from the organisation (magazine/website etc.)
- Attending conferences or reunions
- Going on another assignment
- Supporting those who are doing similar work (e.g. with fundraising, prayer, encouragement, practical help)
- Becoming a volunteer at home, perhaps providing information to others thinking of humanitarian work
- Getting involved with issues related to justice, fair trade, human rights, climate change, or other issues related to poverty
- Making friends with people from the same continent who live nearby.

Tell them how they can obtain further help (e.g. counselling or medication) if they want it, now or at any point in the future. If you think they would benefit from further help, make this a strong

recommendation and explain why you think it would be helpful. See appendix 5 for a list of some of the reasons to recommend professional help and information about how to find it.

Arrange to contact them for a follow-up conversation in about 2-4 weeks' time to see how they are doing.

Quotation from a returned aid worker:
"Debriefing made me aware of possible reactions to expect and it was reassuring to know that there was further help if needed."

10. Close

Summarise some of the important things which have arisen from the session (for example, remind them that their reactions are normal, and encourage them to try out anything which they have said helps them cope with stress). Ask them how they are feeling now. Affirm them and thank them for sharing their story with you, in some way that is genuine for you. (For example, "it has been a real privilege to hear about your work. It sounds like you have done a great job in difficult circumstances – I doubt that many people would have done as well as you did. Thank you for sharing so honestly with me".)

Follow-up

If you have arranged a follow-up conversation, make sure you record it in your diary so that you do not forget to contact them in about two weeks (or sooner if that seems more appropriate e.g. if they are experiencing difficulties).

As with the Critical Incident Debriefing follow-up (see above), you can arrange for the follow-up to be in person or by internet or phone. Areas to cover include:

- How have things been since we met for your debriefing?
- Have you thought of anything else you would like us to talk about, or any more questions you wish to ask?
- You mentioned that you were experiencing (*list any symptoms of stress they mentioned e.g. difficulty sleeping or concentrating; irritability; low mood; extreme tiredness).* Has that got any better or worse since we met? Have you noticed any other changes?
- You said that you were going to (*remind them of the things they intended to try to reduce stress e.g. exercise more; take a holiday; contact friends; explain to your boss why you have less energy; write down your feelings; listen to relaxing music).* Have you managed to do that yet? How has that gone?

If they are feeling worse or symptoms are persisting and getting in the way of normal life, they should be encouraged to seek further help (e.g. from their doctor).

If things seem to be going OK, remind them how they can contact you or get help if they want to in the future.

A debriefer does not need to provide answers. The purpose is to sit with the individual until they feel heard, they have begun to integrate their overseas experience into their life, and they have a sense of 'closure' to that experience and are ready to move on.

©CHS Alliance 2018

(b) Routine end-of-assignment debriefing for groups

As discussed in section 17 above, debriefing can take place in groups as well as on a one-to-one basis. The group may be composed of a team who worked together, or they may be people who were working in different parts of the world who have never met each other before but are united by the common bond of humanitarian work and the experience of adjusting to being 'home' afterwards. Group debriefing can help to break down the sense of isolation that is often felt when individuals return 'home'.

If the group is very small (e.g. two or three people), the same structure can be followed as used with individuals (see above). For larger groups, because of time constraints, it may be necessary in step 2 to ask each person to identify the single worst aspect of their experience, rather than three or four issues. Everyone should be given time to make their choice before anyone states their choice aloud. Then everyone should be asked to list their topic without at this stage discussing it; topics can be written on a flip-chart if one is available. It is important for the debriefer to explain that it does not matter if they choose the same issue as someone else. Once all the topics have been listed, the debriefer can suggest discussing them in a coherent order, e.g. grouping together similar issues.

Often people in the group find that the issues they would have chosen second or third are covered by someone else, so they do not miss out on hearing those aspects discussed as well as their first choice. The debriefer should remind the group that those who still have topics they want to discuss at the end of the debriefing will be invited to attend an individual debriefing later.

(c) Routine end-of-assignment debriefing for short-term teams

The above format can also been used for short-term teams. It should be remembered that a proportion of people struggle with feelings of depression and difficulty readjusting to the 'home' situation even if they have only been away for a matter of weeks or months.

However, it can also be reasonable to adapt the structure when debriefing short-term teams. If there have not been any apparent problems on the trip, and people are in good spirits, it can feel awkward to start by asking about the worst experience. Instead, a less formal approach might be taken, for example:

1. Introductions (as usual – purpose, confidentiality, etc.)

Then encouraging each group member to respond in turn to the following:

2. How was your time of humanitarian work? How did your expectations compare with reality?

3. Do you have any recommendations for the organisation about how they could have better prepared or supported you, or made it a better experience for you? *(This can help start people talking, and break down the defenses of people who might be worrying that debriefing is an attempt to expose their own 'weaknesses'. It suggests that the organisation may be willing to learn from them, and can help reduce any feelings of anger.)*

4. What was the worst part of the experience for you?

5. What was the best part for you? Do you have any funny stories to tell?

6. How have relationships within the team been?

7. How do you feel about being back 'home'? What sort of things have people said? Have your friends and family seemed interested? *(Provide information as appropriate about reverse culture shock; people not showing interest in details, etc.)*

8. How have you been feeling since getting back? Any tiredness / sleeping problems / irritability / impatience / headaches / pains / tearfulness / low mood / recurrent thoughts about it all / difficulty concentrating etc? (*Educate about normal reactions – see Handout 2.)*

9. What have you found helpful? What might help you to relax and adjust over the coming days? Who can you talk to – is there anyone who *is* really interested? *(See Handout 3 for ideas.)*

10. Who you can contact, if you want to talk things over in future (e.g. the organisation / GP / a counsellor)?

11. How can you use this experience in the future? How can you stay involved? How can you turn this into something that will influence your future life? (*Ideas e.g. joining a local fair-trade or justice group / ways to educate others about the country / opportunities to be a representative for*

©CHS Alliance 2018

humanitarian organisations / ways to give time, money or prayer support / publishing articles about this work, etc.)

12. Any concerns, questions, or anything else you would like to speak about?

Sometimes short-term groups are only allocated a very small amount of time for debriefing, e.g. at a 're-entry weekend'. When that is the case, it can be helpful to ask everyone the following simple questions:

1. What did you do?
2. What did you learn?
3. How is your life different now?
4. What *could* be different in the future because of your experience?

Because such a brief discussion does not allow time to describe difficult experiences while away or since return, it is important that individual debriefing is made available for those who want to take it up.

If more time is available (for example a whole weekend set aside for a reunion and debriefing), some teams enjoy using creative methods to help them reflect on their experiences. For example, they could start by considering a light-hearted question such as, "If you were going to write a book about your humanitarian experiences, what section(s) of the bookshop would it go in? For example: travel, adventure, romance, comedy, history, science fiction, biology, cookery, religion, music?". Or "what road-sign best describes your experience?" Another good ice-breaker is to ask each team member to bring an object or photo which in some way represents part of their trip, and to speak about it for a few minutes at the start of the session. This can also help prepare them to give a short summary of their trip to people who might be interested but not want to hear a lot of detail.

Other creative methods include recording team jokes; making a video or DVD (funny or serious) about the experiences; creating a picture, collage or a photograph album; writing songs, prayers or poems; listing memorable quotes and events. The team could choose 12 photographs to create a calendar as a reminder of their experience over the next year. They might not manage to produce the calendar themselves, but could choose pictures, and if they have taken digital photographs there are many companies who offer to use these to make a calendar. There are also opportunities to turn photographs into t-shirts, mugs, notebooks or other lasting reminders of their trip.

In addition, each team member could be asked to write a letter to themselves, as a reminder of any good intentions about how they plan to make their short-term trip have longer term benefits. For example, they might write to remind themselves to send copies of photos to the people they met, or to buy fair-trade bananas once a week. If possible, goals should be specific. The team member should seal the envelope and address it to themselves. The person organising the debriefing can collect the letters and post them three months later to remind people of their intentions. If an activity like this is planned, it should be clear that it is voluntary and that the letters will not be read by anyone else. Care should be taken to avoid making team members feel under pressure or guilty; the aim is to help them reach goals they wish to reach.

If time allows, team reunions can also be used as a time to train team members in the skills of giving presentations.

©CHS Alliance 2018

Ideally, the leaders of short-term teams can be trained to lead short 'debriefing' sessions regularly during the assignment. For example, a team serving for two months might meet for a couple of hours once a week to discuss together issues such as:

- How is everyone on the team feeling?
- What is going well?
- How is the task going?
- What is difficult/stressful/unpleasant?
- Suggestions for improvements and for tackling or coping with difficulties
- How are relationships?
- How is team morale and support? How can this be improved?
- What has been learned?
- What positive impact are they making?

Some teams debrief like this every evening.

'The debriefing time each night turned out to be the highlight of the trip!' (www.brigada.org).

More resources on short-term missions are available from www.shorttermmissions.com/articles.

©CHS Alliance 2018

19. Cross-cultural issues and national staff

(a) General issues

> "Humanitarian organisations should work to improve their performance in staff support and to reduce differential support practices for national and international staff."
>
> (IASC Guidelines on mental health and psychosocial support in emergency settings, p.86, www.humanitarianinfo.org/iasc/)

Expatriate humanitarian workers are not the only people in relief and development settings who can experience stress and might benefit from debriefing. National staff (and other local people) can also experience such symptoms, and may in fact be at higher risk. In one study, clinical depression was found among 54% of national staff, and PTSD among 34%. The figures for expatriate staff were considerably lower (15% appeared to have depression, and 13% PTSD; J. Fawcett, 2002, 2003). In another study, Lopes Cardozo et al. (2005) compared expatriate relief workers in Kosovo with Kosovar Albanian relief workers. National staff were found to have significantly higher rates of depression, PTSD and anxiety, and lower rates of alcohol abuse, than expatriate staff. The same researchers found that fewer than 3% of national staff received personal debriefing (Lopes Cardozo & Salama, 2002). Ager et al. (2012) found high levels of symptoms of depression (68%), anxiety disorders (53%) and PTSD (25%) among Ugandan humanitarian workers.

When considering whether debriefing should be offered to national staff or to local people from a non-Western culture (e.g. to a community which has experienced trauma through war or natural disaster), it may be useful to consider the following points.

Interventions which are offered in the Western world may be inappropriate in other settings (Bracken & Petty, 1998; Summerfield, 1999). However, when interventions are adapted for the local culture, they may be very helpful (Dyregrov et al., 2002). The definition of what is 'traumatic' may vary from one society to another. For example, in some cultures the destruction of religious symbols is perceived as traumatic (Terheggen et al., 2001), whereas in other cultures it is not. Where war is seen as a matter of religious significance, the death of a relative in the war front may be experienced as a triumph and not a trauma (De Silva, 1993). A Korean friend said to me, "For you, a dog dying may be traumatic. For me, it may be an item on the menu!"

In some cultures, rape victims and their families are considered shameful, and the victim may even be put to death if the rape is disclosed. To offer the victim an opportunity to talk about the rape might terrify them. Even if the issue is not sexual assault, there may be a reluctance to disclose intimate material outside a close family setting (Summerfield, 1999). There may also be a major stigma associated with seeking any help associated with mental health, and debriefing may be regarded in this category. For example, in certain parts of Sudan, if a man is known to have had 'mental health treatment', his sisters will be unable to marry as the family will be labelled as 'mentally unstable' and regarded as having bad genes. This naturally makes people resistant to receiving psychological support. As well as ensuring absolute confidentiality for anyone who does receive support, and trying to educate the community about the nature of debriefing (so removing the stigma), it can be helpful to find out who people in this culture *do* talk to. There may be an elder, a wise man, a grandparent or friends who can provide a helpful listening ear without any stigma being attached. For those who are literate, writing down thoughts and feelings may also be beneficial.

In parts of Latin America, it may be necessary for a debriefer to build a relationship with a debriefee before they will feel free to talk, as people do not talk intimately where there is no relationship. It may

©CHS Alliance 2018

be helpful to have a meal together to chat before debriefing, and for the whole debriefing experience to be less formal.

In some environments, people may reject offers of psychological support because their main concerns are for food, housing, safety and education or employment. They may feel angry that resources are being 'wasted' in offering psychological support when they need help with more practical matters first.

When 'specialists' are brought in to 'help' people after a disaster, local methods of coping are sometimes swept aside. This can leave people feeling devalued. In subsequent occasions of distress they may feel less able to take initiative and support each other. In contrast, when local people are encouraged to believe that they can do something for themselves, and their ways of coping are validated, they are likely to feel empowered, enthusiastic and more hopeful about the future. As long as the practices are not harmful (physically, psychological or spiritually), it may be beneficial to encourage people to use the resources which are already available to them, offering any additional resources to supplement these rather than replace them.

Although personal debriefing has been used in a variety of cultures, empirical research on its effectiveness in non-Western cultures is sparse. If it is decided that debriefing should be offered in addition to local means of support, one should discuss its appropriateness first with people from that culture. It is important to consider whether the process needs to be modified in order to make it culturally appropriate. It is helpful if at least one of the debriefers is familiar with the culture of the person who is being debriefed. If the debriefer is not from the relevant culture, they should at least try to gain an understanding of the culture in advance – including finding out about such issues as the use of eye contact, how to address people (are first names acceptable?), personal space (how close should we sit?), touch, and humour. It may be essential for the debriefer to be the same gender as the debriefee. Age may also be important – in cultures which esteem older people, it might be considered insulting to offer an older person debriefing from a much younger debriefer.

In some cultures, decisions (for example concerning further help) tend to be made by a group rather than by an individual. Some cultures find the concept of individual debriefing difficult to grasp, as such matters are discussed in groups, not one-to-one.

> "North American trauma processes are most likely to focus on talking as the road to healing. A major source of healing is in the internal thinking processes of an individual, which is then externalised in verbal conversations with a mental health professional. Healing is an individual achievement gained through this process. By contrast, many African healing processes focus on the group or the community. Talking is not necessarily the preferred activity and can be viewed as unnecessary or even counter-productive. Physical actions such as dance, massage, walking and fasting may underlie many approaches to healing. Healing of an individual is not seen as the primary objective. Healing of the community, family or even the whole people group is what is required."
> (J. Fawcett, 2003, p. 221–222)

Having said this, it is important to remember that cultures change over time. Both group and individual debriefing have been used successfully in many parts of Africa, as well as throughout Asia and Latin America. It is important that we continue to ask people what support they would like, rather than make assumptions. Awareness that the support for national staff may need to be different from the support given to expatriate staff is no excuse for ignoring the needs of national staff, which happens all too often.

©CHS Alliance 2018

National staff of NGOs routinely report finding their work stressful, just as international staff do. Their list of stressors is, however, somewhat different. For example, Ager et al. (2012) studied stress among Ugandan humanitarian workers in Gulu. The most common sources of stress are shown in the table.

Percentage of Ugandan humanitarian workers reporting moderate to extreme stress from various chronic stressors

Stressor	%
Economic/ financial problems	86
Workload too high	65
Unequal treatment of expatriate and national staff	59
Feeling powerless to change situation of beneficiaries	58
Separation from close relatives	57
Uncertainty if peace will continue	53
Lack of recognition from management	50
Conflict between co-workers	44
Travel difficulties / restrictions	43
Lack of direction by management	40
Assigned duties out of professional training	39
Excessive heat, cold or noise	39
Lack of recognition from beneficiary community	33
Armed security necessary	23

In a study involving three NGOs in Nicaragua, local staff reported that the most stressful parts of their work were (with number 1 being the most stressful):

1. Job insecurity
2. The work is upsetting
3. The need for more training to do the work (especially language; computer; technical skills; finances)
4. Health concerns
5. Too much work
6. Inadequate pay
7. Relationship problems within the team
8. The work causes stress e.g. having to make difficult decisions
9. Inadequate equipment or resources to do the work
10. Too little work
11. Friends and family don’t understand the work
12. Communication problems
13. The hours worked (start and finish times) cause a problem

©CHS Alliance 2018

14. The work is too boring
15. Role ambiguity
16. Difficulties due to different languages or cultures within the team
17. Team changes too often
18. Work is dangerous or bad for health
(Lovell-Hawker, 2006)

Job insecurity was also reported to be the top cause of stress among national staff in Bangladesh. Bangladeshi staff also listed financial problems (inadequate pay), accommodation difficulties and family dislocation as major causes of stress. Female fieldworkers were more adversely affected than their male colleagues (Ahmad, 2002).

In West Africa, national staff report stress related to the violence of war; economic stress; problems getting education for their children; and over-work (Carr, 2006). In India, national staff reported high levels of secondary traumatic stress (Shah, Garland & Katz, 2007).

