

Psychological Debriefing in Cross-Cultural Contexts: Ten Implications for Practice

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Abstract: *Crisis interventions following exposure to traumatic events have become common in most western and in some non-western countries. The literature regarding early interventions, specifically the use of Psychological Debriefing (PD), is grounded in a western context. Little has been written of its use in different cultural settings. This article focuses on the use of PD in different cultural settings, as well as some of the conceptual issues related to cross-cultural trauma research and practice, which inevitably have implications for the use of early intervention. Ten key implications for practice are suggested. [International Journal of Emergency Mental Health, 2007, 9(1), pp. 37-45].*

Key words: *early intervention; Critical Incident Stress Management, psychological debriefing; posttraumatic stress; culture; cultural contexts; practice*

The use of psychosocial interventions has become a standard part of disaster interventions across cultures. For example, the International Federation of Red Cross and Red Crescent Societies (IFRC) has over the past decade developed a range of programs through the IFRC Reference Centre for Psychosocial Support, hosted by the Danish Red

Cross, which coordinate resources, assessments, training, and evaluation of psychosocial programs following complex emergencies. Further evidence has recently emerged from research conducted following the Tsunami about the mental health impact of major disasters in different cultural contexts (Yule, 2006). However, the implementation of psychosocial support programs has become controversial in recent years because some researchers have argued against the use of early interventions, such as Psychological Debriefing (PD), following traumatic events (Rose & Bisson, 1998). In this article we will (1) address some of the issues and confusion concerning early interventions, specifically PD; (2) discuss extant evidence and use of early interventions cross-culturally and (3) outline ten implications for the use of early intervention across different cultures.

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Early Intervention

In order to discuss the role of early interventions it is first necessary to clarify what we mean by early interventions post-trauma. The umbrella term ‘early interventions’ has been used to refer to a variety of different types of intervention. However, it is generally accepted that this would encompass a range of interventions which would come under the construct of Critical Incident Stress Management (CISM).

Critical Incident Stress Management (CISM)

CISM has been clearly articulated in a comprehensive review by Everly and Mitchell (2000). CISM refers to a comprehensive, systematic, and integrated multi-component crisis intervention package that enables individuals and groups to receive assessment of need, practical support, and follow-up services following exposure to traumatic events in the workplace. In addition, it facilitates the early detection and treatment of post-trauma reactions and other psychological sequelae (Mitchell, 1983; 1988). One of the components of CISM is Critical Incident Stress Debriefing (CISD). However, for the purposes of this article, we will use the term Psychological Debriefing (PD). Dyregrov (1989) coined the term *Psychological Debriefing* (PD). Dyregrov has always maintained that PD is about the same as CISD and, especially in Europe, CISD and PD have become interchangeable; they essentially *do* mean the same thing. The main difference (apart from the names of some of the phases) is that Dyregrov (1997) places more emphasis on group process than does the ICISF model. The former has been developed within a European context and may therefore reflect a different tradition for groups and structure than in the US. The other difference is the use of the word *psychological*, which may in some organizational and cultural contexts have negative connotations. PD, like CISD, was also originally developed within the field of crisis intervention and is a structured intervention facilitated through a series of stages. What is also important to note is that CISM is neither counselling nor psychotherapy and was never intended as a ‘psychological treatment.’ This is important because confusion can arise when the terms are used interchangeably, as has occurred throughout the literature.

The Cochrane Report

Despite the widespread use of CISM, it has become controversial in recent years due, in part, to the publication of

The Cochrane Report (1998; 2000). The Cochrane Report (1998; 2000) has been interpreted as providing evidence against early intervention. Thus, before we consider different cultural contexts, it is important to briefly review the main conclusions of the Cochrane Report.

