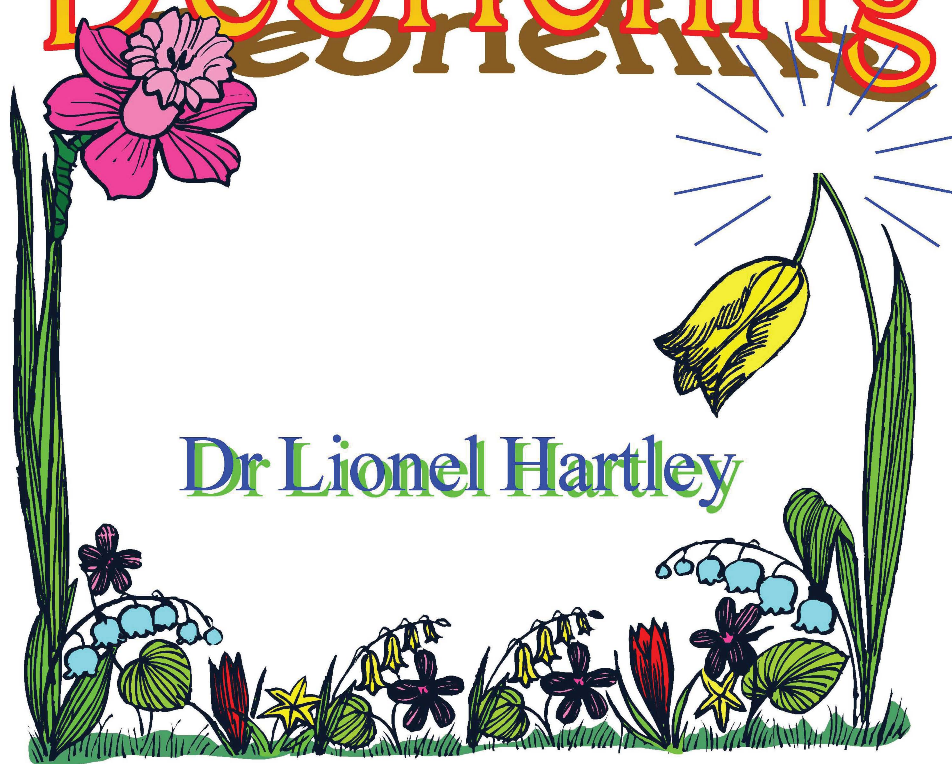
Clinical Debriefing



Dr Lionel Hartley

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Clinical Debriefing

what are its goals?

How we go about doing it.

And what are its limitations?

Clinical Debriefing

By Lionel D C Hartley, PhD

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This is a transcript of a seminar on professional clinical debriefing presented by Lionel Hartley for Salubrity™ Seminars. It has been retained in its conversational style to avoid the insalient editing-out of some crucial point.

Let us start first with a definition. Debrief has been coined from the French phrase, *'de Brief'*, *'de'* meaning 'from' and *'Brief'* meaning 'instructions given'.

Therefore debriefing is **to discuss an outcome pertaining to a previous experience**.

Debriefing is not interrogation, and in our context is defined as

'the process of defusing, disencumberancing and developing following counselling or critical incident.'

Like all technical definitions, this definition has components which need defining.

'Defusing' is usually a deliberately created opportunity for workers to obtain brief support when they finish a shift.

This may be through sharing a report with personnel on the next shift, a brief report or discussion on an area of concern, or merely a 'how did it go today?' from the supervisor.

'Disencumberancing' is a cumbersome seventeen-character word, which simply means unloading pent-up emotion through retelling frustrational and traumatic experiences.

And ***'developing'*** pertains to the exercise of sharing experiences, of receiving information about normal reactions and responses, and developing strategies for future use.

A ***'Critical incident'*** is any serious and stressful event, which either happens to you, someone close to you, or someone you may be called upon to counsel.

Counsellors who experience a critical incident themselves are in just as much a need of debriefing as counsellors less directly involved, if not more so.