Staff of a Christian NGO in Sudan (during the conflict in Darfur of 2006) listed their top 10 causes of stress as follows (Lovell-Hawker, 2006):

Staff from North Sudan	**Staff from South Sudan**
1. Injustice	**1.** Comprehensive Peace Agreement (CPS) implementation
2. Poverty	**2.** Darfur peace agreement
3. Discrimination (in team)	**3.** High bride price
4. Provocation	**4.** Polygamy
5. Insecurity	**5.** Insecurity
6. Lack of time management	**6.** Death of leaders
7. Weather (seasons)	**7.** Termination from jobs (job insecurity)
8. Communications (radios, emails, languages)	**8.** Divorce
9. Family issues	**9.** HIV/Aids and bird flu
10. Getting required permits	**10.** Work load, and traffic jams at rush hour

©CHS Alliance 2018

Staff from Kenya, Sierra Leone and Eritrea working in Sudan	British staff working in Sudan
1. Environment; climate	**1.** No church
2. Language	**2.** Relationship problems (team and family)
3. Culture (e.g. dress)	**3.** Being away from home
4. Security	**4.** Workload / work hours
5. Cross-cultural issues	**5.** Different ways of working
6. Homesickness	**6.** Language
7. Communication (e.g. phone)	**7.** Culture
8. Negative feedback on work	**8.** Lack of familiar leisure
9. Absence of church / spiritual support	**9.** Insecurity
10. Long working hours and days	**10.** Frustrated plans; restrictions; bureaucracy; environment; food; guilt; concerns; unmet expectations

These are some of the issues which may be discussed in debriefing sessions. It might be noted that the national Sudanese staff reported more 'wider issues' (rather than just work-related issues) as stresses than did expatriate staff – for example referring to injustice, poverty, peace agreements and family problems. People from 'holistic' cultures do not tend to separate their life into compartments such as 'work' and 'the rest of life'. Debriefers should try to be aware of this.

While some westerners do not feel comfortable talking about private matters unless they have privacy, in certain Eastern cultures the opposite is the case, and people do not feel safe to talk unless their relatives or friends are present. Group debriefing may be more appropriate than individual debriefing. The composition of the group may have to be considered carefully, taking issues of hierarchy or caste into account. For instance, in Nepal a *'peon'* (e.g. a cleaner) will not feel able to speak out if their programme manager is in the same group.

When debriefing is offered, the debriefer should ensure that everyone understands the purpose of debriefing. For instance, in some Asian cultures if people disclose a deep problem they expect the listener to 'fix it' for them – but debriefing does not promise to do that. There is also a need to be sensitive to any religious beliefs and practices. For example, will the debriefee need to have a break during the session to adhere to their prayer time? Is it a day of fasting, in which case it may be insensitive to offer a drink?

In some traditions, people will not cry in front of others or discuss their feelings openly, as this may be perceived as a criticism of God's will, or believed to weaken the family in their struggle to survive. In Bali, grief is muted because it is believed that emotional agitation will impede the journey of the deceased, and prayers for the deceased will not be heard unless they are spoken calmly (Rosenblatt, 1993). A Burundian proverb states, "a man's tears flow on the inside" – that is, they should never be seen. When debriefing someone who holds such a belief, it would not be helpful simply to say "crying is useful and normal", as they may conclude that the debriefer is either foolish or a liar. The individual may, however, find it helpful during the 'teaching' stage to consider the health benefits of crying (see

©CHS Alliance 2018

Lutz, 1999). This should occur as a discussion, rather than a monologue from the debriefer. The debriefer should make every effort to understand the views expressed and not cause offence.

In certain cultures, vengeance is routinely sought after a perceived 'wrong', and forgiveness is regarded as a weakness. Again, it might be possible to gently explore these ideas during the teaching stage. It is useful to be aware of any relevant rituals which may be observed in a culture, for example rituals concerning bereavement. Such rituals may be very helpful (Lovell, Hemmings & Hill, 1993). Some communities use story-telling, plays, dance or music to express emotions (Blomquist, 1995). It is also useful to know what it is people try to avoid doing. For example, it may seem natural to suggest walking as a means of reducing stress and tension. In Nepal, however, such a remark might be seen as unhelpful, because many people perceive walking as a sign of poverty and something to be avoided. Encouraging team sports may be more acceptable.

One should also be aware of the normal stress-related symptoms in the particular culture. For example, in El Salvador people talk about suffering from '*nervios*' (describing nervousness, anxiety, fear, anger, bodily pains, shaking and trembling), and '*calor*' (meaning heat, which they describe as intense heat passing through the body either for a short period or for several days, and not restricted to menopausal women) (Jenkins, 1996).

Some cultures do not even have a word for 'depression' or 'guilt', while in others showing anxiety causes loss of face, so emotional distress is translated into physical pain. For instance, people might talk about headaches, abdominal pain and feeling weak rather than discussing emotional pain (Rack, 1982). Buddhists may present with generalised feelings of hopelessness which appear similar to depression but are not, because Buddhism implies that "hopelessness lies in the nature of the world" (see Terheggen et al., 2001). When suffering is accepted as an all-pervasive presence in the world, one can feel hopeless without being distressed, because of the attitude of acceptance.

It is helpful to try to understand what people perceive as the cause of different symptoms. For example, Blomquist (1995) discovered that some Liberians who experienced flashbacks or other intrusive thoughts believed that their enemies were using supernatural forces to cause them to feel as if they were re-experiencing a painful event. It helps if the debriefer is aware of such beliefs.

Debriefers should always try to find out in advance what sources of follow-up support and professional help are available in the area. It is unethical to raise expectations of further help when no such assistance is available. If there really is no possibility of on-going support, one should question whether debriefing should be offered at all. Even if there is a possibility of professional help, such help may be considered unacceptable if it is based on a world-view which is not in harmony with the beliefs of the individual.

J. Fawcett (2002) has described how local staff in Honduras were offered appropriate and effective support in coping with stress after Hurricane Mitch. This approach included conducting an assessment of the needs of local staff; providing information about stress and trauma and their management, and discussing what stress looked like in their culture and traditional methods of reducing or coping with it. Organisational and individual stress were both considered. Similar procedures may be effective in other parts of the world. Evaluation is especially important after debriefing in a new context, as we should seek to learn from each new experience.

©CHS Alliance 2018

The use of debriefing in South Africa: a case study
"The KwaZulu-Natal Programme for Survivors of Violence makes an interesting case study of the use of [personal debriefing] in a different cultural context. It is a non-profit NGO which aims to rebuild the social fabric of communities most severely affected by violence in that province. Debriefing in this context is utilised … offering small groups the opportunity to discuss various issues affecting their communities following exposure to traumatic events … The sessions are often held in the community, perhaps in one of the community leaders' home. There may be more than one session … debriefing is adapted to suit the needs of the community and would appear to be informal and semi-structured, utilising narrative and story-telling."
(Regel & Courtney-Bennett, 2002)

In summary, we should consider the needs of national staff as well as expatriates, and we should be aware of cross-cultural differences when debriefing anyone who is not from our own culture (see Regel, Joseph & Dyregrov, 2007, for further discussion and references on this topic). Many national workers appreciate personal debriefing and find it helpful, although it may need to be adapted for them. But in some instances, debriefing may not be appropriate, and alternative forms of support should be provided.

For further information, see the manual *Supporting staff responding to disasters: Recruitment, briefing and on-going care* (Lovell-Hawker, 2011), available from www.chsalliance.org/files/files/Resources/Tools-and-guidance/Supporting-staff-responding-to-disasters-recruitment-briefing-and-on-going-care.pdf.

Debriefing should ideally be in the first language of the person who is being debriefed. Even when someone is relatively fluent in a second language, the most effective processing of emotional issues occurs in the mother tongue. If an interpreter is to be used, they should be selected very carefully (see below).

©CHS Alliance 2018

(b) Advice for working with interpreters

1. Select carefully. Ideally, the interpreter should be:

- acceptable to the person being debriefed (e.g. ethnic group and gender)
- skilled and sensitive in interpreting
- a patient listener
- able to cope with hearing and repeating distressing information
- not currently suffering from personal loss or trauma
- preferably not a friend or relative of the person being debriefed (as it is best to have a neutral, objective interpreter who is not involved with the situation).

2. Aim to develop a good working relationship with the interpreter.

3. Before the session, explain what you plan to do so that the interpreter knows what to expect.

4. Explain that it is important to interpret as directly as possible, without adding or subtracting or re-phrasing anything, as the actual words used can be very significant.

The most common mistakes interpreters make include changing open questions into leading questions, altering the content of questions, and adding their own comments (Price, 1975). Ask them to speak in the 'first person' when interpreting. Be aware that some words do not have an exact translation, and ask them to tell you if they are having difficulty translating a word. (For example, it is difficult to find an equivalent for 'depression' in some languages.)

5. Keep questions and remarks clear and concise.

6. Ensure that the interpreter is clear about confidentiality, and accepts this. They should sign a document promising to maintain confidentiality.

7. Explain that silence can be very helpful, and if there are silences they should not feel they need to repeat a question or 'push' the debriefee to respond.

> "I asked for an interpreter but I was misunderstood. Instead they provided an interrupter."

8. If the interpreter knows more about the client's culture than you do, let the interpreter know if you would like them to explain any cultural issues that emerge.

If they do, make sure they let you know what information they are providing themselves rather than translating.

9. Consider where everyone will sit, so that you can all see each other easily. Remember to introduce the interpreter to the debriefee.

10. Allow twice the usual time for the debriefing, to allow for interpreting.

11. After the session, make time to debrief the interpreter – they may feel distressed by what they have heard.

©CHS Alliance 2018

If the interpreter is accompanying the debriefer for a period of time (e.g. interpreting in different locations during a visit), try to find ways to socialise or have fun with them between sessions, providing some light relief between the heavy work of interpreting.

For further information, see *Working with interpreters: Guidelines for psychologists* available as a free download at https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Working%20with%20interpreters%20-%20guidelines%20for%20psychologists.pdf.

See also Van der Veer (1995) and Baker (1981).

(c) Useful resources in languages other than English

See Appendix 2B and 2C for symptoms of stress in Spanish and French, and Appendix 3B for stress management strategies in Spanish.

Websites which provide useful information in languages other than English include:

www.headington-institute.org

Includes free online training modules covering a range of subjects including trauma, stress and resileince. Some are available in Arabic, French, Portuguese, Spanish and Russian.

www.famillejetaime.com

French resources for helping families.

20. Children

(a) After a traumatic experience

It is common to attempt to shelter children from distress by trying not to mention concerns in front of them. Adults tend to underestimate the intensity and longevity of traumatic events on children (Dyregrov et al., 2002). When a family has been involved in a traumatic or stressful experience, even young children can pick up that something is wrong. It is much more frightening for them to know that something is the matter but not know what (allowing their imagination to run riot) than for them to hear about what is happening and share their own thoughts and feelings. Parents should try to resolve any tensions that occur between themselves, as children can sense tension and worry about it. Often children blame themselves for bad things happening, if there is no-one to reassure them that it is not their fault.

It is good to include children in discussions about difficulties or changes, and to allow them to ask questions. Parental consent should be obtained before other people work with their children. For general guidelines on how to listen to children and teenagers, and how to talk to them, see Faber & Mazlish (1999; 2005).

Discussions with children do not have to occur in a formal debriefing setting. In fact, it is generally better to create an informal space (e.g. sitting on beanbags, sofas or the floor). It helps to have an

> "For children to 'play out' their experiences and feelings is the most natural dynamic and self-healing process in which children can engage. Play is a medium of exchange and restricting children to verbal expression automatically places a barrier to a therapeutic relationship by imposing limitations that in effect say to children 'You must come up to my level of communication and communicate with words.'"
> (Landreth, 1991, p.10)

©CHS Alliance 2018

attractive room with suitable pictures and toys in. Young children can be given an opportunity to draw what has happened, or act it out with toys or puppets, and to share their feelings. It is important to consider what is best for each child. A fun book for helping young children to identify feelings is *How are you peeling: Foods with moods* (Freymann & Elffers, 2004).

Parents should be given information about reactions children commonly have after trauma (see below), and should receive support in helping their children (see Richman, 1995). It is important to re-establish a sense of security and routine (e.g. a bedtime routine, a school routine, clubs or sports, family prayer times). Children sometimes feel guilty about their reactions. They should be given permission to cry or not to cry, and to play or not to play, without feeling bad about their reaction. If they are upset by their strong feelings, then can be reassured that “the bad feelings won’t last for ever, they will go away over time”. Try to limit activities that may cause anxiety (e.g. television news; scary programmes or stories).

Parents can be taught ‘warning signs’ which would indicate the need for further help, and what to do if they notice these (see Appendix 5). It is essential to take note of such ‘warning signs’, because children, as well as adults, can suffer from disorders such as post-traumatic stress disorder (PTSD) or depression, which require professional intervention. In fact, research suggests that traumatic events experienced before age 11 are three times more likely to lead to PTSD than events experienced after 12 years of age (Davidson & Smith, 1990).

When possible, try to allow children to complete activities which they have begun (e.g. a game, or making something). This gives the child the sense that things can be finished and achieved, and restores a sense of hope, control, predictability and security. This is especially important if the child feels that they had no control over major decisions (e.g. the decision to move), and if they had to leave before finishing their school or completing activities which they had looked forward to (e.g. a sports event, graduating from school or a celebration).

Older children and adolescents may benefit from sharing in a family debriefing, and may also appreciate a separate debriefing away from their parents. (The parents should also be offered time to talk without the children being present if there are sensitive or distressing details which the children do not need to hear, or which the parents are unwilling to mention in front of the children.) If children are to be involved in a family or group debriefing, it is helpful to have someone available to look after them if it appears appropriate for them to leave at any point.

The child, parents and organisation should agree with the debriefer about what feedback, if any, will be given so that everyone is clear about confidentiality. The debriefer should also explain to the child, in appropriate language, why they are meeting with them. Otherwise the child may think that they are being questioned because they have done something wrong, or they may worry that the debriefer will take them away from their family or not allow them to see their friends again. The debriefer’s explanation can be simple, e.g. “I heard about the nasty thing that happened, and I would like to help you. I talk to a lot of children who see nasty things, and try to help them feel a bit less bad. We can talk about what happened, and I can let you know things that might help you feel a bit better”.

Dyregrov (1991) has written about how to adapt the critical incident debriefing procedure for use with children. Yule (1992) found that children who had received critical incident debriefing reported fewer fears, less avoidance and fewer intrusive memories five months after a disaster than children who were not debriefed. Similarly, Stallard and Law (1993) reported that debriefing greatly reduced the distress of seven girls who survived a school bus crash. For adolescents who have experienced a traumatic event together, a group debriefing may be the most helpful intervention.

Children can be asked questions such as:

- Where were you at the time of the event?

©CHS Alliance 2018

- What happened?
- How did it happen?
- Why do you think it happened?
- What were your thoughts and feelings – then and now?
- What did you do to help yourself?
- What have others done to help you?
- What would you like to happen now, to help you more?

Any rumours or incorrect beliefs can be dispelled. Children should be told that their responses are normal and understandable reactions to stress. (See below for common effects of trauma on children.)

Every child is different, and so their individual needs should be considered when deciding what kind of support might be best for them. Supporting the parents is almost always the most important factor, as they will then be better able to support the child. When children receive an individual debriefing, it should only last for as long as they are able to concentrate. Johnson (1993) suggests that debriefing for pre-school children should generally last only 15–30 minutes. Children between the ages of five and 11 may benefit from a 30–60 minute session. Eleven-to-14-year-olds cope with 45–90 minute session, and above the age of 14 the usual two-hour (or longer) debriefing is recommended. Some children find it easier to talk while walking around and this should be allowed. If someone who the child already knows and trusts (e.g. a teacher) has been trained in debriefing, they might be the best person to work with the child.

Children can be taught simple steps they can take to help them cope with their reactions. For more details, see the manual *Children and disaster: teaching recovery techniques* (Smith et al., 1999), and the work of the children and war foundation (www.childrenandwar.org).

Children should not be forced to talk, or be emotionally 'suffocated' by people who want to help. Some children, and most teenagers, also need 'private space' where they can be alone, undisturbed.

Effects of trauma on children

- May show sadness
- May lose interest in normal activities
- May lack energy and concentration or have memory problems
- May withdraw from people
- May become hyperactive or display anger or disobedience
- May return to earlier patterns of behaviour e.g. bed-wetting; clinging; crying a lot; thumb-sucking; their school work may deteriorate
- May stutter or become mute
- May have difficulty sleeping, have bad dreams, or scream while asleep
- May have a loss of appetite and headaches, stomach-aches etc.
- May have anxiety and fears (e.g. of darkness, or being separated from parents)
- May act out traumatic events in play or art
- May have repetitive, intrusive thoughts about the experience
- May try to avoid thinking or speaking about the experience, and avoid people or places associated with it
- May be especially upset when they lose something (e.g. a toy or a book)
- May expect to die young, and so not make any plans for the future
- May feel guilty (e.g. that they are alive when others have died, or that they did not stop a bad experience from happening)
- May have a heightened alertness to possible danger (e.g. be unwilling to travel by plane)

©CHS Alliance 2018

- May take unnecessary risks (e.g. riding a bicycle very fast; going for long walks alone). This may help them to feel brave in the face of danger
- Older children may use alcohol, drugs or self-harm to try to block out the pain.

"One child from a war-torn land, when asked to smile for the camera, said 'I don't know how to'."