The Cochrane Report on PD (Wessley, Rose, & Bisson, 1998) provided evidence that PD might have negative effects on participants. As a result, many organizations and professionals stopped utilizing PD as a crisis intervention technique. There are, however, reasons why this conclusion should be approached cautiously. First, the studies reviewed by Wessley, Rose, and Bisson (1998) consisted of randomized controlled trials (RCTs) of single sessions with individuals who were primary victims of trauma (e.g., exposed to burn trauma and motor vehicle accidents). CISM approaches are not usually intended as single sessions but involve follow-up and are chiefly designed for use with secondary victims. Second, there were also a number of methodological shortcomings in the studies of the Cochrane Report. In a number of the studies reviewed, there was a lack of or inappropriate training for those providing PD as it is defined above. Third, the techniques employed by the intervention in the studies was not always as articulated above by either Mitchell and Everly (1999) or Dyregrov (1990). For example, in one study it is stated that “debriefing involves the use of intense imaginal exposure” (Bisson, Jenkins, & Alexander, 1997). PD, as described above, does not entail imaginal exposure. Fourth, not all of the studies were interviewer-blind. In their 1996 study of MVA victims, Hobbs and colleagues merged assessment with the interventions and follow-up, perhaps compromising “interviewer blindness.”

For these reasons, the conclusion to the Cochrane report should be approached cautiously, as many of the studies included in the review were not concerned with CISM or PD procedures as they are generally accepted by workers in the field. In addition, what has been termed PD in the Cochrane report has often been viewed as a form of psychotherapy or counselling (Davidson, 2004; Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002; Summerfield, 1995). Previous articles have made a clear distinction of the difference in terminology. However, in the field, practitioners who are not adequately trained may use the terms interchangeably and thus inaccurately, with the potential to cause confusion in recipients. PD as reviewed by Rose and Bisson (1998) has been viewed as a form of counselling or psychotherapy and, although it is a form of psychological help, it is

psychoeducational rather than concerned with the reconfiguration of personality or altering personal defenses as is the case with counselling and psychotherapy.

We concur with the Cochrane Report that organizations that seek to help disaster stricken populations or to serve their own personnel should refrain from single-session debriefings, but we also argue that it would be going beyond the evidence to over-generalize the findings of the Cochrane Report to a) all early interventions b) counselling and psychotherapy or c) the plethora of research pertaining to the successful use of PD in a variety of contexts, but simply not considered for inclusion in the Review because they were not randomized control trials. Our response to the Cochrane Report is to call for a broader range of follow-up services as part of comprehensive, multi-component early intervention strategies (e.g., Everly & Langlieb, 2003; Flannery, Everly, & Eyler, 2000; Raunch, Hembree, & Foa, 2001; Litz, Gray, Bryant, & Adler, 2002). There is also a need for further research on early intervention procedures more widely defined. Work published subsequent to the Cochrane Report appears to have provided 'evidence' that PD may be harmful, but there is also evidence that early intervention utilizing PD can be beneficial. Adequate early intervention procedures in the workplace, following disasters and in other contexts have been shown to have beneficial effects across a spectrum of outcomes (Boscarino, Adams & Figley, 2005; Deahl, Srinivasan, & Jones, 2000; Richards 2001; Dyregrov & Gjestad, 2003). Solomon, Shklar, and Mikulincer (2005) evaluated front-line treatment based on the principles of proximity, immediacy, and expectancy used in early intervention and showed that even after twenty years the use of these principles was associated with improved outcomes.

The Use of Psychological Debriefing in a Cross-Cultural Context

Considering early interventions in different cultural contexts, it seems prudent to be even more cautious about generalizing the findings of the Cochrane Report to non-Western cultures. First, it is important to recognize that our conceptions of suffering are cultural specific. People differ in what they believe and understand about life and death, what they feel, what elicits those feelings, the perceived implications of those feelings, their expression and appropriateness of certain feelings, and strategies for dealing with feelings (see, Rosenblatt, 1993). A cross-cultural perspective demonstrates the variety, for example, in people's responses to death and

dying and the process of mourning. Rather than being process-orientated, mourning is seen as an adaptive response to specific task demands arising from loss that must be dealt with regardless of individual, culture, or historical era (Hagman, 1995). Stroebe (1992-1993) challenges the belief in the importance of 'grief work' for adjustment to bereavement. Stroebe examined claims made in theoretical formulations and principles of grief counselling and therapy concerning the necessity of working through loss. Several authors have shown how grief reactions are patterned by the culture, formed by one's society's belief systems, expectations, values and norms for relationships, and bonds (Eisenbruch, 1991; Stroebe & Schut, 1998; Wikan 1990). This will influence both expression and duration of grief reactions across different cultural settings. In essence, sensitivity to the culturally appropriate needs for ritual in responding to grief and providing for privacy and personal needs are paramount. Evidence for the role of early intervention must be evaluated within its cultural context.