Examples of critical incidents would be:

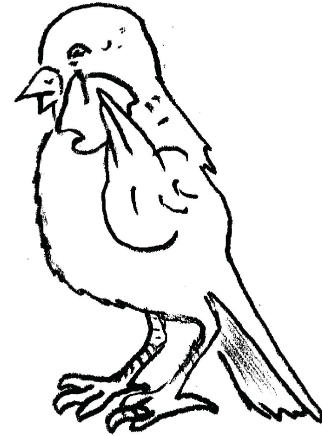
A serious accident, the death of someone (especially a child), violent deaths such as murder or suicide, many deaths at one time, rape, personal disaster such as vehicle or air crashes, disasters such as earthquakes, fires & floods, shooting and community violence, or being robbed, mugged or assaulted, etc.

Let us then talk specifically about debriefing -

What are its goals,

how we go about doing it,

and what are its limitations?

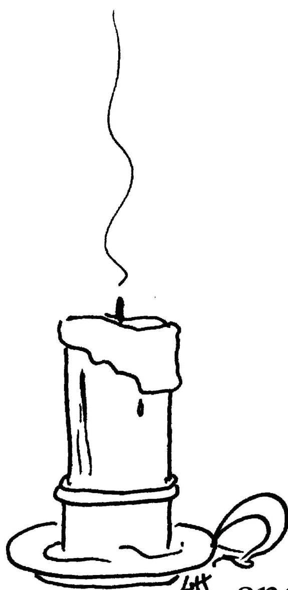


Firstly let us remember that the immediate consequence of any traumatic life experience is

LOSS.

Assisting in the coping with loss presents one of the greatest challenges to every counsellor, as almost every caller will be experiencing the emotions associated with loss in some way.

For example, relationship problems reveal a plethora of both real and imagined losses -



loss of support,
loss of intimacy,
loss of self esteem,
loss of progenity *(which also occurs in hysterectomy & menopause)*,
loss of status,
loss of freedom,
loss of dignity,
loss of choice,
loss of control,
and a loss of faith in people or in God.

And coping with loss involves the dealing with the emotions such as:

shock, fear, anger, helplessness, sadness, shame....

And other effects such as tension, sleep disturbance, dreams & nightmares, fearfulness, intrusive memories and feelings, numbness, irritability, depression, social withdrawal, physical sensations, mental reactions, and self-medication.

Lets look at these, one at a time...

Shock

There is often a disbelief at what has happened, the person experiences denial - often the first two words are 'Oh, no!' The person may experience physical or emotional numbness - the loss may seem unreal. The may think that they are really only dreaming. There is often a slow comprehension of what has happened, even if other or later observers can explain it simply.

* disbelief at what has happened
* numbness - the loss may seem unreal, like a dream
* slow comprehension of what has happened

Fear

There are a number of possible fears that may need to be dealt with, such as the fear of further of damage to oneself or of death. This is often linked with the fear of a recurrence of the event. Sometimes these fears are real, sometimes imagined. Either way

they are real enough for the person involved, to necessitate action. Fear may come about when the person becomes aware of their personal vulnerability, of the way they acted or are still acting, especially if these involve panicky irrational feelings.

* of damage to oneself, of death
* of recurrence of the event
* through awareness of personal vulnerability
* panicky irrational feelings

Anger

Anger may be very specific - aimed at individuals who are perceived as being those who caused it or 'allowed it to happen'. Or anger may be more generalised, such as the outrage at what has happened or the personal frustration at one's helplessness in dealing with the injustice and senselessness of it all.

Anger may be directed at a Deity due to the seeming absence of divine intervention - 'Where is/was God?' Or the person may be expoeriencing non-specific generalised anger and irritability.

* Anger at who caused it or 'allowed it to happen'
* outrage at what has happened
* at the injustice and senselessness of it all
* at the seeming absence of divine intervention - 'Where is God?'
* generalised anger and irritability

Helplessness

The feeling of helplessness, especially in one trained to support others, can be quite overwhelming. Crises, especially natural disasters, have an uncanny habit of bringing out human powerlessness as well as revealing our strengths.