"Many children are relieved to learn, not only that there is an explanation for how they feel, but also that they are not the only ones experiencing what may be to them rather strange reactions and that they are not going mad."
(Yule, 2003, p.180)

Some suggestions on how to help children presenting with specific trauma reactions (taken from the website of the Community Stress Prevention Center in Israel)

Reaction	Emotional Symptoms	Treatment
The child clings to his parents all the time	Is not prepared to stay on his own. Is not prepared to go to kindergarten or school.	Return the child's self-confidence. Be with him as much as is possible, talk with him to calm him down. Keep to a normal daily routine.
Eating problems	Lack of appetite, sickness, spitting.	Do not force the child to eat, do not fight with him. Keep to regular times for meals and regular eating habits. Do not worry. A healthy child will request food of his own accord.
Personal hygiene problems	Regression in toilet behaviour.	Do not get angry or get involved in a struggle with the child, it will only increase the tension. Talk with the child to calm him down. Help him to establish regular toilet times.
Night fears	Fear of being alone in the dark, of going to bed at night, of waking up and of nightmares.	Be with the child when he is afraid, by his bed, not yours. Try to keep to fixed bedding times. Try not to give sleeping tablets except under medical advice. Talk with the child about his fears.
Physical discomfort	Stomachache, headaches.	Be with the child, play or talk with him about his fears. Consult the doctor but do not give any medication without a prescription.
Aggression	Physical aggression towards family members and others. Aggression and stubbornness in order to overcome feeling helpless.	Talk with the child and encourage him to express himself. It is important to let the child understand that there is a limit to his requests and his aggression. An angry child must be stopped and firmly made to calm down. He should be allowed the chance to express his fears and anger through drawing, acting or in words.

©CHS Alliance 2018

Reaction	Emotional Symptoms	Treatment
Concentration difficulties	Thumb-sucking, more intense masturbation, stuttering or tics.	Do not be afraid of the phenomenon, do not make threats or punish. Calm the child. With stuttering or tics one should consult an expert (doctor or psychologist).
Other difficulties	Difficulty in focusing concentration on one thing, confusion, boredom, not knowing what to do or what to play with.	Give the child short, simple, clear tasks to return him slowly to balance.

Useful books for helping children with specific problems

Sleep problems

Quine, L. (1997). *Solving children's sleep problems.* Beckett-Karlson.

Anxiety

Spence, S., Cobham, V., Wignall, A. & Rapee, R. (2000). *Helping your anxious child: A step-by-step guide for parents.* New Harbinger Publications.

Anger

Whitehouse, E. & Pudney, W. (1997). *A volcano in my tummy: Helping children to handle anger*. Gabriola Island BC: New Society Publishers.

Trauma

Alexander, D. (1999). *Children changed by trauma*. Oakland, CA: New Harbinger Publications.
Herbert, M. (1996). *Post-traumatic stress disorder in children*. Leicester: Blackwell BPS books.
Kilbourn, P. (Ed.). (1995). *Healing the children of war.* Monrovia, CA: MARC.

Grief

Dyregrov, A. (1991). *Grief in children: A handbook for adults.* London: Jessica Kingsley.
Goodall, J. (1995). *Children and grieving*. London: Scripture Union.
Heegaard, M. (1991). *When something terrible happens: Children can learn to cope with grief (drawing out feelings).* Woodland Press.
Mundy, M. (1998). *Sad isn't bad.* Indiana: Abbey Press.

Difficulties in 3–8-year-olds

Webster-Stratton, C. (2006). *The incredible years: A trouble-shooting guide for parents.* Seattle, WA: Seth Enterprises.

In addition, information about helping children cope with war and terrorism is available at www.aacap.org (search for "Terrorism and war: how to talk to children").

For further information about how to help children effected by *mass* trauma (e.g. a terrorist attack or war), see Webb (2004). The most important factor can be keeping the children with their parents, if this is at all possible, and helping the parents to cope, as this will help to reassure the children.

Quotation from a six-year-old child of missionaries
'When I'm angry I need to have a cold shower. It cools me down on the outside and the inside."

©CHS Alliance 2018

Teachers should be informed about any difficult events that a child has experienced, so that they can be patient and supportive towards the child.

If a child appears to be experiencing significant problems following a traumatic event, it is important to refer them on for further help. The family doctor may be able to refer them to a psychiatrist or a clinical psychologist. An international list of therapists who work with Third Culture Kids (TCKs) is available from www.internationaltherapistdirectory.com. For more information about when and where to obtain professional help, see Appendix 5. Further information about common childhood mental health problems is available from www.aacap.org and www.rcpsych.ac.uk. Teenagers who have concerns about relationships, sexuality and sexual health can obtain information from www.loveforlife.org.uk.

(b) Routine debriefing for children on return 'home'

Children who spend a significant part of their developmental years in a culture which is not their parents' home culture are known as 'Third Culture Kids' (TCKs).

When a family has returned home after a period of humanitarian service with no traumatic incidents, it can be helpful to include the children in a family debriefing, or (for older children) to debrief them individually or with other children. Some children reveal aspects of the culture which they disliked, even though they may not have been through identifiable traumatic incidents. For example, they may have struggled with constantly being stared at, or feeling different to those around them. Or they may have felt that their parents were so busy with their humanitarian work that they had no time for the child. They may have found it hard to make friends, or they might have suffered grief because so many of their friends were also expatriates and moved away. The poverty around them may have distressed them. Others loved the host culture and do not want to come 'home' to their parents' culture. Each child will have a different story which should be listened to.

Quotation from a missionary father regarding his sons Andrew and Paul:
"[The language school] did not realise that we had two children. We were in a very small room. Andrew had to sleep on a shelf in the cupboard, and Paul's carrycot occupied all the floor space … The children were cared for at a language school nursery in a nearby garden. Andrew hated it and cried whenever we left him. It was after several days … that we discovered that the nursery attendant was tethering him to a bench for the day, so that she did not have to keep running after him."

(Webster, 2007, p.45)

Moving can be stressful in itself, as a report from The American Academy of Child and Adolescent Psychiatry (1999) makes clear:

Quotation from The American Academy of Child and Adolescent Psychiatry (1999):
"Moving to a new community may be one of the most stress-producing experiences a family faces. Frequent moves or even a single move can be especially hard on children and adolescents. Studies show children who move frequently are more likely to have problems at school. Moves are even more difficult if accompanied by other significant change in the child's life, such as ... loss of family income, or a need to change schools."

Children can be helped to explore the similarities and differences between the cultures they have lived in. It can be helpful to divide a piece of paper in four and ask them to write or draw what they like and dislike about the culture they lived in and the culture they are now living in. They can also be asked

©CHS Alliance 2018

about their feelings about leaving friends (and perhaps places and possessions they have loved); and their attempts to adjust to life in a new culture and make new friends. They may have strong feelings (perhaps of anger or grief). They may be encouraged to tell their story in a creative way, for example through drawing, puppets, music, clay or play-dough; creating a collage; making a 'time line' of their life; writing a poem or song; making a photo album, scrapbook, or memory box; or choosing objects which symbolise their experiences. It is also helpful to contact them before the debriefing to ask them to bring some 'treasures' with them, which they have brought back from 'their' country. These might be photos or special objects from their time in another country.

During debriefing, children can be asked what sort of things help them when they are feeling unhappy. They might want to pack a rucksack with helpful things to remind them of their coping strategies. For example, they might put in their bag photos of their friends, a notebook they can draw their feelings in, a toy they like to cuddle, a ball to play with, a drawing of a safe place they like to go to and a book they enjoy reading. When they feel sad they can open the rucksack to remind them of things which might help them feel better.

More detailed information about debriefing TCKs can be found on the website www.globalconnections.co.uk (click on 'Forums' and select 'Third culture kids forum' then 'Forum papers').

Poem by a Third Culture Kid

Wings and roots

They recommend
You give a child roots
When young,
And wings,
When older.

You gave us wings
When we were born,
So that we could find our roots
When older.

Yet roots will always beckon
Wings to settle down,
And wings resist
The thought of chains.

So born with wings
The natural drive to fly
Will always prevent
Roots from growing deep

(Hannah Tow)

One family decided that they would each choose an object which symbolised how they had felt when they first returned 'home', and also how they were feeling three months later.

The nine-year-old boy selected a leaf and a rock: 'The leaf is how I was when we first got here. I was fragile; anything bad could rip me to shreds (demonstrated dramatically). But now I have good friends and I'm a rock. It would take a miracle to break me.'

His 11-year-old brother chose a back-scratcher: 'I picked this because it's boring, and I'm bored. I can't do the things I used to do in (country X). Besides it has pieces missing, just like me.'

Their father picked the *Handbook of Style*: 'I feel I am constantly being evaluated, that I have to put every comma and capital in exactly the right space. The year seems like one long job interview.'

The mother put a glue stick in a fruit bowl: 'I don't fit in.'

Foyle (2001), Pollock and Van Reken (2009) and Knell (2001) provide some useful guidance on helping children and adolescents with such transitions. Pollock and Van Reken also list organisations which provide support for children in this position (these children being known as 'Third Culture Kids' or TCKs). Roman (2000) provides discussion starters and activities to help young children process their move and learn about their new culture. Quick (2010) offers guidance for TCKs who are returning to their parents' culture to begin university.

Books for children on relocation

Schubeck, C. (2000). *Let's move together.* Orange, CA: SuitCase Press.
Dyer, J. (1998). *Harold and Stanley Say Good-bye.* Australia: MK Merimna.
Ballard, R. (1994). *Good-bye, House*. New York: Greenwillow Books.
Williams, K.L. (1991). *When Africa was home.* New York: Orchard Books.
Howlett, B. (1993). *I'm new here*. Boston: Houghton Mifflin.
Roman, B.D. (2000). *Let's move overseas.* Wilmington NC: B.R. Anchor Publishing.
Weber, B. (1998). *Ira says good-bye.* Boston: Houghton Mifflin.
Fritz, J. (1982). *Homesick – My own story.* New York: Yearling.
Brammer, D. (1994). *Peanut butter friends in a chop suey world.* Greenville SC: Bob Jones University Press.
Gray, N. (1988). *A country far away.* New York: Orchard Books.
Cadnum, M. (1997). *The lost and found house.* New York: Penguin.

See also the websites www.branchor.com and www.tckworld.com for more book recommendations.

It should be remembered that the place which is considered 'home' by the parents may not be perceived as 'home' by the children. In fact, most TCKs feel that they do not really fit in anywhere – they have no real 'home'. For older children, it can be a source of great frustration when other people constantly refer to them as having 'come home', when in fact they are now in a foreign country. Children who have grown up outside their parents' home culture often gravitate towards other children who have also lived abroad. They can benefit from attending holidays which are organised especially for children who have returned from living abroad. For details about events in the USA (known as 're-entry seminars', taking place over several days) see www.interactionintl.org/home.asp. In the UK, highly successful summer holidays are organised for the children of missionaries; see www.globalconnections.co.uk and choose 'events'. Children who have been home-schooled may especially benefit from camps, as they can help them to socialise with other children who have had similar experiences. One camp leader found that some home-schooled children did not know how to play practical jokes until they attended a camp! Learning how to play with other children may help reduce the risk that they will be bullied if they enter school in their passport culture later.

If there is no opportunity to link up with other TCKs in person, it is worth looking for an 'online community' through a TCK website such as www.tckworld.com. These websites are useful while the families are on assignments as well as when they return to the passport country. Websites can provide a sense of continuity between these two 'separate lives'.

Other websites on TCKs

1. www.oscar.org.uk/service/children
2. Other relevant websites are listed at the end of Handout 1.

Many TCKs want to remain in contact with their friends in other countries. Social networks can help in this regard.

Be aware that TCKs who return to their home country may be bullied by other children. See www.bullying.co.uk for advice about bullying.

Quotations from TCKs
"How many times can you have your heart torn out without finally dying?" (Anonymous, in Knell, 2007, p.95)

"I knew how to drive; I didn't know how I had to do a driving test." (Anonymous)

It is important to bear in mind that many TCKs are very positive about their childhood experiences in different cultures and also adjust well if and when they move to their parent's culture (Pollock & Van Reken, 2009). Many become mature, well-adjusted, sociable and likeable adults, and a significant number are also high achievers. We should not assume that they will develop problems. During a debriefing, they should be given an opportunity to express aspects about their lifestyle which they regard as positive, as well as any which they regard as negative or a challenging. The box below gives examples of positive things some TCKs have said.

Positive quotations from TCKs, about their lifestyle
"There's a beauty in experiencing new places."
"I made great friends that last forever even though they live so far away."
"Travel and living in another country gave me a broad view of life."
"Infinitely more exciting than my contemporaries in the UK."
"Cultural awareness improves job opportunity."
(Knell, 2001, p.28)

21. Debriefing media personnel

"Covering wars and disasters can be traumatic for journalists, but they're often either unaware of the impact, or unwilling to admit it. The effect is likely to be greatest on photographers, reporters and producers on the scene, but even in newsrooms far from the disaster area, the stress of longer-than-normal hours and repeated exposure to graphic video can take a toll. Research shows that trauma can have serious, long-term effects on a journalist's ability to function."
(www.newslab.org)

Media personnel (researchers, journalists, photographers, camera teams, etc.) covering disasters and traumatic stories have a particularly difficult job to do. While other people may be exposed to a distressing image or story on a single occasion, media personnel may have to see or hear it again and again, as they edit their work and decide what material to present to others. They may feel guilty about seeking out other people's suffering to report, and guilty at *not* selecting some stories.

"It is increasingly recognised that media professionals can be personally affected by reporting on traumatic events. This can happen even when a journalist has covered such stories for many years and has not been overly distressed by them before."

(www.responseability.org)

Debriefing for media personnel can follow the standard format, but the debriefer should be particularly aware of the possibility that vivid images or sounds may be experienced as ongoing flashbacks. Issues related to guilt should also be considered, and the debriefee should be assured that their reactions are normal. Some feel that they must be uncaring people because they can do their work without being distressed by it. They can be reassured that this can be a normal response to the job they have to do.

"Surgeons have to learn to overcome the natural instinct not to hurt someone. In the same way journalists who cover suffering, violence, and disaster must overcome some natural instincts if they are to do their jobs well."

(www.poynter.org)

Because the culture of journalism is a 'macho' one, journalists can feel embarrassed to admit to any difficulties. They may find it helpful to read the experiences of other journalists and relevant research, showing that trauma responses are normal. Appendix 9 lists websites for media personnel.

©CHS Alliance 2018

22. Debriefing at a distance (e.g. by phone or internet)

There are many advantages to face-to-face debriefing. It can be easier to show empathy and warmth when sitting with the person who is being debriefed, and it is also easier to pick up cues from body language. Many people feel more comfortable when a conversation is face-to-face and appreciate the personal contact. Silences feel less awkward in a face-to-face setting than when on the phone. Face-to-face debriefings are generally longer than 'remote' debriefings, and this extra time tends to be helpful.

It can be more difficult to catch and understand every word when debriefing by phone/internet (e.g. due to accents, a poor line, volume or background noise). Do the benefits of remote debriefing outweigh the problems, even if you only hear a third of what is said, and have no non-verbal feedback to provide extra cues? If it is possible to find a local debriefer who can meet with the person face-to-face, that might be more effective than remote debriefing. This is especially true for people who feel uncomfortable with phones/ technology and value face-to-face relationships – which is the case in many cultures. Appendix 5 gives some suggestions for finding local debriefers.

However, sometimes there is no debriefer nearby. In such cases, debriefing by internet or telephone may be an acceptable alternative. Some people regard this as 'a lifeline' during a difficult time. It can be cost-effective and time-efficient, as travel is unnecessary. Avoiding transport is also better for the environment, especially when flights would have been involved for a face-to-face meeting. Research on therapy by internet or phone indicates that it can be effective (e.g. Mohr, Ho, Duffecy et al., 2012; Cassels, 2012).

Remote debriefing can have various different formats:

- Speech only (e.g. by telephone or an internet programme without using a webcam. These programmes include Skype (www.skype.com), Google+ (http://plus.google.com/), Zoom (https://zoom.us/) and Vsee (http://vsee.com). There are many others. For brevity, I will use Skype as an example as this is frequently used by humanitarian workers).
- Seeing and hearing each other (e.g. videoconference or using a webcam with a programme such as those mentioned above).
- Written text such as email or a 'chat' programme (e.g. Skype chat, or MSN Messenger).

Different people prefer (and have access to) different options. Some people are more open when communicating by phone or internet than they are face-to-face. Some locations don't have fast enough broadband speed to allow high-quality visual contact, and so it can be better to use speech-only communication, or even written text. On the other hand, if there is a good quality webcam option, body language can be picked up and it can feel almost like being with the person. Here are some issues to consider before offering remote debriefing:

1. Do you have sufficient training / experience to offer remote debriefing? In addition to training in general debriefing, there are some special skills when working by phone or internet. There are relevant training courses and books such as Jones & Stokes (2009) and Rosenfield (1997). Although these books refer to counselling, many of the issues are also relevant for debriefing. *'Guidelines for online counselling and psychotherapy'* are available for free download from www.bacp.co.uk. *'Guidelines for telephone counselling and psychotherapy'* can be purchased from the same website.

2. Are you insured to provide remote services? For example, do you hold professional liability insurance which covers working worldwide? Some therapists in the USA are only licensed for an individual state, and are not licensed to provide therapy outside that state, including by telephone or internet.

3. What are the risks to security and confidentiality? Can you ensure that no-one else can access the information? Do you encrypt messages and use secure email addresses? In high-risk security settings, do you need to use a password so that both sides can be confident the person they are speaking to is genuine?

Most therapists licensed in the USA will not use Skype for therapy, because it is not compliant with the Health Insurance Portability and Accountability Act (HIPAA). They state that all Skype chat messages are the property of Skype and are stored on a Skype server, compromising patient confidentiality. There are HIPAA-compliant alternatives, including Skype for business (which costs money), and Zoom and VSee, but people are often unfamiliar with these. Skype is often more secure than email, as it encrypts both login details and content. Email is stored on servers and is the property of the internet service provider. Phone calls can also be intercepted.