Green and Honwana (1999) and Summerfield (1999) have been critical of debriefing, arguing that many of the major aid organizations, such as UNICEF, USAID, Save the Children, and the Christian Children's Fund, should exercise caution when developing psychosocial programs to assist war affected children. Similar concerns were expressed by the Overseas Development Institute (ODI) report regarding the Disaster Emergency Committee (DEC) Kosovo Appeal Funds (ODI, 1999/2000) psychosocial interventions and the plethora of counselling and therapy programs in the region. However, the ODI report also advocated for early interventions for staff workers to help with the stressful nature of humanitarian work (ODI, 1999/2000, p.124). Again, here are examples of confusion in the terminology combined with misconceptions about PD and what constitutes psychosocial interventions, counselling, and therapy. Dyregrov and colleagues (2002) argue that it is possible to be culturally sensitive in such cases by working closely with local agencies to ensure the culturally appropriate application of methods and the integration of the host culture's natural healing systems and processes. Evidence is limited, not surprisingly, and randomized controlled research is not available; but other research and experience suggests ways in which this might be implemented. One example is the South Africa's Kwa Zulu Natal Program for Survivors of Violence.

The Kwa Zulu Natal Program for Survivors of Violence (KZNSV) provides an insightful case study of the use of

early intervention in a different cultural context. A non-profit NGO, it aims to rebuild the social fabric of communities most severely affected by violence in Kwa Zulu Natal province. It offers holistic community-based interventions through community development. It provides a range of interventions, ranging from personal development work, education, and training to trauma counselling, conflict resolution, and debriefing. Early intervention in this context is utilized very much along the lines of the crisis intervention model outlined previously, offering small groups the opportunity to discuss various issues affecting their communities following exposure to traumatic events (e.g. witnessing or being subject to political and criminal violence, rape, sexual assault, and domestic violence). The sessions are often held in the community, perhaps in one of the community leaders' homes. There may be more than one session, and follow-up sessions are included. Therefore 'debriefing' in this example is adapted to suit the needs of the community and would appear to be informal and semi-structured, utilizing narrative and storytelling (Zandile Nhlenghwa, KZNSV Coastal Co-ordinator, personal correspondence).

Similarly, in South Africa, many trauma service providers have been gradually shifting from their traditional roles of dealing with survivors of torture in a post-apartheid society. Some are being utilized by numerous organizations for the provision of post-trauma related support where indicated, providing a broad range of interventions for dealing with trauma survivors. Psychological debriefing and other forms of early interventions for groups and individuals, clearly viewed as different from "counselling" and therapeutic interventions, are provided. In the cultural context of a multi-ethnic country, such as South Africa, the need for flexibility, adaptability, and the ability to be responsive to the needs of various ethnic groups was an important consideration. Additionally, in dealing with complex communities where political violence and high crime rates are a major consideration, early interventions are seen as pragmatic and practical responses in dealing with survivors.

Mercer, Ager, and Ruwanpura (2005), in their article on Tibetan exiles, illustrate how traditional non-western coping strategies and cultural practices can be supplemented by western interventions following conflict and forced migration. They also suggest that the facility may accommodate explanatory models as a key factor in the acceptability of the project, as well as accommodating the views and priorities of local stakeholders. Likewise Straker and Moosa (1994) present

a case and discuss the use of western inspired early interventions (telling their story several times), along with the use of African rituals and healing practices; they attribute the successful outcome to the integration of these methods.

Asylum seekers and refugees in the United Kingdom

What we know about early intervention does not necessarily apply in other cultures, and this is of course also true when we work with asylum seekers in the U.K. The use of debriefing with asylum seekers in the U.K. in assessment centres has also been reported (Izycki, 2001), although little detail is provided other than to indicate that the model used is the Three Stage Model. This model essentially adapts Mitchell's 7-stage model into three phases: facts, feelings, and future (Letts & Tait, 1995). It is suggested that the PD techniques mentioned previously be used alongside elements of crisis intervention, indicating that it is possibly being used for a different purpose. The rationale for utilizing a debriefing intervention is not provided and no indication is given as to evaluation or intended outcomes, which begs the question of the appropriateness or utility of such an intervention in such instances.