If using Google+, be careful not to name more than one person in a 'circle'. If you do, one of the others within that group could join your conversation.

A VPN encrypts internet data and can prevent anyone from 'hearing' your conversations (which may be especially useful if using wireless internet) – see www.uk2.net/vpn.

It is good to be aware of confidentiality concerns and to inform potential clients of any risks. Many humanitarian workers and missionaries use Skype, phone and email routinely. In the author's experience, many are happy to use them for debriefing as well, as they believe the benefits outweigh the small risk that someone else could access the conversation. For further discussion of Skype and confidentiality, see Hawker & Hawker (2016).

4. Remote debriefing may work best with people you have met before (e.g. during a briefing).

5. Decide whether a webcam will be used at either or both ends of the conversation, and find out if both parties are happy with this arrangement. A webcam can add non-verbal communication clues, which is helpful, but it may also slow the connection down so much that it interferes with the conversation. Some people use the webcam for introductions during the first few minutes (which may assist rapport at the start), but then switch it off to reduce delays. Other people are satisfied with speaking to a photograph on the screen. Asking both sides to download a photograph can be better than talking to a blank screen. Humorous pictures can be unhelpful during serious conversations.

6. The session should be set up clearly and well: Who will initiate the contact, and at what time? Be aware of any difference in time zones. If using the internet you may wish to avoid 'peak' times of day when the internet is likely to be slower. Who covers any cost of the call? What will happen if the call can't get through or lines are cut off – is there a back-up (e.g. by telephone or email – ensure you have contact details)? This is especially important if the line is cut off at a crucial point (e.g. when the person has just disclosed something very upsetting) – can you contact them by some other method to respond to what has been said?

7. Be clear about your confidentiality policy, and the exclusions to it, just as in a face-to-face setting.

8. Both parties should treat this appointment with as much importance as if it was a face-to-face contact. Use 'do not disturb' notices to avoid interruptions, and ensure there is privacy and quiet at both ends (as much as possible). Aim for comfort at both ends too, with water and tissues available, and comfortable chairs and temperature. If speaking by phone, a headset might assist comfort during long calls.

©CHS Alliance 2018

9. Silences are more awkward on the phone/ internet than when speaking face-to-face. People may wonder whether the debriefer is still listening. The debriefer should allow silences, but also give plenty of indications that they are still paying attention (e.g. 'mmm'; 'that sounds really difficult', 'it's OK to take your time, just pause for a bit if you need to', or summarising what has been said, etc). However, if there is a bad echo or speaking breaks up the flow due to a delay, 'mmms' may need to be kept to a minimum!

10. Be aware that the debriefee might hear if you are typing, or even writing, notes as you go along. This can give the impression that you are not concentrating on what they are saying.

11. Check that the debriefee understands what you are saying, especially if you cannot see their expression for clues. If you use abbreviations (or 'text language' when typing), check that they understand. If you do not understand abbreviations they use, ask. If you want to use emoticons in text, check first whether they like them, as some people find them irritating. If you are typing your communication, check that it is not full of errors, as that would suggest you are not taking them seriously or you feel too busy to give them sufficient time.

12. Don't worry if remote debriefing is shorter than the standard face-to-face debriefing. 60–90 minutes is not unusual for a remote debriefing session.

13. At the end of the debriefing, be clear about follow-up. It is recommended that the debriefer initiates the follow-up, which is generally about 2-4 weeks after the debriefing (depending on need). Tell them when you will contact them again, and how (e.g. email or phone).

14. Using (secure) email to summarise the session afterwards can be a useful reminder of key points, and can help to clear up any misunderstandings. This is especially useful if you think some key messages might not have been understood (perhaps due to a bad line, or different accents). Some people also use written comments (e.g. the 'chat' function) to supplement during the session if there are difficulties understanding what is said. Using this too much can disturb the flow of the debriefing, but occasional use might be helpful.

15. If you are debriefing a group and can't see them, ask each person to say their name when they speak (unless you are sure you recognise each voice). Consider asking the group to pass one microphone around and switch off any other microphones, as this might improve the clarity of what you hear.

16. Be clear in advance what you will do if you have serious concerns about the person you are debriefing (e.g. if you detect a risk of suicide, or if they appear to be in a state of psychosis or otherwise highly vulnerable). Before the session, consider who can reach them quickly if they need urgent help (e.g. is there a partner, colleague or someone from another organisation nearby who can assist until professional help is available?) Do you know how to contact the nearest hospital or health service? If they are in severe danger, you may need to over-ride confidentiality and take action to ensure their safety. You can let them know that you will do this. Who do you need to inform (e.g. their line manager)?

As phone debriefing had gone on for about an hour before the debriefer discovered that she was speaking to a man, not a woman as she had assumed from the voice. Learning point: check the gender before you start!

©CHS Alliance 2018

23. Care for the debriefer

Hearing about difficult experiences can leave debriefers with 'secondary trauma', 'vicarious trauma' or 'compassion fatigue'– that is, they may feel traumatised or emotionally drained by the things which they have heard. Hearing about the worst things that go on around the world can leave an impression that the world is an awful place and people cannot be trusted. This is a biased picture, as we can also hear many stories about wonderful people and events. It is important to retain a sense of balance.

Debriefers need to take care of themselves by:

1. Not offering debriefing when they are under significant stress or experiencing grief themselves.
2. Recognising their limitations and boundaries, and being willing to refer people on for further help when required. The debriefer should not feel responsible for 'fixing everything' and making everyone feel better.
3. Not taking it personally if the debriefee displays anger during the debriefing. This is probably a symptom of the debriefee's stress.
4. Having a break after debriefings (for at least 30 minutes), as they can be emotionally draining.
5. Having someone available to off-load onto after debriefing. Without breaking confidentiality, they should be able to talk about how they have been affected by the debriefing,
6. Receiving supervision and support. Both individual and peer supervision sessions can be very beneficial.
7. Limiting the number of debriefings they conduct to a number which does not feel draining to them. This will vary from person to person and depend on what they do during the rest of their time.
8. Recognising when they themselves are showing signs of stress, and routinely doing things which help them to cope with stress (see Handout 3).
9. If desired, working alongside another debriefer, especially if debriefing a group of people.

For further information on this topic, see Figley (1995). Information and help on secondary trauma can also be downloaded free from www.headington-institute.org (click on 'Online training' and select 'trauma').

©CHS Alliance 2018

24. Conclusion

(a) The package of care

Debriefing by itself is not enough to ensure that humanitarian workers are adequately cared for. Debriefing should be seen as just one component of a whole package of care (Gamble, Lovell, Lankester & Keystone, 2001). The package is sometimes referred to as Critical Incident Stress Management.

Part of the package of care is Psychological First Aid (PFA) which should be offered after any traumatic incident. Like medical first aid, PFA provides initial support, until further help (if it is needed) arrives. PFA may include ensuring safety; helping people to contact family members; providing food and shelter and other practical help; offering comfort and reassurance; listening; and providing information. A major aim is to help reduce arousal, as this will reduce the likelihood that the person will develop post-traumatic stress later (Dyregrov & Regel, 2012). A free manual on this topic, from WHO, can be downloaded from http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf.

For humanitarian workers, the package of care should include:

- Careful selection and placement
- Adequate training (including about the relevant culture; culture shock; conflict resolution; negotiation skills; problem-solving; working in teams, etc.)
- Medical preparation (vaccinations etc.)
- Security briefing / training (including teaching on do's and don'ts to increase safety, and written contingency plans to be followed in the case of evacuation, hostage taking or other crises – see Goode, 1995)
- Briefing / training on dealing with stress and critical incidents (as preparation for adverse experiences can reduce the adverse effects of trauma; see Alexander & Wells, 1991)
- Support while on assignment
- Psychological First Aid following any traumatic incident
- Critical Incident Debriefing if needed
- Preparation for return 'home'
- Debriefing 1–3 weeks after return 'home'
- Follow-up
- Continuing care / referral for further help if required
- Support for the family should also be provided, if applicable.

These issues are covered in the manual *Supporting staff responding to disasters: Recruitment, briefing and on-going care* (Lovell-Hawker, 2011), available at www.chsalliance.org/files/files/Resources/Tools-and-guidance/Supporting-staff-responding-to-disasters-recruitment-briefing-and-on-going-care.pdf.

The package of care should be considered as a fundamental part of policy planning and as a way to increase general staff well-being and improve programme effectiveness. The CHS Alliance aims to promote good practice in the management and support of international humanitarian personnel, which includes such a package of care. The Core Humanitarian Standard (CHS) is a useful tool for agencies wishing to strengthen their commitment to staff in this vital area. See www.corehumanitarianstandard.org.

©CHS Alliance 2018

25. Summary

Humanitarian workers are at risk of experiencing traumatic events and on-going experiences of stress and change. Studies which have suggested that critical incident debriefing might be ineffective had serious methodological flaws. Research specifically with aid workers indicates that personal debriefing can help to reduce stress-related symptoms.

A structured form of debriefing is recommended. A structure for Critical Incident Debriefing and a structure for routine debriefing are presented in this manual.

Final tips for debriefers:

1. Maintain confidentiality (unless there is a duty to disclose e.g. suicide risk or abuse/ safeguarding issue)
2. Be a good listener
3. Show warmth, and affirm the debriefee for the things they have done well
4. Use a structure, such as the one described above
5. Do not rush the debriefing process
6. Reassure that symptoms of stress are normal
7. If symptoms seem severe (e.g. clinical depression or PTSD), recommend professional help (and know how this can be accessed)
8. Tell the debriefee how they can get further help in future should they want it (e.g. if symptoms of stress persist or become worse)
9. Offer a follow-up communication a few weeks after the debriefing, to check how things are
10. Take care of yourself, by receiving regular support and supervision and additional training if you feel that would be useful.

©CHS Alliance 2018

References and resources

(a) References

Adler, A. B, Castro, C. A. & McGurk, D. (2008). Time-driven battlemind psychological debriefing: A group-level early intervention in combat. Military Medicine, 174, 22-28.

Adler, A.B., McGurk, D., Bliese, P.D., Hoge, C.W. & Castro, C.A. (2009). Battlemind debriefing and battlemind training as early interventions with soldiers returning from Iraq: Randomization by platoon. Journal of Consulting and Clinical Psychology, 77, 5, 928-940.

Ager, A., Pasha, E., Yu, G., Duke, T., Eriksson, C. & Cardozo, B.L. (2012). Stress, mental health, and burnout in national humanitarian aid workers in Gulu, Northern Uganda. Journal of Traumatic Stress, 25, (6), 713.

Ahmad, M.M. (2002). Who cares? The personal and professional problems of NGO fieldworkers in Bangladesh. Development in practice, 12, 2, 177-191.

Alexander, D. A. & Wells, A. (1991). Reactions of police officers to body-handling after a major disaster: a before-and-after comparison. British Journal of Psychiatry, 159, 547-555.

Alexander, D. W. (1999). Children Changed by Trauma. Oakland, CA: New Harbinger Publications.

American Academy of Child and Adolescent Psychiatry (1999). Children and family moves. AACAP Handout 14. Online at www.aacap.org.

Arendt, M. & Elklit, A. (2001). Effectiveness of psychological debriefing. Acta Psychiatrica Scandinavica, 104, 423-437.

Armstrong, K. (2000). Multiple stressor debriefing as a model for intervention. In B. Raphael & J. P. Wilson (eds.) Psychological debriefing: Theory, practice and evidence. Cambridge: Cambridge University Press pp. 290-301.

Armstrong, K. R., Lund, P. E., Townsend McWright, L., & Tichenor, V. (1995). Multiple stressor debriefing and the American Red Cross: The East Bay Hills fire experience. Social Work, 40, 83-90.

Armstrong, K. R., Zatzick, D., Metzler, T., Weiss, D. S., Marmar, C. R., Garma, S., Ronfeldt, H., & Roepke, L. (1998). Debriefing of American Red Cross personnel: Pilot study on participants' evaluations and case examples from the 1994 Los Angeles earthquake operation. Social Work in Health Care, 27, 33-50.

Baker, N.G. (1981). Social work through an interpreter. Social Work, 26, 391-397.

Beck, A. T. & Steer, R. A. (1987). Beck Depression Inventory Manual. San Antonio: Psychological Corporation, Harcourt Brace Jovanovich Inc.

Bilinda, L. (1996). The colour of darkness: A personal story of tragedy and hope in Rwanda. London: Hodder & Stoughton.

Bilinda, L. (2006). With what remains: A widow's quest for truth in Rwanda. London: Hodder & Stoughton.

Bisson, J. I., Jenkins, P. L., Alexander, J., & Bannister, C. (1997). Randomised controlled trial of psychological debriefing for victims of acute burn trauma. British Journal of Psychiatry, 171, 78-81.

Blomquist, C. (1995). A community of care: ministry to children in war. In P. Kilbourn (Ed.), Healing the Children of War (pp. 215-224). Monrovia, California: MARC.

Bracken, P.J., & Petty, C. (Eds). (1998). Rethinking the Trauma of War. London, England: Save the Children/ Free Association Books.

Brewin, C.R., Rose, S. & Andrews, B. (2003). Screening to identify individuals at risk after exposure to trauma. In R. Orner & U. Schnyder (Eds.) Reconstructing early intervention after trauma: Innovations in the care of survivors. Oxford: Oxford University Press. pp. 130-142.

British Psychological Society (2002). Psychological Debriefing: Professional practice board working party. Leicester, UK: BPS.

Busuttil, W. (1995). Interventions in post traumatic stress syndromes: Implications for military and emergency service organisations. Unpublished M. Phil thesis, University of London.

Campfield, K.M. & Hills, A.M. (2001). Effect of timing of Critical Incident Stress Debriefing (CISD) on posttraumatic symptoms. Journal of Traumatic Stress, 14, (2), 327-340.

Carr, K. F. (2006). The Mobile Member Care Team as a means of responding to crises: West Africa. In L. Barbanel & R. J. Sternberg (Eds.), Psychological Interventions in Times of Crisis. New York: Springer Publishing Company.

Cassels, C. (2012). Telemental Health Dramatically Cuts Psychiatric Hospitalization Rates. The American Psychiatric Association's 2012 Annual Meeting, Abstract SCR10-3, presented May 6, 2012.

Chemtob, C.M. (2000). Delayed debriefing: after a disaster. In B. Raphael & J.P. Wilson (eds.) Psychological Debriefing: Theory, practice and evidence. London: Cambridge University Press, pp. 227-240.

Chemtob, C., Tomas, S., Law, W. & Cremniter, D. (1997). Post-disaster psychosocial interventions: a field study of the impact of debriefing on psychological distress. American Journal of Psychiatry, 154, 415-417.

Danieli, Y. (2002). (Ed.) Sharing the front lines and the back hills – International protectors and providers: Peacekeepers, humanitarian aid workers and the media in the midst of crisis. New York: Baywood Publishing Company.

Davidson, J. & Smith, R. (1990). Traumatic experiences in psychiatric outpatients. Journal of traumatic Stress Studies, 3 (3), 459-475.

Deahl, M.P., Srinivasan, M., Jones, N., Neblett, C. & Jolly, A. (2001). Evaluating psychological debriefing: Are we measuring the right outcomes? Journal of Traumatic Stress, 14, 3, 527-529.

Department of Health (2001). Treatment choice in psychological therapies and counselling. London: Crown. (At www.doh.gov.uk).

De Silva, P. (1993). Post-traumatic stress disorders: cross-cultural aspects. International Review of Psychiatry, 5, 217-229.

Donovan, K. (1992). The Pastoral Care of Missionaries. Lilydale: Commodore Press.

Dyregrov, A. (1989). Caring for helpers in disaster situations: psychological debriefing. Disaster Management, 2, 25-30.

Dyregrov, A. (1991). Grief in children: a handbook for adults. London: Jessica Kingsley Publishers.

©CHS Alliance 2018

Dyregrov, A. (1996, March). The process in critical incident debriefing. Paper presented at the European Conference on Traumatic Stress in Emergency Services, Peacekeeping Operations and Humanitarian Aid Organisations, Sheffield, England.

Dyregrov, A. (1997). The process of psychological debriefing. Journal of Traumatic Stress, 10, 589-606.

Dyregrov, A. (1999). Helpful and hurtful aspects of psychological debriefing groups. International Journal of Emergency Mental Health, 3, 175-181.

Dyregrov, A., Gupta, L., Gjestad, R. & Raundalen, M. (2002). Is the culture always right? Traumatology, 8, 3, 135-145.

Dyregrov, A. & Regel, S. (2012). Early interventions following exposure to traumatic events: Implications for practice from recent research. Journal of Loss and trauma, 17, 1-21.

Dyregrov, K. (2004). Bereaved parents' experience of research participation. Social Science and Medicine, 58, 391-400.

Ehlers, A. (1998, December). An experimental study of exposure to traumatic memories. Paper presented at the meeting of the European Society for Traumatic Stress Studies, Oxford, England.

Ehlers, A. & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. Behaviour Research and Therapy, 38, 319-345.

Ehlers, A. & Clark, D.M. (2003). Early psychological interventions for adult survivors of trauma: A review. Society of Biological Psychiatry, 53, 817-826.

Ehlers, A., Mayou, R. A., & Bryant, B. (1998). Psychological predictors of chronic posttraumatic stress disorder after motor vehicle accidents. Journal of Abnormal Psychology, 107, 508-519.

Emmons, R. (2007). Thanks! How the new science of gratitude can make you happier. Geneva, IL: Houghton Mifflin Harcourt.

Eriksson, C.B., Vande Kemp, H., Gorsuch, R., Hike, S. & Foy, D.W. (2001). Trauma exposure and PTSD symptoms in international relief and development personnel. Journal of Traumatic Stress, 14, 205-212.

Esterling, B. A., Antoni, M. H., Fletcher, M. A., Margulies, S., & Schneiderman, N. (1994). Emotional disclosure through writing or speaking modulates latent Epstein-Barr virus antibody titers. Journal of Consulting and Clinical Psychology, 62, 130-140.

Everly, G.S., Boyle, S.H. & Lating, J.L. (1999). The effectiveness of psychological debriefing with vicarious trauma: a meta-analysis. Stress Medicine, 15, 4, 229-233.

Everly, G.S. & Mitchell, J.T. (1999). Critical incident stress management (CISM) – a new era and standard of care in crisis intervention, 2nd edition. USA: Chevron Publishing Corporation.

Everstine, D.S. & Everstine, L. (1993). The trauma response: Treatment for emotional injury. New York: WW Norton & Co.

Faber, A. & Mazlish, E. (1999). How to talk so kids will listen and listen so kids will talk. Collins: 1999.

Faber, A. & Mazlish, E. (2005). How to talk so teens will listen and listen so teens will talk. Collins: 1999.

Fawcett, G. (1999). Ad-Mission: The briefing and debriefing of teams of missionaries and aid workers. Harpenden, England: Self-published.

©CHS Alliance 2018

Fawcett, J. (2002). Care and support of local staff in Christian humanitarian ministry. In K. O'Donnell (ed.) Doing Member Care Well: Perspectives and practices from around the world. Pasadena, CA: William Carey.

Fawcett, J. (2003). Stress and Trauma Handbook. Monrovia, CA: World Vision.

Figley, C.R. (Ed.) (1995). Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized. New York: Brunner / Mazel.

Foa, E. B. & Kozak, M.J. (1986). Emotional processing of fear: Exposure to corrective information. Psychological Bulletin, 99, 20-35.

Foyle, M. (2001). Honourably Wounded: Stress among Christian Workers. Second Edition. London: Monarch Books.

Foyle, M. (2003). Debriefing. Personal communication.

French Blaker, L. (2007). Heart of Darfur. London: Dodder & Stoughton.

Freymann, S. & Elffers, J. (2004). How are you peeling: Foods with moods. New York: Scholastic.

Gal, R. & Mangelsdorff, A. D. (Eds.). (1991). Handbook of Military Psychology. Chichester, England: John Wiley & Sons.

Gamble, K., Lovell, D. M., Lankester, T., & Keystone, J. (2001). Aid workers, expatriates and travel. In J. Zukerman & A. J. Zukerman (Eds.), Principals and Practice of Travel Medicine. Chichester, England: John Wiley & Sons.

Gardner, L. M. (1992). Crisis intervention in the community. Chapter 10 of Missionary Care, Ed. K. O'Donnell & M. L. O'Donnell. California: William Carey Library.

Global Connections (1997). Code of best practice in short-term mission. London, England: Global Connections. Available online at www.globalconnections.co.uk.

Goodall, J. (1995). Children and Grieving. London, England: Scripture Union.

Goode, G. S. (1995). Guidelines for crisis and contingency management. International Journal of Frontier Missions, 14, 211-216.

Greenberg, N., Thomas, S.L., Iversen, A., Unwin, C., Hull, L. & Wessely, S. (2003). Do military peacekeepers want to talk about their experiences? Perceived psychological support of UK military pacekeepers on return from deployment. Journal of Mental Health, 12, 6, 565-573.

Hawker, D.M., Durkin & Hawker, D.S.J. (2011). To debrief or not to debrief our heroes: That is the question. Clinical Psychology and Psychotherapy, 18,(6), 453-463. (Published online at http://onlinelibrary.wiley.com/doi/10.1002/cpp.730/abstract). DOI: 10.1002/cpp.730. First published online 19 December 2010.

Hawker, D.M. & Hawker, D.S.J. (2016). Skype therapy: More or less confidential than traditional therapy? Clinical Psychology Forum, 286, 39-43.

Hay, R., Lim, V., Blocher, D., Ketelaar, J. & Hay, S. (2007). Worth Keeping: Global perspectives on best practice in missionary retention. Pasadena, CA: William Carey Library.

Heegarde, M. (1991). When something terrible happens: Children can learn to cope with grief. Chapmanville, WV: Woodland Press.

Hobbs, M. & Adshead, G. (1997). Preventative psychological intervention for road crash survivors. In M. Mitchell (Ed.), The Aftermath of Road Accidents (pp. 159-171). London, England: Routledge.

Horowitz, M. J. (1975). Intrusive and repetitive thoughts after experimental stress. Archives of General Psychiatry, 32, 1457-1463.

Horowitz, M. J., Wilner, N., & Alvarez, W. (1979). Impact of event scale: A measure of subjective distress. Psychosomatic Medicine, 41, 209-218.

Horsfall, T. (2004). Rhythms of grace: Finding intimacy with God in a busy life. Eastbourne: Kingsway Publications.

Hughes, O. (2002). Training, supervision and assessment of competence. In British Psychological Society (Ed). Psychological Debriefing: Professional practice board working party. Leicester, UK: BPS. pp 25-30.

Jacobs, J., Horne-Moyer, H.L., Jones, R. (2004). The effectiveness of Critical Incident Stress Debriefing with primary and secondary trauma victims. International Journal of Emergency Mental Health, 6, 5-14.

Janoff-Bulman, R. (1992). Shattered Assumptions: Towards a new psychology of trauma. New York: The Free Press.

Jenkins, J.H. (1996). Culture, emotion and PTSD. In A. J. Marsella et al. (eds.). Ethnocultural aspects of Posttraumatic Stress Disorder. Washington, DC: American Psychological Association. pp. 165-182.

Jones, G. & Jones, J. (2003). Teamwork. Bletchley: Scripture Union.

Jones, G. & Stokes, A. (2009). Online counselling. Basingstoke: Palgrave Macmillan.

Johnson, K. (1993). Trauma in the lives of children: Crisis and stress management techniques for teachers, counsellors, and student services professionals. Alameda, CA: Hunter House Books.

Jordan, P. (1992). Re-entry. Seattle, WA: YWAM.

Kilbourn, P. (Ed.). (1995). Healing the Children of War. Monrovia, CA: MARC.

Kinchin, D. (2007). A guide to psychological debriefing. London: Jessica Kingsley Publishers.

Kingdon, D., Tyrer, P., Seivewright, N., Ferguson, B., & Murphy, S. (1996). The Nottingham study of neurotic disorder: influence of cognitive therapists on outcome. British Journal of Psychiatry, 169, 93-97.

Koval, S. (1987). Midwest Flight 151: trauma and rescuers. MA thesis, Cardinal Stritch University.

Knell, M. (2001). Families on the Move. London: Monarch Books.

Knell, M. (2007). Burn up or splash down: Surviving the culture shock of re-entry. Waynesboro GA: Authentic Books.

Kraus, R.P. (1997). Psychological debriefing for victims of acute burn trauma. British Journal of Psychiatry, Letters to the editor, 171, 583.

Lazarus, R.S. & Folkman, S. (1984). Stress, Appraisal & Coping. New York: Springer.

Lazovik, J. (1995). Remembering how to stay well: a regenerative tool for counselling centre staff. Journal of College Student Psychotherapy, 9 (4), 57-77.

Lee, C., Slade, P. & Lygo, V. (1996). The influence of psychological debriefing on emotional adaptation in women following early miscarriage: A preliminary study. British Journal of Medical Psychology, 69, 47-58.

Litz, B.T., Adler, A.B., Castro, C.A. et al. (2004). A controlled trial of group debriefing. 20th Annual Meeting of the International Society for Traumatic Stress Studies, November 14-18, New Orleans, LA.

Lopes Cardozo, B. & Salama, P. (2002). Mental health of humanitarian aid workers in complex emergencies. In Danieli, Y. (Ed.), Sharing the Front Lines and the Back Hills, pp. 242-255. New York: Baywood Publishers.

Lopes Cardozo, B. et al. (2005). The mental health of expatriate and Kosovar Albanian humanitarian aid workers. Disasters, 29, (2), 152-170.

Lovell, D. M. (1997). Psychological adjustment among returned overseas aid workers. Unpublished doctoral dissertation, University of Wales, Bangor.

Lovell, D.M. (1999a). Chronic fatigue syndrome among overseas development workers: A qualitative study. Journal of Travel Medicine, 6, 16-23.

Lovell, D. M. (1999b). Evaluation of Tearfund's critical incident debriefing process. Internal paper produced for Tearfund, Teddington, England.

Lovell, D. M., Hemmings, G., & Hill, A. B. (1993). Bereavement reactions of female Scots and Swazis. British Journal of Medical Psychology, 66, 259-274.

Lovell-Hawker, D. (2002). Debriefing after traumatic incidents, and at the end of assignments. In K. O'Donnell (ed.) Doing Member Care Well: Perspectives and practices from around the world. Pasadena, CA: William Carey.

Lovell-Hawker, D. (2004). Cultural adaptation. In J.S. Keystone, P.E. Kozarsky, D.O. Freedman, H.D. Nothdurft, B.A. Connor (eds.) Travel Medicine. Edinburgh: Mosby.

Lovell-Hawker, D. (2006). Understanding local (national) staff. Paper presented at the People In Aid Symposium on Employee Wellbeing, London, 19th October 2006.

Lovell-Hawker, D. (2011). Supporting staff responding to disasters: Recruitment, briefing and on-going care. London: People In Aid.

Lutz, T. (1999). Crying: The natural and cultural history of tears. New York: W.W. Norton & company.

MacNair, R. (1995). Room for Improvement: The management and support of relief and development workers. London, England: Overseas Development Institute.

Martin, T.L. & Doka, K.J. (2000). Men don't cry … women do. Philadelphia, PA: Brunner / Mazel.

Mayou, R.A., Ehlers, A. & Hobbs, M. (2000). Psychological debriefing for road traffic accident victims. British Journal of Psychiatry, 176, 589-593.

McConnan, I. (1992). Recruiting Health Workers or Emergencies and Disaster Relief in Developing Countries. London, England: International Health Exchange.

McKay, L. (2007). My hands came away red. Chicago: Moody Publishers.

Mitchell, J. T. (1983). When disaster strikes ... the critical incident debriefing process. Journal of the Emergency Medical Services, 8, 36-39.

Mitchell, J.T. & Everly, G.S. (1997). The scientific evidence for critical incident stress management. Journal of Emergency Medical Services, 22, 86-93.

Mitchell, J.T. & Everly, G.S. (1993). Critical incident stress debriefing – an operations manual for the prevention of traumatic stress among emergency services and disaster workers. USA: Chevron Publishing Corporation.

Mitchell, J. & Gray, B. (1990). Emergency Services Stress. Brady: New Jersey.

Mohr, D.C., Ho, J., Duffect, J et al. (2012). Effect of telephone-administered vs face-to-face cognitive behavioural therapy on adherence to therapy and depression outcomes among primary care patients: a randomized trial. Journal of the American Medical Association, 307, 2278-2285.

Murray, E. J., Lamnin, A., & Carver, C. (1989). Emotional expression in written essays and psychotherapy. Journal of Social and Clinical Psychology, 8, 414-429.

NICE (2005). Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. (Clinical guideline 26. Developed by the National Collaborating Centre for Mental Health). London: National Institute for Clinical Excellence.

O'Donnell, K. (ed.) (2002). Doing Member Care Well: Perspectives and practices from around the world. Pasadena, CA: William Carey.

Orner, R. (2003). A new evidence base for making early intervention in emergency services complementary to officers' preferred adjustment and coping strategies. In R. Orner & U. Schnyder (eds.) Reconstructing early intervention after trauma: Innovations in the care of survivors. Oxford: Oxford University Press. pp. 142-153.

Parkinson, F. (1997). Critical Incident Debriefing. London, England: Souvenir Press.

Parkinson, F. (2001). Debriefing and research. Counselling and Psychotherapy Research, 1, 177-180.

Paton, D. (1992). International disasters: Issues in the management and preparation of relief workers. Disaster management, 4, 183-190.

Paton, D. & Purvis, C. (1995). Nursing in the aftermath of disaster: orphanage relief work in Romania. Disaster Prevention and Management, 4, 45-54.

Pennebaker, J. W. (1989). Confession, inhibition, and disease. In L. Berkowitz (Ed.), Advances in experimental social psychology (Vol. 22, pp. 211-244). New York: Academic.

Pennebaker, J. W. & Beall, S. K. (1986). Confronting a traumatic event: Toward an understanding of inhibition and disease. Journal of Abnormal Psychology, 95, 274-281.

Pennebaker, J. W., Kiecolt-Glaser, J. K., & Glaser, R. (1988). Disclosure of traumas and immune function: health implications for psychotherapy. Journal of Consulting and Clinical Psychology, 56, 239-245.

Pennebaker, J. W. & O'Heeron, R.C. (1984). Confiding in others and illness rate among spouses of suicide and accidental-death victims. Journal of Abnormal Psychology, 93, 473-476.

Petrie, K. J., Booth, R. J., Pennebaker, J. W., Davidson, K. P. & Thomas, M. G. (1995). Disclosure of trauma and immune response to a Hepatitis B vaccination program. Journal of Consulting and Clinical Psychology, 63, 787-792.

©CHS Alliance 2018

Pirolo, N. (2000). The Reentry Team: Caring for your returning missionaries. San Diego, CA: Emmaus Road International.

Pollock, D. C. & Van Reken, R. E. (2009). Third Culture Kids: Growing up among worlds. London: Nicholas Brealey Publishing.

Price, J. (1975). Foreign language interpreting in psychiatric practice. Australian and New Zealand Journal of Psychiatry, 9, 263-267.

Quick, T. (2010). The global nomad's guide to university transition. Summertime.

Rack, P. (1982). Race, Culture and Mental Disorder. London, England: Tavistock Publications.

Raphael, B. (1977). Preventative intervention with the recently bereaved. Archives of General Psychiatry, 34, 1450-1454.

Raphael, B. & Wilson, J.P. (Eds) (2000). Psychological debriefing: Theory, practice and evidence. Cambridge: Cambridge University Press.

Regel, S. & Courtney-Bennett, H. (2002). Cultural issues with an impact on psychological debriefing. In British Psychological Society (Ed). Psychological Debriefing: Professional practice board working party. Leicester, UK: BPS. pp 64-71.

Regel, S., Joseph, S. & Dyregrov, A. (2007). Psychological debriefing in cross-cultural contexts: Ten implications for practice. International Journal of Emergency Mental Health, 9, 1, 37-45.

Richman, N. (1995). Communicating with children: Helping children in distress. London: Save the Children.

Rick, J. & Briner, R. (2000). Trauma management vs. stress debriefing: What should responsible organisations do? Institute for Employment Studies, 1-7.

Robinson, R. (2000). Dealing with emergency services: Critical Incident Stress Management. In B. Raphael & J.P. Wilson (Eds.) Psychological debriefing: Theory, practice and evidence. Cambridge: Cambridge University Press, pp. 91-107.

Robinson, R. C. & Mitchell, J. T. (1993). Evaluation of psychological debriefings. Journal of Traumatic Stress, 6, 367-382.

Robinson, R. C. & Mitchell, J (1994). Getting some balance back into the debriefing debate. The Bulletin of the Australian Psychological Society, 17, 5-10.

Robinson, R. C., Mitchell, J, T. & Murdoch, P. (1995). The debate on psychological debriefings. Australian Journal of Emergency Care, 2, 6-7.

Rogers, C. (1988). The changing shape of security for NGO field workers. Together, 9-11.

Roman, B.D. (2000). Let's move overseas. Knoxville, TN: B.R. Publishing.

Rose, S. & Bisson, J. (1998). Brief early psychological interventions following trauma: A systematic review of the literature. Journal of Traumatic Stress, 11, 4, 697-710.

Rose, S., Bisson, J., Churchill, R. & Wessely, S. (2006). Psychological debriefing for preventing post traumatic stress disorder (PTSD). (Cochrane Review). In: The Cochrane Library, Issue 3, 2006. Oxford, England: Update Software.

Rose, S., Bisson, J. & Wessely, S. (2003). Psychological debriefing for preventing post traumatic stress disorder (PTSD). (Cochrane Review). In: The Cochrane Library, Issue 1, 2003. Oxford, England: Update Software.

Rosenfield, M. (1997). Counselling by telephone. London: Sage.

Rosenblatt, P. (1993). Cross cultural variations in the experience, expression and understanding of grief. In D.P. Irish, K.F. Lundquist & V. Jenkins (Eds.) Ethnic variations in dying, death & grief: Diversity in universality. Washington, DC: Taylor & Francis pp.13-20.

Rottenberg, J., Bylsma, L.M. & Vingerhoets, A.J.J.M. (2008). Is crying beneficial? Current directions in psychological science, 17, 6, 400-404.

Shah, S.A., Garland, E. & Katz, C. (2007). Secondary traumatic stress: prevalence in humanitarian aid workers in India. Traumatology, 13, 1, 59-70.