Early interventions following conflict and disasters are often used at a time when there is a breakdown in traditional systems of care, (i.e., when there is a cultural trauma; Stamm, Stamm, Hudnall, & Higson-Smith, 2004). It is important that the use of early interventions does not accelerate cultural disintegration, but works to nurture and supplement healing elements within the indigenous culture. This is especially true for asylum seekers who are already displaced from their own culture. Thus, culturally appropriate early interventions should stimulate a sense of identity, support self-efficacy, and work to re-establish structure and meaning on both an individual and collective level. However, we would also caution that respect for cultural traditions should not prevent us from confronting traditional practises that may further complicate the situation for those affected by a trauma (Dyregrov, Gupta, & Raundalen, 2002).

The use of early intervention within humanitarian aid organizations

As part of preparation for a recent chapter in the British Psychological Society's (BPS) Professional Practice Board Working Party Report on Psychological Debriefing (BPS,

2002), one of the authors (SR) contacted a number of humanitarian aid organizations to elicit current practice, training, use of protocols and procedures, supervision, follow-up, and evaluation. Among the agencies that responded, it was clear that their welfare departments supply support, advice, and early intervention to providers in the field or upon their return from a mission. There are clear protocols in place for the delivery of the interventions, and supervision guidelines are provided. Members of the debriefing teams also have refresher training and updating.

In 2000, the United Nations High Commissioner for Refugees (UNHCR), during the Kosovo operations, utilized CISM and peer debriefing training in the field for UNHCR staff, (conducted by SR). This training was evaluated by all participants with quantitative and qualitative feedback and was conducted in conjunction with the welfare department, both in Geneva and in the field. Follow-up arrangements were organized with UN Counsellors in the field to provide the overall structure for those personnel identified as requiring further support.

Many organizations have a proactive policy and model to support their emergency workers when they are exposed to a critical incident. Some have adapted a debriefing model to suit their needs and have identified three areas: Ongoing (or cumulative) critical incident stress; group versus individual procedures; and field versus post-mission procedures. Protocols have been developed for ongoing stress, for a three-phase group, and for complementary individual sessions (Cohen de Lara-Kroon & van den Berkof, 2001). It is known that many of the other aid organizations are providing PD and other CISM support, though it is unclear which particular models have been selected and used.

The International Federation of Red Cross and Red Crescent Societies (IFRC/RC) Reference Centre for Psychosocial Support, hosted by the Danish Red Cross, was established in 1993. The Reference Centre has been instrumental and innovative in the development of a community-based Psychological Support Program (PSP). This is a short, modular training program intended as an adjunct to basic Red Cross work and aimed at addressing the psychological support needs of both volunteers and the public in case of a major disaster. The program now has a roster of mental health professionals who are able to provide assessment and training to other Red Cross National Societies in the PSP program. In June 2001, the IFRC used the WHO theme of mental health

to launch a document entitled *Psychological Support: Best Practices from Red Cross and Red Crescent Programs* (IFRC/RC, 2001). The document highlighted best practice as demonstrated by fifteen programs throughout the world that had developed PSP programs following disasters or civil conflict.

In this program early interventions are addressed from a supportive community-based perspective. The guidelines for the implementation of a psychological support program in emergencies have not endorsed PD as a routine model, because of the “scientific disagreement about the effectiveness of the approach...” (IFRC, 2001, p.8), or “because of possible negative effects”(World Health Organization, 2003). A major factor for the inclusion of such statements has been the impact of the Cochrane Review on practice, yet the Cochrane Review also stated that “we are unable to comment on the use of group debriefing, nor the use of debriefing after mass traumas” (Wessley, Rose, and Bisson, 1998, p.10).

A survey of 24 Red Cross National Societies who said they used PD as part of their range of interventions following disasters or critical incidents was undertaken to assess the current use of PD as an early intervention strategy. This was also an opportunity to gauge the use of PD across different cultures. What is clear is that some form of early crisis intervention, in the form of different group formats, is in place in many instances, though there are wide variations in training, supervision, and evaluation (Regel and Courtney-Bennett, 2002). Some NSs have adopted their own model or adhered to a culturally specific model, as in the case of the French Red Cross (Lebigot, 2001). It is also clear that the controversy did not deter many Red Cross and Red Crescent National Societies from continuing what they perceived as “a necessary practice.” This view is supported by the results of a meta-analysis of studies of psychological debriefing with vicarious trauma in emergency care providers (Everly, Boyle, & Lating, 1999)

Undertaking Psychological Debriefing in Different Cultural Settings – Ten Implications for Practice

This literature review examined the impact of the cultural context following traumatic events and has highlighted the following ten issues and implications for the use in the practice of early intervention. It must be noted that these implications are derived from, but not necessarily based on, the current literature review and that empirical support is necessary to test their efficacy.

1. Different ethno-cultural groups have differential responses to traumatic events that will become apparent in the context of a group session. In addition, building trust and establishing a safe environment for such meetings may be especially difficult when the facilitator is from a different cultural or racial background than the participants.
2. Many non-Western ethnic groups present symptoms somatically rather than psychologically or existentially; this has implications for the development of a cohesive narrative and the interpretation, contextualization and normalization of traumatic responses
3. There is a need for more research among ethno-cultural minority populations to identify the sources of strength and resiliency that mediate the onset, course, and outcome of Posttraumatic Stress Disorder (PTSD). This would impact on the educational and support elements of the intervention process. For example, there would be less need to emphasize the role of community support as that is often a given in different cultures, a view supported by those attending psychosocial training programs in Somalia, Korea, and Japan, where there was a universal recognition among participants (all drawn from local communities) that the community would gather resources and support as necessary in the event of a disaster or crisis.
4. Some researchers have suggested that, whereas intrusive thoughts and memories of a traumatic event may transcend cultural experiences, the avoidance/numbing and hyper-arousal symptoms may be highly determined by ethno-cultural affiliation. This has implications for the application of more sophisticated interventions and explanations in the psycho-educational phases of the intervention process.
5. The need to use interpreters will influence interactions and compound difficulties mentioned above. Therefore, careful discussion of the process in psychological debriefing will be essential. In addition, this will also affect the time frame of the intervention, posing possible constraints on participation and attendance.
6. Culturally based willingness to accept different “therapeutic” formats (e.g., individual vs. group interventions) may have an impact on the intervention. In many cultures, story telling and discussion in a group context and setting is often common, thus making the idea of discussing difficult experiences more acceptable.
7. A consideration of indigenous expressions of disorder, idioms of distress, formats, language, and concepts is vital in order to contextualize attribution and meaning arising out of a crisis.
8. Early intervention in a cross-cultural setting must be offered within a broader context and framework, integrating ethno-cultural factors, rituals, problems of meaning and language, metaphors, cultural symbolism, and awareness of adaptational/acculturation pressures.
9. Early intervention conducted in a cross-cultural setting should also be carried out within a structured framework, ensuring follow-up arrangements for ongoing support. This is especially important in the context of humanitarian aid organizations where delegates are exposed to critical incidents and stressors in the field.
10. Finally, the cultural sensitivity and sophistication of the facilitator is paramount when discussing pertinent aspects of the trauma, such as those related to sexual matters or to death.

The above points are not intended as a comprehensive checklist, but merely offered as factors that should be considered if early intervention, such as PD, is applied in different cultural settings. The challenge remains of how best to approach interventions with these populations in a culturally relevant framework. More research is now needed on the precise nature of interventions across cultures, organizations working with diverse cultures and populations affected by extreme traumatic events. Due to the paucity of literature in the field, longitudinal prospective studies are needed to examine the effects of cumulative stressors in humanitarian aid workers. There are also a number of implications for practice, especially with regard to the practice of early interventions in different cultural settings and contexts. The ability to be flexible and adapt robust crisis intervention strategies and techniques is essential, as is the ability to distinguish between therapy and sound psycho-educational interventions for individuals and groups following exposure to traumatic events (Marsella, Friedman, & Gerrity, 1996).

CONCLUSION

This article has addressed a range of issues that impact on the use of early intervention in different cultural contexts. Our review suggests that many organizations use early intervention, including various forms of PD, despite the criticism of such approaches and the pressure to cease the practice. There is reason to believe that early interventions are often helpful. We now need further evaluations that are able to address the various criticisms of the Cochrane Report. In many other cultures the notion of psychological or psychosocial support following traumatic or extremely stressful events is viewed as common sense and a humanitarian act, whether this is in the form of low key support or more professionally driven psychological interventions. There are clear examples of good practice among some of the key humanitarian aid organizations with clear protocols and practice frameworks in place. The relatively widespread use of early intervention in culturally diverse settings, such as the International Federation of Red Cross and Red Crescent Societies (IFRC), is an indication that the need for support mechanisms of some kind for volunteers, aid workers, and survivors of disasters or critical incidents are deemed to be essential. Finally, we have outlined ten issues for consideration that we think should inform future practice and research in understanding effective early interventions.