Slim, H. (1995). The continuing metamorphosis of the humanitarian practitioner: Some new colours for an endangered chameleon. Disasters, 19, 110-126.

Smith, P., Dyregrov, A., Yule, W., Gupta, L., Perrin, S. & Gjestad, R. (1999). Children and Disaster: teaching recovery techniques. Bergen, Norway: Foundation for Children and war. (www.childrenandwar.org).

Smyth, J. M. et al. (2002). Structured writing about a natural disaster buffers the effect of intrusive thoughts on negative affect and physical symptoms, The Australian Journal of Disaster and Trauma Studies, 2002 (1).

Stallard, P. (2000). Debriefing adolescents after critical life events. In B. Raphael & J.P. Wilson (eds.) Psychological Debriefing: Theory, practice and evidence. London: Cambridge University Press, pp. 213-224.

Stallard, P. & Law, F. (1993). Screening and psychological debriefing of adolescent survivors of life-threatening events. British Journal of Psychiatry, 163, 660-665.

Storti C. (1991). The Art of Coming Home. Yarmouth, ME: Intercultural Press.

Stratton, E. (2003). Famine & face packs: The realities of relief work. Carlisle: Lifestyle.

Stuhlmiller, C. & Dunning, C. (2000). Concerns about debriefing: challenging the mainstream. In B. Raphael & J. P. Wilson (eds.) Psychological debriefing: Theory, practice and evidence. Cambridge: Cambridge University Press pp. 305-320.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. Social Science and Medicine, 48, 1449-1462.

Taylor, W.D. (Ed.). (1997). Too Valuable to Lose. Pasadena, California: William Carey Library.

Tedeschi, R.G., Park, C.L. & Calhoun, L.G. (1998). Posttraumatic growth: Positive changes in the aftermath of crisis. Mahwah, NJ: Lawrence Erlbaum Associates.

Terheggen, M.A., Stroebe, M.S. & Kleber, R.J. (2001). Western conceptualisations and eastern experience: A cross-cultural study of traumatic stress reactions among Tibetan refugees in India. Journal of Traumatic Stress, 14, 2, 391-404.

Tuckey, M.R. & Scott, J.E. (2014). Group critical incident stress debriefing with emergency services personnel: A randomized controlled trial. Anxiety, Stress and Coping, 27, 1, 38-54.

Turnbull, G., Busuttil, W. & Pittman, S. (1997). Psychological debriefing for victims of acute burn trauma. British Journal of Psychiatry, Letters to the editor, 171, 582.

Van der Veer, G. (1995). Psychotherapeutic work with refugees. In R.J. Kleber, C.R. Figley & B.P.R. Gersons (eds.) Beyond trauma: Cultural and Societal Dynamics. New York: Plenum Press pp. 151- 170.

Watts, R. (2000). Debriefing after massive road trauma: perceptions and outcomes. In B. Raphael & J. P. Wilson (eds.) Psychological debriefing: Theory, practice and evidence. Cambridge: Cambridge University Press pp. 131-144.

Webb, N.B. (ed.). (2004). Mass trauma and violence: Helping families and children cope. New York: The Guilford Press.

Webster, D. (2007). The Shimmering Heat: Memories of a bush doctor in East Africa. Rushden, UK: Stanley Hunt Printers.

Wessely, S., Rose, S & Bisson, J. (2000). Brief psychological interventions ("debriefing") for trauma-related symptoms and the prevention of post traumatic stress disorder (Cochrane Review). In: The Cochrane Library, Issue 3, 2000. Oxford, England: Update Software.

Yule, W. (1992). Post-traumatic stress disorder in child survivors of shipping disasters: the sinking of the 'Jupiter'. Journal of Psychotherapy and Psychosomatics, 57, 200-205.

Yule, W. (2003). Early intervention strategies with traumatized children, adolescents, and families. In R. Orner & U. Schnyder (eds.) Reconstructing early intervention after trauma: Innovations in the care of survivors. Oxford: Oxford University press. pp. 177-183.

(b) Useful websites

See also Handout 1 for websites related to re-entry and expatriates (adult and children), and Handout 9 for websites for media personnel

www.resilientexpat.co.uk (Information and services for expatriates.)

www.chsalliance.org (CHS Alliance website, including resources on quality, accountability and people management in the humanitarian and development sector, as well as capacity strengthening workshops and events.)

www.antaresfoundation.org (Stress briefings etc.)

www.Barnabas.org (Information about re-entry seminars for TCKs, debriefing, free retreats, and encouragement letters for missionaries.)

www.comhlamh.org (For humanitarian workers who have returned to Ireland, includes information about a free 'coming home weekend', careers tuition, referral to counsellors, and other support.)

www.crossculturalworkers.com (Includes free e-books on cross-cultural issues.)

www.crusebereavementcare.org.uk (For bereavement care and information.)

www.figt.org (Families in global transition – useful resources related to children and families.)

www.globalconnections.co.uk (A website primarily for Christian organisations, this contains many papers relevant to humanitarian work, including a *Code of best practice in short-term mission*.)

www.globaled.us/peacecorps (The Peace Corps, including a crisis management handbook and workbook, and a rape response workbook.)

www.globalmembercare.com (Resources for mission workers worldwide.)

www.headington-institute.org (Very useful papers on aspects connected to stress and trauma among workers. This includes online training modules which can be downloaded at no cost. Some are avail;able in other languages).

www.hostageuk.org (Help in cases involving kidnapping.)

www.humanitarian-psy.org/ (The Centre for Humanitarian Psychology, Geneva. Offers confidential, psychological support to expatriates online.)

www.membercare.org (member care resources.)

www.mindandsoul.info (About mental health issues and Christianity. Includes articles on stress and depression, podcasts, and blogs.)

www.mindfulnext.org (Mindfulness for NGOs, devoted to building resilience)

www.missionarycare.com (Offers free e-books and information sheets, including on reentry, TCKs and adolescence.)

www.oscar.org.uk (Information, advice and resources about mission work.)

www.syzygy.org.uk (Resources, debriefing and practical help for mission personnel, especially those who 'don't fit into boxes'.)

www.trauma-pages.com/ (Useful trauma information, including principles for working with traumatised children..)

(c) Training courses

If you are interested to learn more about debriefing, including details about training courses, please contact the author of this manual, Dr Debbie Hawker (www.resilientexpat.co.uk). Debbie can travel to provide tailored in-house training for organisations, and she also provides multi-agency training in the UK for mixed groups. Debriefing training can be tailored to the needs of participants, and is usually done over one or two days.

Feedback from participant at an Effective Debriefing training course with Debbie Hawker:

"One of the participants has been working with our organisation for well over 20 years, is a bit of a cynic and with a tendency to being critical, commented that he thinks it's the best training he's ever had … The day was relevant to us all; was really well managed; you clearly have the 'credibility' to teach us much about debriefing … It was really good!"

©CHS Alliance 2018

Appendices

You may photocopy these handouts for non-commercial use. If you do so, please cite this manual as your source.

©CHS Alliance 2018

Appendix 1: Coming Home (for humanitarian workers) – Handout 1

This handout may be useful to distribute to **humanitarian workers** who have recently returned home after working in a different culture.

Coming 'home'

After working in a different culture, many people find that it takes quite some time to readjust to being back 'home'. In fact, home may no longer feel like home, as it is so different to what you have become used to.

Although 15% of returned expatriates ('repatriates') report that they had positive feelings about returning to their own country (some admitting that they felt relieved to return home), another 25% report having mixed feelings, and 60% report predominantly negative feelings. It is common to feel confused; disoriented; 'like a fish out of water'; exhausted; frustrated with materialism; overwhelmed by the amount of choice in supermarkets (e.g. by six different brands of diet dog-food!), or to have a sense of loss. Such feelings are sometimes referred to as 'reverse culture shock'. Some people feel disappointed that expectations they had before they went abroad have not been fulfilled. Others have experienced problems while they have been away, and so have not enjoyed the experience as much as they had hoped. Some people have to return earlier than they expected.

Many repatriates have signs of mild depression for a short period after returning to their own country. These may include a lack of energy; sleeping problems; irritability; difficulty concentrating or making decisions; a change in appetite; tearfulness; feeling unhappy, and feeling overwhelmed by small tasks. Some people find that they think a lot about their humanitarian experiences, perhaps having pictures about these experiences intruding into their thoughts, or dreaming about them. For other people there is a sense of numbness, and the time abroad seems distant or unreal. Some repatriates feel like they are living in two different worlds, and try to cope by not thinking about their humanitarian experiences.

It is important to realise that **such symptoms are completely normal** after living in a different culture, just as a grieving process is normal and expected after the death of someone you love. Although not everyone has such symptoms, many people do. It is important that you do not criticise yourself for feeling this way, or get depressed about feeling depressed. People who accept their feelings as a normal part of the readjustment process tend to get over them more easily. It often takes between 18 months and three years before people feel completely 'at home' again in their own culture. People who adapted most to the culture they worked in and were most involved generally take longer than those who were not so involved with the local culture. Rushing to another humanitarian assignment is generally not a good idea, as this causes more stress, with yet another adjustment, and makes the next re-entry even more difficult. It is generally better to wait until you feel more settled before considering another move, strange as that might sound.

Among the findings of a survey of one group of people who had returned home after spending two years or more working in another country were the following:

Difficult aspects of resettlement:	Reported by:
Communicating the humanitarian experience	58%
Fitting in again	53%
Finding work	41%
Lack of money	32%

©CHS Alliance 2018

Finding accommodation	12%

If you find it difficult to fit in again, you should remind yourself that so do most other repatriates, but they are able to readjust in time.

The most common adjustment difficulty reported was communicating the humanitarian experience. Most repatriates want to tell their family and friends about the things they have experienced (as otherwise they feel like they are a stranger at home, as no-one really knows them or understands what they have experienced). But communication is often difficult. Be prepared for the fact that many people won't seem interested in hearing about your experiences abroad, and their eyes may glaze over as soon as you start talking, or they may ask seemingly stupid questions and appear to miss the point. There are a number of reasons for this, and it does not mean that you are boring!

Many people find it hard to imagine life in another culture, and so do not know what to ask (especially if they feel that their questions would reveal their ignorance). Try to imagine how you might react if someone started telling you about a topic you understand little about. You might 'drift off', and that is what people tend to do when you start discussing a different culture. Some people may feel that their lives are boring in comparison with your life, and they may choose to opt out of the conversation as they feel unable to compete (and perhaps feel inferior, or jealous of the opportunities you have had). If you have been living in a less developed nation, some people will feel guilty about their own affluent lifestyle, and want to avoid further conversation on the topic.

To deal with these reactions, it is useful to prepare a 20-second description of your experience, and then wait for the response. People who genuinely want to know more will ask you questions. Otherwise, it may be easiest to let the conversation drop. Friends may be eager to tell you their own news. If you listen and ask them questions, they may be willing to listen to you once they have finished talking. People have a limited attention span, so let your stories come out gradually, telling people a bit more each time you see them, rather than trying to share everything at one sitting.

It is worth seeking out people who *are* interested in your experiences abroad. Otherwise you could feel very isolated and as if your life has two disconnected parts, 'then' and 'now'. It can be worth getting in touch with others who have lived abroad. Repatriates tend to understand each other, even though they may have lived in very diverse places. The organisation you travelled with may be able to put you in touch with other repatriates. Some organisations run conferences, reunions or re-entry seminars for returned humanitarian workers, which can be a great way of having fun, sharing experiences with people who are interested, and learning that your reactions are normal! Some areas have local groups for repatriates. It might be worth forming one if there is not one already in your area. An advertisement in a local newspaper can be used for publicity. Social media groups can be helpful if there are no local groups.

Whether your experiences were positive, negative or mixed, relating them to someone who understands can help you move on to the next step in your life. As well as talking with friends and family, many people find it helpful to have a more formal debriefing session. Personal debriefing has been defined as "telling your story to someone who understands, until you are heard in such a way as to bring 'closure' to your experience, so that you are free to move on". Personal debriefing is recommended for all humanitarian workers, as it can help you reflect on your experiences, clear up any remaining issues, and enhance self-understanding and personal growth. To request personal debriefing, contact the organisation you were working for, or www.resilientexpat.co.uk.

If you experience symptoms of stress or depression, take special care of yourself. Do not berate yourself, as such symptoms are a normal part of re-entry. Moving cultures is exhausting. It is important that you take sufficient time to rest and relax on your return. You may need to sleep more than normal. Try to avoid making major decisions until you have had some time to readjust. Even if people

©CHS Alliance 2018

keep asking, “Are you going to go back?” or “When are you going to get a job?”, do not feel forced into making decisions too soon. It may be helpful to turn down some invitations at first, and take things slowly for a while. On the other hand, it is important that you do not avoid all forms of activity. Prioritise the things you want (or need) to do.

Doing things which you enjoy and which give you a sense of achievement can help defeat feelings of depression. Spend time with supportive people, and look for opportunities to laugh. Moderate exercise, like walking, helps to reduce feelings of stress, and acts as a natural anti-depressant. To look after your health, try to eat a balanced diet. Avoid increasing your alcohol intake or using recreational drugs or excessive caffeine, as these can interfere with your readjustment. Cry if you feel like crying – it is a healthy thing to do. Do not take on too much, but set yourself small, achievable goals. Recognise when you are under stress and do things which help you to relax. Accidents are more common at times of tiredness and stress, so take extra care, especially when driving (remembering that driving in your country of residence may be quite different from driving in the country you visited).

Try not to dwell on negative thoughts. Think about what you achieved and learned. This is not to deny that there may also have been negative experiences, but it can help you to see that the experience has not been meaningless. Some of the positive results which people often mention are new friendships; being of help to others; personal growth; a deeper appreciation of the simple things of life; a sense of achievement, and greater confidence.

If you have no difficulty thinking about the positives, but feel very negative about ending the assignment or returning home, try to remind yourself of the good aspects of being back home (and some of the things which you missed or did not like about your humanitarian experience). Try to see both cultures in balance, the good and the bad. Consider writing down your thoughts and feelings about your time abroad. If you like to write, also write down how you are feeling now that you are back. If you do not like writing, find someone to talk to about it instead. Research has shown that writing or talking about thoughts and feelings has both physical and emotional benefits.

After having allowed yourself some space to adjust, begin to slowly build up your level of activity again. If you are spending a lot of time alone, gradually seek out ways to meet people. For instance, could you invite friends or neighbours round, or go to a gym, or join a club, or get involved with a church or other group, or volunteer to help with a charity?

There are lots of ways you can maintain links with the culture you were living in. One is to see if you can meet people from that culture within your home community. Is there a local society for people from that region? Can you offer hospitality to international students or refugees/ asylum seekers? In addition, try to stay in touch with some of the friends you made, and keep up with news of any project you were working on. Does the organisation you were with have a website or newsletter? Keeping in touch can create a sense of belonging. If you were working for justice, environmental issues or poverty issues abroad your may wish to channel your skills and interest into continuing to addressing such issues from where you are now.

If you want to return to your professional work but have lost confidence because you have been away for so long, consider going on courses to update your skills. Do not be afraid to ask questions.

If you feel physically unwell, go to your doctor and tell them where you have been, so that they can test for any relevant illnesses (some of which can appear months after your return home). If you are worried about the possibility of being HIV positive, seek confidential counselling to determine whether you would like to be tested. If, after you have been home for more than six weeks, you still have recurrent thoughts about your humanitarian experiences which are interfering with your ability to get on with life, seek professional help. Psychological treatment can help you overcome such difficulties and feel more in control again. Ask your doctor, your employer or a travel clinic to arrange this. Also

©CHS Alliance 2018

speak to your doctor if sleeping problems persist, or if symptoms of depression prevent you from getting on with life, or if you have other concerns about your reactions. Realising when you could benefit from outside help is a sign of strength, not weakness.

Seek help with practical matters as well, if this is likely to be of benefit. Careers advisors and financial advisors can help make adjustment easier. You may find it useful to draw up a budget, as many repatriates have to be careful with money at least initially.

Although this description of difficulties might sound very negative, most people readjust relatively easily after they return to their country of residence, and most say that they would not have wanted to miss the experiences they had, despite any negative feelings they may have on return. Even those who experience depression or stress symptoms completely recover when they receive help. It is important to remember:

- Having some difficulties fitting in when you first return is normal
- Adjustment takes time
- It is best if you do not bottle up your feelings or criticise yourself for having them
- Talking about your experiences can help
- If you are worried about any difficulties, or if symptoms persist, contact someone for help
- You have coped with transitions in the past, and you will get through this too.

You may find the following books and websites useful:

Books

Knell, M. *Burn up or splash down: Surviving the culture shock of re-entry*. Waynesboro GA: Authentic Books, 2007.

Pascoe R. *Homeward Bound: a spouse's guide to repatriation*. North Vancouver, BC: Expatriate Press, 2000. (Especially written for non-working partners of those working abroad.)

Pollock DC, Van Reken RE. *Third Culture Kids: Growing up among worlds.* London: Nicholas Brealey Publishing, 2009. (Excellent material on growing up in another culture – useful for older children and parents.)

Storti C. *The Art of Coming Home*. Yarmouth, ME: Intercultural Press; 1991. (Excellent general book on re-entry, including specific sections on exchange students, volunteers, military personnel, and missionaries and their families.)