REFERENCES

- Bisson J.I., Jenkins P.L., & Alexander, J. (1997) Randomised controlled trial of psychological debriefing for victims of acute burn trauma. *British Journal of Psychiatry*, 171, 78-81
- Boscarino, J.A., Adams, R.E., & Figley, C.R. (2005). A prospective cohort study of the effectiveness of employer-sponsored crisis interventions after a major disaster. *International Journal of Mental Health*, 7, 9-22.
- British Psychological Society (2002) *Psychological Debriefing -Report of the Professional Practice Board Working Party*. British Psychological Society, Leicester, UK
- Cohen de Lara-Kroon, N., & van den Berkof, R. (2001). Debriefing Procedures for Humanitarian Aid Workers. Workshop presented at ESTSS Seventh European Conference on Traumatic Stress, 26-29th May, Edinburgh, Scotland.
- Davidson, J.R.T. (2004) Long-term treatment and prevention of Posttraumatic Stress Disorder. *Journal of Clinical Psychiatry*, 65 [Supplement 1], 44 – 48.
- Deahl, M., Srinivasan, M., Jones, N. (2000). Preventing psychological trauma in soldiers: The role of operational stress training and psychological debriefing. *British Journal of Medical Psychology*, 73, 77-85.
- Dyregrov, A. (1989) Caring for helpers in disaster situations: Psychological debriefing. *Disaster Management*, 2(1), 25-30
- Dyregrov, A. (1997) The process in psychological debriefings. *Journal of Traumatic Stress* 10(4), 589-605.
- Dyregrov, A., & Gjestad, R. (2003). A meritime disaster: Reactions and follow-up. *International Journal of Emergency Mental Health*, 5 (1), 3-14.
- Dyregrov, A., Gupta, L., Raundalen, M (2002). Is the culture always right? *Traumatology*, 8(3).
- Dyregrov, A., Gjestad, R, Raundalen, M. (2002). Children exposed to warfare: A longitudinal study. *Journal of Traumatic Stress Vol. 15* (1), 59-68.
- Eisenbruch, M. (1991). From post-traumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees, *Social Science & Medicine*, 33, 673-680.
- Emmerik, A.P., Kamphuis, J.H., Hulsbosch, A.M., & Emmelkamp, P.M. (2002). Single session debriefing after psychological trauma: A meta-analysis. *Lancet*, 360, 766-771.
- Everly, G.S., Jr., Boyle, S.H., & Lating, J.M (1999) The Effectiveness of psychological debriefing with vicarious trauma: A meta-analysis. *Stress Medicine*, 15, 229-233.
- Everly G.S., Jr., & Mitchell, J.T. (2000). The debriefing “controversy” and crisis intervention: A review of lexical and substantive issues. *International Journal of Emergency Mental Health*, 2 (4), 211-225
- Everly, G.S., Jr., & Langlieb, A. (2003). The evolving nature of disaster mental health services. *International Journal of Emergency Mental Health*, 5(3), 113–119.
- Flannery, R.B., Jr., Everly, G.S., Jr., & Eyler, V. (2000). The assaulted staff action program (ASAP) and declines in assault: A meta-analysis. *International Journal of Emergency Mental Health*, 2(3), 143–148.
- Green, E.C., & Honwana, A. (1999). Indigenous healing of war – affected children in Africa. *Indigenous Knowledge (IK) Notes, No.10, July*, Africa Region’s Knowledge and Learning Centre & World Bank Publications.
- Hagman, G. (1995). Mourning: A review and reconsideration. *International Journal of Psychoanalysis*, 76, 909 – 925.

- Hobbs, M., Mayou, R., Harrison, B. (1996). A randomised controlled trial of psychological debriefing for victims of road traffic accidents. *British Medical Journal*, 313, 1438-1439
- International Federation of Red Cross and Red Crescent Societies (2001) *Guidelines for the Implementation of a Psychological Support Program in Emergencies*. International Federation of Red Cross and Red Crescent Societies: Geneva.
- Izzychi, K. (2001). A safe haven for asylum seekers. *Mental Health Practice*, 4(6) 12-15.
- Lebigot, F. (2001). Le debriefing collectif. *Stress et Trauma*, 1(3), 137–141.
- Letts, C., Tait, A. (1995). Post-raid de-briefing. *Occupational Health Vol. 47*(12), 418-421.
- Litz, B.T., Gray, M.J., Bryant, R.A., & Adler, A.B. (2002). Early intervention for trauma: Current status and future directions. *Clinical Psychology: Science and Practice*, 9, 112-134.
- Marsella, A.J., Friedman, M.J., Gerrity, E.T. (1996) (Eds.) *Ethnocultural aspects of PTSD: An overview of issues research and clinical applications*. American Psychiatric Press: Washington, D.C.
- Mercer, S. W., Ager, A., & Ruwanpura, E. (2005). Psychosocial distress of Tibetans in exile: Integrating Western interventions with traditional beliefs and practices. *Social Science & Medicine*, 60, 179–189.
- Mitchell, J.T. (1983). When disaster strikes - The critical incident stress debriefing process. *Journal of emergency Medical Services, need volume #*, 36-39.
- Mitchell, J.T. (1988). Development and functions of a critical incident stress debriefing team. *Journal of emergency Medical Services, need volume #*, 43-46.
- Mitchell, J.T., & Everly, G.S., Jr. (1999). Critical incident stress management: A new era in crisis intervention. *ESTSS Bulletin*, 6(2), 3-7.
- Overseas Development Institute (1999-2000). Independent Evaluation of Expenditure of DEC Kosovo Appeal Funds, Phase I & II. ODI: London.
- Raunch, S., Hembree, E., & Foa, E. (2001). Acute psychosocial preventive interventions for posttraumatic stress disorder. *Advances in Mind-Body Medicine*, 17, 160–196.
- Regel, S., & Cortney-Bennett, H. (2002). Cultural factors with an impact on psychological debriefing. In *Psychological debriefing: Report by British Psychological Society Professional Practice Board Working Party*, Chapter 9, pp. 64 - 73- British Psychological Society: London.
- Richards, D. (2001). A field study of critical incident stress debriefing versus critical incident stress management. *Journal of Mental Health*, 10, 351-362.
- Rose, S., & Bisson, J. (1998). Brief early psychological intervention following trauma: A systematic review of the literature. *Journal of Traumatic Stress*, 11, 697–710.
- Rosenblatt, (1993). Cross cultural variation in the experience, expression and understanding of grief. In: Irish, D.P., and Lundquist, K.F (Eds.) *Ethnic variations in dying, death and grief: Diversality in universality*. Taylor and Francis: Washington D.C.
- Solomon, Z., Shklar, R., & Mikulincer, M. (2005). Frontline treatment of combat stress reaction: A 20-year longitudinal evaluation study. *American Journal of Psychiatry*, 162, 2309–2314.
- Stamm, B., Stamm IV, H.E., Hudnall, A.C., & Higson-Smith, C. (2004). Considering a theory of cultural trauma and loss. *Journal of Loss and Trauma*, 9, 89–111.
- Stroebe, M.S. (1992-1993). Coping with bereavement: A review of the grief work hypothesis. *Omega: Journal of Death and Dying*, 26, 19-42.
- Stroebe, M., & Schut, H. (1998). Culture and grief. *Bereavement Care*, 17, 7–11.
- Straker, G., & Moosa, F. (1994). Interacting with trauma survivors in contexts of continuing trauma. *Journal of Traumatic Stress*, 7 (3), 457-465.
- Summerfield, D. (1995). Debriefing after psychological trauma: Inappropriate exporting of Western culture may cause additional harm. *British Medical Journal*, 311, 7003, 509
- Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programs in war affected areas. *Social Science and Medicine*, 48, 1449 – 1462.
- Wessely S., Rose, S., Bisson, J. (1998). A systematic review of brief psychological interventions (“debriefing”) for the treatment of immediate trauma related symptoms and the prevention of post-traumatic stress disorder. *The Cochrane Library*, 1998(4).

Wikan, U. (1990). *Managing turbulent hearts*. The University of Chicago Press: Chicago.

World Health Organization (2003) *Mental health in emergencies*. Department of Mental Health and Substance Dependence: Geneva.

Yule, W. (2006). Theory, training and timing: Psychosocial interventions in complex emergencies. *International Review of Psychiatry*, 18 (3), 259-264.