Websites

General expatriate sites

- www.resilientexpat.co.uk
- www.figt.org
- www.expatexchange.com
- www.branchor.com
- www.escapeartist.com
- www.outpostexpat.nl
- www.transition-dynamics.com

Military personnel and their families

- www.nmfa.org

Missionaries

- www.oscar.org.uk
- www.syzygy.org.uk
- www.womenoftheharvest.com (for women)

Expatriate families / partners

- www.expatexpert.com

Third Culture Kids (TCKs) – i.e. expatriate children or teenagers, and adults who grew up outside their parent's home culture

- www.tckworld.com/
- www.crossculturalkid.org
- www.gnvv.org
- www.interactionintl.org
- www.overseasbrats.com

Children of missionaries

- www.mukappa.org

©CHS Alliance 2018

Appendix 2: Symptoms of stress or trauma – Handout 2

The following handout can be used to help **debriefers** to know what the ‘normal’ symptoms of stress are. The handout can also be given to humanitarian **workers**, to help them identify any stress-related symptoms which they are experiencing, and to help teach them that such symptoms are normal among humanitarian workers.

(A) ENGLISH LANGUAGE VERSION

Symptoms of stress or trauma

Physical

Tiredness; Difficulty sleeping, or else spending a lot of time in bed; Nightmares; Headaches; Back pain; Inability to relax; Dry mouth and throat; Feeling sick or dizzy; Pounding heart; Sweating and trembling; Stomach-ache and diarrhoea; Loss of appetite, or over-eating; Feeling very hot or cold; Shortness of breath; Shallow, fast breathing; Hyper-vigilance; Irregular menstruation; Frequent need to urinate; Increased risk of ulcers, high blood pressure and coronary heart disease.

Emotional

Depression; Tearfulness, or feeling a desire to cry but being unable to; Mood swings; Anger (at self or others); Agitation; Impatience; Guilt and shame; Shock; Feelings of helplessness and inadequacy; Feeling different or isolated from others; Feeling overwhelmed/unable to cope; Feeling rushed all the time; Anxiety; Panic/phobias; Loss of sense of humour; Boredom; Lowered self-esteem; Loss of confidence; Unrealistic expectations (of self and others); Insecurity; Self-centred, inability to think about others; Feelings of vulnerability; Feeling worthless.

Behavioural

Withdrawal from others or becoming dependent on them; Irritability; Critical of self and others; Relationship problems; Lack of self-care; Nail-biting; Picking at skin; Speaking in slow monotonous voice, or fast, agitated speech; Taking unnecessary risks (e.g. when driving); Trying to do several things at once; Lack of initiative; Working long hours; Poor productivity; Loss of job satisfaction; Carelessness; Absenteeism; Promiscuity, or loss of interest in sex; Increased smoking or use of alcohol or drugs (including prescription drugs); Excessive spending or other activities to try to take one's mind off the situation; Loss of motivation; Self-harm or suicidal behaviour.

Thought patterns

Concentration and memory difficulties**;** Indecisiveness; Procrastination; Pessimism; Thinking in 'all or nothing' terms; Very sensitive to criticism; Self-critical thoughts; Loss of interest in previously enjoyed activities; Imagining the worst will happen; Preoccupation with health; Expecting to die young; Less flexible; Confusion and disorientation; Excessive fears (e.g. about being attacked); Trying to avoid thinking about problems; Flashbacks, or intrusive thoughts about difficulties; Hindsight thinking ("if only...", "why didn't I..."); Negative thoughts about oneself, one's work, family, the future and the world; Time seems to slow down or speed up; Suicidal thoughts.

Spiritual / Philosophical

Questioning the meaning of life; Loss of purpose; Loss of hope; Changes in beliefs; Doubts; Giving up faith; Legalism; Rigidity; Cynicism; Loss of sense of community with others; Sense of being abandoned; Submission to excessive control (e.g. may join a religious cult); Spiritual dryness; Unforgiveness; Bitterness; Feeling distant from God; Difficulty praying; Anger at God or at life.

©CHS Alliance 2018

(B) SPANISH LANGUAGE VERSION

Síntomas comunes del estrés o trauma

Físicos

- Cansancio
- Dificultad para dormir, o al contrario, pasar mucho tiempo en cama
- Pesadillas
- Dolores de cabeza
- Dolor de espalda
- Dificultad para relajarse
- Boca o garganta seca
- Nauseas o mareos
- Sentir que el corazón late con mucha fuerza
- Sudoraciones y temblores
- Dolor de estómago y diarrea
- Pérdida de apetito, o al contrario, comer demasiado
- Sentir mucho calor o frío
- Sentir que le falta la respiración
- Respiración superficial y muy rápida
- Menstruación irregular
- Necesidad frecuente de orinar
- Riesgo de úlceras, presión alta y enfermedades coronarias

Emocionales

- Depresión
- Llanto, o sentir deseos de llorar pero no poder hacerlo
- Cambios de humor
- Enojo (consigo mismo o con otras personas)
- Agitación, Impaciencia
- Sentimiento de culpa o vergüenza
- Choque
- Sentimiento de impotencia y de no ser suficiente
- Sentirse diferente o aislado de otras personas
- Sentirse abrumado e incapaz de cumplir
- Sentirse apurado todo el tiempo
- Ansiedad, Pánico/fobias
- Pérdida del sentido del humor
- Aburrimiento
- Autoestima baja
- Pérdida de confianza en sí mismo
- Expectativas no realistas (de uno mismo y de otros)
- Inseguridad
- Sentir egoísmo, no poder pensar en los demás
- Sentimientos de vulnerabilidad
- Sentir que no vale nada, inutilidad

©CHS Alliance 2018

De Comportamiento

- Alejarse de los demás o volverse dependiente de ellos
- Irritabilidad
- Criticarse a sí mismo o a los demás
- Problemas interrelacionales
- Falta de auto-cuidado
- Morderse las uñas
- Pellizcarse la piel
- Hablar con voz baja y monótona, o muy rápida y agitada
- Tomar riesgos innecesarios (ej. cuando conduce un vehículo)
- Tratar de hacer varias cosas al mismo tiempo
- Falta de iniciativa
- Trabajar demasiadas horas
- Poca productividad
- Pérdida de satisfacción del trabajo
- Despreocupación
- Ausentismo
- Promiscuidad, o pérdida de interés en el sexo
- Fumar demasiado, o abusar del alcohol o drogas (incluyendo medicamentos)
- Gastos excesivos u otras actividades para tratar de retirar la situación de nuestra mente
- Pérdida de motivación
- Comportamiento autodestructivo o suicida

Patrones de Pensamiento

- Dificultades de concentración y memoria
- Indecisión
- Lentitud
- Pesimismo
- Pensar en términos de “todo o nada”
- Muy sensible a la crítica
- Pensamientos auto-críticos
- Pérdida de interés en actividades que anteriormente disfrutaba
- Imaginarse que va a pasar lo peor
- Preocupación por la salud
- Pensar en morir joven
- Menos flexibilidad
- Confusión y desorientación
- Temores excesivos
- Tratar de evitar pensar en los problemas
- Evitar cualquier cosa que le pueda recordar una experiencia traumática
- Flashbacks, o pensamientos intrusivos sobre las dificultades
- Pensamientos retrospectivos (“si yo hubiera…” “por qué no hice…”)
- Pensamientos negativos sobre sí mismo, sobre su trabajo, familia, el futuro y el mundo
- Le parece que el tiempo pasa más lento o más rápido
- Pensamientos suicidas

©CHS Alliance 2018

Espiritual / Filosófico

- Cuestionar el sentido de la vida
- Pérdida de propósito
- Pérdida de la esperanza
- Cambios en sus creencias
- Dudas
- Abandono de la fe
- Rigidez
- Cinismo
- Pérdida del sentido de comunidad con otras personas
- Sentimiento de abandono
- Sequía espiritual
- No poder perdonar
- Amargura
- Sentirse lejos de Dios
- Dificultad para orar
- Sentir enojo hacia Dios o hacia la vida

©CHS Alliance 2018

(C) FRENCH LANGUAGE VERSION

Symptômes courants du stress

Symptômes physiques

- Fatigue
- Difficulté à trouver le sommeil ou, au contraire, passer trop de temps au lit
- Cauchemars
- Maux de tête
- Mal de dos
- Incapacité de se détendre
- Bouche et gorge sèches
- Sensation de nausée ou de vertige
- Transpiration et frissons
- Maux de ventre et diarrhée
- Perte d'appétit ou boulimie
- Avoir très chaud ou très froid
- Palpitations
- Essoufflement ; respiration courte, rapide
- Besoin d'uriner fréquemment
- (Pour les femmes) absence de règles
- Augmentation des risques d'ulcère, de tension artérielle élevée, de maladie coronarienne

Symptômes émotionnels

- Dépression
- Tendance à pleurer constamment ou envie de pleurer sans pouvoir le faire
- Colère (à l'égard de soi ou des autres)
- Agitation
- Impatience
- Culpabilité et honte
- Sentiments de détresse et d'infériorité
- Se sentir différent ou isolé des autres
- Etre choqué
- Se sentir dépassé / incapable de faire face
- Se sentir tout le temps bousculé
- Anxiété (se sentir craintif, tendu, nerveux)
- Paniques / phobies
- Perte du sens de l'humour
- Ennui
- Diminution de l'estime de soi
- Perte de confiance
- Attentes non réalistes (de la part de soi et des autres)
- Egotisme, incapacité de penser aux autres
- Insécurité
- Sentiment que la vie est une perte de temps et que cela ne vaut pas la peine de se tracasser
- Sentiment de vulnérabilité
- Se sentir méprisable

©CHS Alliance 2018

Symptômes affectant le comportement

- Se détacher des autres ou devenir dépendant d'eux
- Irritabilité et cynisme
- Critiquer soi-même et les autres
- Problèmes relationnels
- Ne pas prendre soin de soi
- Se ronger les ongles
- Tripoter sa peau ou ses boutons
- Parler d'une voix lente et monotone OU avoir un débit verbal rapide, agité
- Prendre des risques inutiles (par exemple, quand on conduit une voiture)
- Essayer de faire plusieurs choses à la fois
- Manque d'initiative
- Travailler pendant des périodes prolongées
- Faible productivité
- Perte de la satisfaction donnée par le travail
- Manque d'attention, provoquant des erreurs et des accidents
- Absentéisme
- Augmentation de l'usage du tabac, de l'alcool ou de la drogue (y compris les drogues délivrées sur ordonnance)
- Promiscuité ou perte d'intérêt pour les rapports sexuels
- Dépenses excessives ou autres activités destinées à éloigner sa pensée du stress
- Etre assis à ne rien faire ; ne rien vouloir faire
- Se blesser volontairement

Symptômes affectant la pensée

- Difficulté à se concentrer et à se souvenir
- Difficulté à prendre des décisions
- Reporter les choses à plus tard
- Penser en termes de « tout ou rien »
- Etre très sensible aux critiques
- Avoir des pensées autocritiques
- Douter de ses propres capacités, de celles des autres
- Etre moins flexible
- Perte d'intérêt pour des activités antérieurement appréciées
- Pessimisme
- Imaginer que le pire va arriver
- Etre inquiet de sa propre santé
- S'attendre à mourir jeune
- Essayer d'éviter de penser aux problèmes / aux contraintes
- Rappel d'images (« flash-back ») ou pensées perturbatrices concernant des difficultés
- Pensées négatives concernant vous-même, votre travail, votre famille, l'avenir et le monde
- Confusion et désorientation
- Le temps semble ralentir ou s'accélérer
- Pensées rétrospectives (« Si seulement … », « Pourquoi n'ai-je pas … »)
- Etre démoralisé
- Pensées suicidaires

©CHS Alliance 2018

Symptômes spirituels

- Sécheresse spirituelle – manque de passion, c'est seulement un devoir
- Manque d'action de grâce
- Incapacité de pardonner
- Amertume
- Se sentir loin de Dieu
- Difficulté à prier
- Changement de croyance
- Devenir rigoriste, ritualiste
- Etre en colère contre Dieu
- Perte de motivation
- Doutes
- S'interroger sur la signification de la vie
- Perte de but
- Abandon de la foi
- Désespoir

©CHS Alliance 2018

Appendix 3: Stress management strategies – Handout 3

The following handout can either be given to humanitarian workers, or else used to provide the debriefer with ideas of strategies to recommend.

(A) ENGLISH LANGUAGE VERSION

Stress management strategies

Different people find different techniques useful for coping with stress. These are some strategies which many people find helpful. It is a good idea to try a few strategies from each of the five categories.

Physical strategies

1. Be self-aware, and spot when you have symptoms of stress. Use this as a warning sign to encourage you to take stock and look after yourself.

2. Physical exercise is a natural anti-depressant and helps to relieve tension. Find an activity you enjoy (e.g. walking, swimming, running, cycling [outside, or a stationary bike], playing sport, an aerobic video, gardening, chopping wood!)

3. Eat a balanced diet with plenty of vitamins. Ensure you are eating enough (for energy), but do not overeat.

4. Relaxation exercises can help your body feel more relaxed and take away aches and pains. Try tensing and relaxing your muscle groups (e.g. your hands, then your eyes, mouth, stomach, toes etc).

5. Reduce your alcohol and caffeine intake, as these tend to magnify feelings of stress or depression.

6. Get enough sleep. Stress is tiring, so you may need to sleep for longer than usual. Having a banana or cup of milk before bed may help. Some people find camomile tea helps them sleep, while others are helped by having a relaxing bath before going to bed, or by putting a drop of lavender oil on their pillow. Some people play 'white noise' to help them sleep despite noise or with quietness.

7. If you are having severe sleeping problems or feeling depressed all the time, you might benefit from taking medication for a while. Speak to a doctor about this. See also the self-help books in Appendix 6.

Emotional strategies

1. Write a journal including your thoughts and feelings. Or, if you prefer, write emails or letters, or tape your thoughts, or talk to someone about them. This helps you process your experiences and stops them going round and round in your head.

2. Talk to friends / family / colleagues about your experiences.

3. Allow yourself to cry if you want to. Emotional tears contain a stress hormone, and so crying helps people feel better.

4. Smiling and laughing can help you feel better. Try watching a funny movie, reading something amusing, or having a laugh with friends.

5. If you feel very distressed, consider seeking help. See appendix 5.

Behavioural strategies

1. Do things that help you relax or that you enjoy (e.g. chat with friends; watch videos; go to a place you like; read; have a relaxing bath; listen to music; draw; do cross-stitch).

2. Do not isolate yourself. Spend time with people you like.

3. Give yourself treats; be kind to yourself.

©CHS Alliance 2018

4. If you feel overwhelmed by having too much to do, try to set yourself small goals and just focus on doing one thing (perhaps starting with an easy task). Prioritise.
5. Be assertive. Delegate tasks, and ask for time off if you need it. Be willing to ask for help.

Thought patterns
1. Realise it is normal to feel low or have symptoms of stress when involved in disaster work. Do not blame yourself – most people have such symptoms. It is not a sign of weakness, and does not mean that you are 'not coping'.
2. Remember that these feelings pass, and you *will* feel better.
3. Lower your expectations of yourself. You do not have to do everything perfectly.
4. Do not become too introspective, or ruminate on your worries.
5. If you have negative thoughts (e.g. "I'm really bad at this job"), try to speak to someone else to get an objective, external perspective. Negative thoughts may be a sign of stress or depression, rather than reality.
6. Remind yourself of times you have coped with stress before, and what helped you then. "Success breeds success" – remembering past times of coping helps you to cope again.

Spiritual / Philosophical strategies
1. Remind yourself of the value of the work you are doing.
2. Remember the good things in the world – the people who are helping others, etc.
3. If you have spiritual beliefs, use these to help you gain a sense of perspective and meaning.
4. Talk with others who share your beliefs or values, or read some books which help sustain your inner life.
5. If you have questions about the meaning of life or why there is suffering, find people to talk to (or email) about these matters.
6. Pray, or ask people to pray for you.
7. If necessary, forgive yourself or other people. If you find it helpful, remind yourself that there will be a day when you will no longer know any suffering, pain, sorrow or tears.

©CHS Alliance 2018

(B) SPANISH LANGUAGE VERSION

Estrategias para el manejo del estrés

Las técnicas para hacer frente al estrés dependen de cada persona. Estas son algunas estrategias que mucha gente considera útiles. Es una buena idea probar algunas estrategias de cada una de las cinco categorías.

Estrategias físicas

1. Sea consciente de usted mismo e identifique cuando usted presente síntomas de estrés. Utilice esto como una señal de advertencia para que usted aprenda a cuidarse.
2. El ejercicio físico es un antidepresivo natural, y ayuda a aliviar la tensión. Busque una actividad que usted disfrute (ej. caminar, nadar, correr, andar en bicicleta, practicar algún deporte, jardinería, cortar madera!).
3. Coma una dieta balanceada con muchas vitaminas. Asegúrese de estar comiendo lo suficiente (para tener energía), pero no coma demasiado.
4. Los ejercicios de relajación pueden ayudar a su cuerpo a sentirse más relajado y a liberarse de los dolores y molestias. Haga la prueba estirando y relajando sus grupos musculares (ej. manos, ojos, boca, estómago, dedos de los pies, etc.).
5. Reduzca su consumo de alcohol y cafeína, ya que estos tienden a incrementar su sentido de estrés y depresión.
6. Duerma suficiente. El estrés produce cansancio, por lo que es posible que usted necesite dormir más de lo normal. Comer un banano o beber un vaso de leche antes de irse a la cama puede ayudar.
7. Si usted tiene severos problemas para dormir, o si se siente deprimido todo el tiempo, tal vez le ayude tomar algún medicamento. Hable con su médico al respecto.

Estrategias emocionales

1. Escriba un diario e incluya sus pensamientos y sentimientos. O si prefiere, escriba correos electrónicos o cartas, o grabe sus pensamientos con una grabadora, o hable con alguien sobre ellos. Esto le ayudará a procesar sus experiencias, y evita que den vueltas en su cabeza.
2. Hable con sus amigos / familia / colegas acerca de sus experiencias.
3. Permítase llorar si desea hacerlo. Las lágrimas emocionales contienen una hormona del estrés, de modo que llorar ayuda a las personas a sentirse mejor.
4. Sonreír y reír también pueden ayudarle a sentirse mejor. Trate de ver una película graciosa, lea algo entretenido, o simplemente ríase de algo con sus amigos.
5. Si se siente sumamente afligido, considere buscar la ayuda de su médico.

Estrategias del comportamiento

1. Haga cosas que lo ayuden a relajarse o que usted disfrute (ej. platicar con amigos, ver una película, ir a un lugar que le guste, leer, escuchar música, dibujar, jugar algún juego).
2. No se aisle. Pase algún tiempo con personas que le agraden.
3. Cómprese algo, sea agradable con usted mismo.
4. Si se siente abrumado porque tiene demasiadas cosas que hacer, trate de ponerse pequeñas metas y enfóquese en hacer una sola cosa (tal vez iniciando con una tarea sencilla). Priorice.
5. Sea enérgico. Delegue tareas y solicite tiempo libre si lo necesita. Esté dispuesto a pedir ayuda.

Patrones de pensamiento

1. Dese cuenta de que es normal sentirse afligido o tener síntomas de estrés. No se culpe – la mayoría de las personas tienen estos síntomas. No son una señal de debilidad, y no significa que usted no sea capaz de hacer frente a las cosas.
2. Recuerde que estos sentimientos son pasajeros, y usted se sentirá mejor.

©CHS Alliance 2018

3. Baje un poco las expectativas que tiene de usted mismo. Usted no tiene que hacer todo a la perfección.
4. No sea demasiado introspectivo, ni piense demasiado en sus preocupaciones.
5. Si tiene pensamientos negativos (ej. "soy realmente malo para este trabajo"), trate de hablar con otra persona para obtener una perspectiva externa objetiva. Los pensamientos negativos pueden ser una señal de estrés o depresión, más que la realidad.
6. Recuerde cuántas veces le ha hecho frente al estrés en ocasiones anteriores, y qué fue lo que lo ayudó entonces. "El éxito genera éxito" – recordar ocasiones anteriores en que ha logrado enfrentar al estrés le ayudará a enfrentarlo otra vez.

Estrategias espirituales/filosóficas
1. Recuerde el valor que tiene el trabajo que usted está haciendo.
2. Recuerde las cosas buenas que hay en el mundo – gente buena ayudando a otras personas, etc.
3. Si tiene creencias espirituales, utilícelas para que le ayuden a ganar un sentido de perspectiva y significado.
4. Hable con otras personas que comparten sus creencias ó valores, o lea libros que le ayuden a mantener su vida interna.
5. Si tiene preguntas sobre el significado de la vida o por qué hay tanto sufrimiento, busque a alguien con quien hablar acerca de estos temas.
6. Ore, o pida a otras personas que oren por usted.
7. Si es necesario, perdónese a usted mismo o perdone a otras personas.
8. Si le resulta útil, recuerde que habrá un día en el que usted ya no sentirá ningún sufrimiento, ni dolor, ni habrán aflicciones ó lágrimas.

©CHS Alliance 2018

Appendix 4: Symptoms of post-traumatic stress disorder (PTSD) – Handout 4

This handout is intended for **debriefers** (rather than to be given to humanitarian workers). If a debriefer thinks that a humanitarian worker may be experiencing PTSD, they should recommend professional treatment (as such treatment can help people recover).

Symptoms of post-traumatic stress disorder (PTSD)

Post-traumatic stress disorder is diagnosed in people who meet the following criteria:

A. They experienced or witnessed a traumatic event (e.g. involving actual or threatened death or serious injury to self or others), and felt intense fear, helplessness or horror.

B. They 're-experience' the event in one (or more) of the following ways:

- Recurrent and intrusive distressing recollections of the event
- Recurrent nightmares about it
- Acting or feeling as if the event were recurring (e.g. flashbacks)
- Intense psychological or physiological distress at exposure to reminders of the trauma.

C. Persistent avoidance of stimuli associated with the trauma and numbness of general responsiveness, shown by 3 (or more) of:

- Efforts to avoid thoughts, feelings or conversations about it
- Efforts to avoid activities, places or people associated with the trauma
- Inability to recall an important part of the trauma
- Markedly diminished interest in significant activities
- Feeling detached from others
- Restricted range of affect (e.g. unable to have loving feelings)
- Sense of a foreshortened future.

D. Persistent symptoms of increased arousal shown by two (or more) of:

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hyper-vigilance
- Exaggerated startle response.

E. Symptoms in B, C, and D have persisted for more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

©CHS Alliance 2018

Predictors that someone is at risk of developing PTSD

Symptom severity in the initial days after a trauma is not a good predictor, as symptoms are common at this point and usually decrease naturally.

Symptom levels from around 2–4 weeks after the trauma are a strong predictor of later symptoms. People who endorse at least six symptoms of re-experiencing or arousal (see B and C above) are at high risk of developing PTSD (Brewin, Rose & Andrews, 2003).

Other predictors include:

- Mentally 'giving up' and feeling helpless during the trauma
- Excessively negative appraisal of symptoms (e.g. thinking "I'm going crazy"), and negative appraisals of the responses of other people
- Highly distressing intrusive thoughts about the trauma, experienced as happening again 'in the here and now' (rather than as something from the past), and experienced as fragments unconnected to what happened before or after
- Ruminating about the trauma
- Physical consequences (e.g. chronic pain or health problems)
- Subsequent stressful events
- Lack of social support / negative response from other people
- Depression.

(Ehlers & Clark, 2003)

©CHS Alliance 2018

Appendix 5: When and where to obtain professional psychological or psychiatric help – Handout 5

The following handout is intended as an information source for debriefers.

If, during a debriefing, an individual appears to fall into any of the following, professional psychological or psychiatric treatment should be recommended, to enable them to make a full recovery.

1. Suicide risk
2. Signs of psychosis (e.g. losing touch with reality; delusions; hallucinations; paranoia)
3. Anorexia nervosa or bulimia nervosa
4. Post-traumatic stress disorder (see Appendix/Handout 4)
5. Clinical depression
6. Serious alcohol or substance misuse, or other damaging addictions
7. Self-destructive behaviour
8. Violence towards others / serious anger problems
9. Anxiety attacks or agoraphobia
10. Severe sleeping problems
11. Chronic fatigue syndrome
12. Fear of being HIV positive.

If you, or they, are concerned, it is worth recommending professional help.

More information about most of these conditions (including how to recognise them, the most effective treatments, and guidelines for patients) can be downloaded free from www.nice.org.uk.

With children, specialised help should also be provided if any of the following occur:

1. There are dramatic changes in behaviour / personality
2. Daily functioning is severely impaired and developmental activities interrupted
3. They talk wishfully about being dead
4. There is an indication the child may have been abused
5. There is an inability to form relationships
6. They consistently refuse to attend school, or their grades drop and do not recover
7. They lose all interest or pleasure in things they previously enjoyed
8. They report hearing or seeing things which are not really there (not just an imaginary friend)
9. They fail to eat enough or sleep enough to remain healthy
10. They appear persistently sad over a period of several weeks.

Where to obtain further help:

The first person to contact is usually the person's own medical doctor. They can generally make a referral to a clinical psychologist or psychiatrist if this is needed, and some surgeries have a counsellor working within the practice. If you do not wish to go through a GP, use the contact form at www.resilientexpat.co.uk to request a current list of specialists (in the UK and worldwide) who offer emotional support to humanitarian workers.

For help in responding to crises, see Crisis Consulting International at www.CriCon.org (or email info@CriCon.org).

©CHS Alliance 2018

An international list of therapists who work with Third Culture Kids is available from http://internationaltherapistdirectory.com.

The following website provides cognitive behavioural therapy (CBT) self-help programmes for people suffering from depression:

- https://moodgym.com.au/

©CHS Alliance 2018

Appendix 6: Recommended self-help books – Handout 6

In addition to the self-help books listen below, many self-help handouts and resources are available free from www.getselfhelp.co.uk

a) For sleep problems

Sharp, T. J. (2001). The good sleep guide. Harmondsworth: Penguin Books.

b) For traumatic stress

Herbert, C. & Wetmore, A. (1999). Overcoming traumatic stress: A self-help guide using cognitive behavioural techniques. London: Robinson.

c) For anxiety

Dryden, W. (2003). Letting go of anxiety and depression. London: Sheldon Press.

Kennerley, H. (1999). Overcoming anxiety: A self-help guide using cognitive behavioural techniques. London: Robinson.

Marks, I.M. (2002). Living with fear: Understanding and coping with anxiety. Maidenhead: McGraw-Hill.

Williams, C. (2003). Overcoming anxiety: a five areas approach. London: Hodder Arnold.

d) For depression – general

Burns, D. (1999). Feeling good: the new mood therapy. New York: Avon Books.

Cantopher, T. (2003). Depressive illness: The curse of the strong. London: Sheldon Press.

Padesky, C. & Greenberger, D. (1995). Mind over Mood: Cognitive treatment therapy manual for clients. New York: Guilford Press.

e) For depression – Christian perspective

Lawson, M. (2006). D is for depression: Spiritual, psychological and medical resources for healing depression. Tain, Ross-shore: Christian Focus Publishing.

Lockley, J. (2002). A practical workbook for the depressed Christian. Milton Keynes: Authentic Lifestyle. (The author is a G.P. who has personal experience of depression. There is a video available).

Meier, P. (2005). Blue Genes. Wheaton: Tyndale House.

Williams, C., Richards, P. & Whitton, I. (2002). I'm not supposed to feel like this. London: Hodder & Stoughton.

f) For manic depression (bipolar disorder) or mood swings

McKeon, P. (1995). Coping with depression and elation. London: Sheldon Press.

Scott, J. (2001). Overcoming mood swings: A self-help guide using cognitive behavioural techniques. London: Robinson.

©CHS Alliance 2018

g) For binge eating

Fairburn, C. (1995). Overcoming binge eating. New York: Guilford Press.

h) For low self-esteem

Fennell, M. (1999). Overcoming low self-esteem. London: Robinson.

i) For chronic fatigue

Burgess, B & Chalder, T. (2005). Overcoming chronic fatigue: A self-help guide using cognitive behavioural techniques. London: Robinson.

j) For addictions

Dryden, W. & Matweychuk, W. (2000). Overcoming your addictions. London: Sheldon Press.

k) For perfectionism

Antony, M. & Swinson, R. (1998). When perfect *isn't* good enough: Strategies for coping with perfectionism. Oakland, CA: New Harbinger Publications.

l) Assertiveness training

Alberti, R. & Emmons, M. (2001). Your perfect right: Assertiveness and equality in your life and relationships. Atascadero, CA: Impact.

m) On overall emotional wellbeing (including time management, problem-solving, building self-confidence, improving relationships, averting alcohol problems and breaking bad habits)

Butler, G. and Hope, T. (1995). Manage your Mind. Oxford: Oxford University Press.

©CHS Alliance 2018

Appendix 7: Summary for Critical Incident Debriefing (for debriefers) – Handout 7

1. Introductions

Who you are (your experience of debriefing and humanitarian work); who they are; purpose of debriefing; it is confidential; usually lasts about 3 hours.

2. The facts about the experience

Ask them to describe what happened, from beginning to end. (Prompt if necessary e.g. "what happened next?").

3. The thoughts during and after the experience

E.g. What was your first thought when you realised something was wrong? What were your thoughts during the incident?

Was there any point at which you thought you or others were going to die? What have you been thinking about it since it happened?

4. Sensory impressions and feelings

- Were there any sights, sounds or smells that were especially vivid or that stick in your mind?
- What were your feelings during the incident?
- What was the worst part for you? What were your feelings then?
- Did you cry at any point?
- How have you been feeling since the incident?
- Have you noticed any changes in yourself – physically, emotionally, spiritually or socially? (E.g. tiredness; sleeping problems; concentration or memory difficulties; guilt; anger; inability to relax; difficulty making decisions; tearful or unable to cry etc. Use handout if desired.)

5. Teaching about normal signs of stress

- Signs of stress are normal in the circumstances – you are not over-reacting.
- These signs usually disappear by themselves.

6. Coping strategies, and future plans

- What methods can you use to reduce stress? (Use handout if desired.)
- What support is available to you / who can you talk to?
- What are your plans for the future? (E.g. for the next few weeks)
- Give information about how to obtain further help if they desire it, or if symptoms do not improve (e.g. counselling; GP).

7. Ending the session

- Has anything positive come out of this incident?
- Do they have any questions or comments they want to raise?
- Arrange a follow-up phone call or email in about 2-4 weeks to check how they are
- Summarise the session (e.g. anything they have agreed to try), and end.

©CHS Alliance 2018

Appendix 8: Summary for Debriefing on Return Home (for debriefers) – Handout 8

1. Introductions

Who you are (experience of debriefing and humanitarian work); who they are; purpose of debriefing; it is confidential, and usually lasts about 3 hours. If you do not already have the information, ask general details – where they have been, for how long, when they returned. **Overview: how was it?**

2. Identifying what was most troubling

Identify about 3 or 4 events/issues which were most stressful, upsetting or troubling – the worst parts. (E.g. a particular incident or disturbing sight; a relationship or communication difficulty; something to do with the job or the agency; overwork; boredom; the culture or living conditions; being far from friends and family; a health problem; any regrets.)

3. Facts, thoughts and feelings

Take each of the troubling events/stresses in turn, and ask about the facts; then the thoughts; then the feelings. **Do not rush!**

4. Any other aspects you want to talk about?

5. Signs of stress

Did you notice any changes in yourself at any point during the assignment (physically, socially, emotionally or spiritually)? What about now? (E.g. tiredness; sleeping problems; concentration or memory difficulties; guilt; anger; inability to relax; difficulty making decisions; tearful or unable to cry etc. Use handout if desired.)

6. Normalising and teaching

- Symptoms are normal in the circumstances – you are not over-reacting.
- What methods can you use to reduce stress? (Use handout if desired.)
- What support is available to you / who can you talk to?

7. Return 'home'

How has the return 'home' been? (Talk about normal 'reverse culture shock' and adjustment. Use handout if desired.)

8. Anything that was positive?

©CHS Alliance 2018

Was there anything good or meaningful about your time? What was best? Did you learn anything? Are you glad you went? Is there anything positive about being back?

9. The future

- Ask about future plans, including any plans to stay involved with similar issues
- Tell them where they can get further help if they want it (offer to make referral if appropriate)
- Ask whether they have any questions, or anything else they want to say
- Offer a follow-up meeting if appropriate. Otherwise arrange to follow up by phone or email (usually about 2-4 weeks later) to see how they are.

10. Closing

Summarise the session, and ask how they are feeling now.

©CHS Alliance 2018

CHSAlliance
QUALITY. ACCOUNTABILITY. PEOPLE MANAGEMENT

Appendix 9: Helpful websites for media personnel (for debriefers and humanitarian workers) – Handout 9

www.dartcenter.org (Offers advice and online self-study units for media personnel about traumatic stress. Also a useful booklet entitled *Breaking bad news*. Also a bulletin board for journalists to share their experiences.)

www.newslab.org

www.poynter.org (Search for 'trauma', and you will find many useful pages.)

www.responseability.org

©CHS Alliance 2018

CHSAlliance
QUALITY. ACCOUNTABILITY. PEOPLE MANAGEMENT

Evaluation Form

Name of publication:

---

1. Why did you purchase this resource? Project research/Reacting to external event/other reasons?

---

2. How useful did you find the information?

☐ 1 = Extremely useful ☐ 2 = Useful ☐ 3 = Moderately useful ☐ 4 = Not at all useful

3. What element was most useful for you and why?

---

4. What element was least useful and why? How can it be improved?

---

5. How have you used the knowledge gained from this resource in your organisation?

---

6. Have you forwarded this resource to others? Please give details (including numbers):

---

7. What level of impact has it had on you/your team/your organisation?

☐ 1 = Very high ☐ 2 = High ☐ 3 = Some ☐ 4 = Low ☐ 5 = None

Please give examples:

---

8. Does this resource represent good value for money? Please specify: ☐ Yes ☐ No

Comments:

©CHS Alliance 2018

9. What resources would you like to see introduced in the future? Do you feel that we are adequately anticipating your needs?

10. How did you find out about this resource? Please specify:

☐ Direct marketing from CHS Alliance ☐ CHS Alliance website ☐ Word of mouth ☐ Workshop

Thank you for taking the time to give us your feedback. We may wish to contact you in a few weeks to further assess whether the skills/knowledge gained from this resource have had an impact in your place of work. If you would like to take part in this, please specify:

Your name: Contact details – Tel/Skype: Time Zone: GMT +/- hrs

Please email this evaluation to info@chsalliance.org.

©CHS Alliance 2018