* crises may bring out human powerlessness as well as strengths

Sadness

The observation of human destruction and losses of every kind may bring about feelings of sadness. The loss of the belief that the world is safe may precipitate gloom, and the realisation that life is not as predictable as one imagined can be depressing.

* about human destruction, and losses of every kind
* for the loss of the belief that the world is safe and predictable

Shame

For having been exposed as helpless, 'emotional', or needing others may be a dreadfully humiliating experience for some. The recollection that, in the time of crisis, one did not act as one would have wished, brings about feelings of personal shame, and sometimes guilt.

* for having been exposed as helpless, ‘emotional’, or needing others
* for not having acted as one would have wished

These feelings are quite common. Expressing them allows nature to heal. They usually last for short periods and gradually diminish. Different feelings may be more dominant as time goes by.

In addition to these there may often be other effects such as:

Tension

Tension may present itself in a variety of ways: tight muscles especially around the neck (causing a feeling of choking or strangulation), tightness or churning in the stomach, excessive salivation, being easily startled or frightened, ‘on edge’ feeling ‘tense’.

* more easily startled
* ‘edgy’

Sleep disturbance

This is more than (and includes) the simple inability to sleep. Often when we try to cope with loss we encounter thoughts that prevent sleep. In our mind we may replay the incident over and over again, trying to make sense out of it. These replays may fill our dreams or we may have nightmares of the incident or other frightening events or possible outcomes.

* inability to sleep
* thoughts that prevent sleep

* replaying the incident
* Dreams & nightmares of the incident or other frightening
events or possible outcomes

Fearfulness

Fearfulness, as diferentiated from fear (above), is a generalised anxiety in regard to the incident or in relation to locations associated with the incident. We may feel anxious about going to the same location because we are fearful of a repeat of the incident or, if we are convinced that that will not happen, we may feel anxious because we fear possible emotions that being near (or at) the location will arouse.

* of the incident or locations associated with the incident

Intrusive memories & feelings

These are pervasive memories & feelings which permeate our being and interfere with concentration and daily life. We may experience episodes of recall with flashbacks to the incident. When we attempt to shut them out we feel numb, so our feelings and thoughts become seemingly deadened and we feel deprived of or lose vitality.

* interfere with concentration and daily life
* flashbacks
* attempts to shut them out which leads to deadening of feelings and thoughts

Numbness

This is the consequence of intrusive memories, where our feelings seem to be 'shut down'. We no longer have an interest in certain things - more especially we tend to avoid anything that evokes emotions. Anything that may be or become a reminder is 'blocked out'.

* feelings seem to be 'shut down'
* loss of interest
* avoiding things that evoke emotions, such as reminders

Irritability

We may become irritable, with frequent mood swings

* frequent mood swings

Depression

Clinically, depression is more than just sadness, it is a real mourning over the event or past events. Or depression may be non-specific. Depression may be the consequence of dwelling upon or experiencing guilt about how one behaved before, during and/ or after a incident.

* about the event or past events
* non-specific depression
* guilt about how one behaved

Social withdrawal

This may be both, or either, a need to be alone and a fear of being with others. Fear, shame, embarrassment at the shedding of tears or public displays of emotion, stress due to noise or crowds, guilt - all are factors which precipitate withdrawal.

* a need to be alone
* fear, shame, embarrassment, stress, guilt

Physical sensations

In addition to the above, someone suffering loss may experience some or all of the following:

Physical sensations

* tiredness or fatigue
* palpitations
* tremors
* breathing difficulties
* headaches
* tense muscles
* aches and pains
* loss of appetite
* diarrhoea or constipation
* loss of interest in sex
* nausea
* menstrual disturbance

and many other symptoms

Mental reactions

* poor concentration
* difficulty thinking
* self doubts
* poor short-term memory
* loss of confidence
* confusion

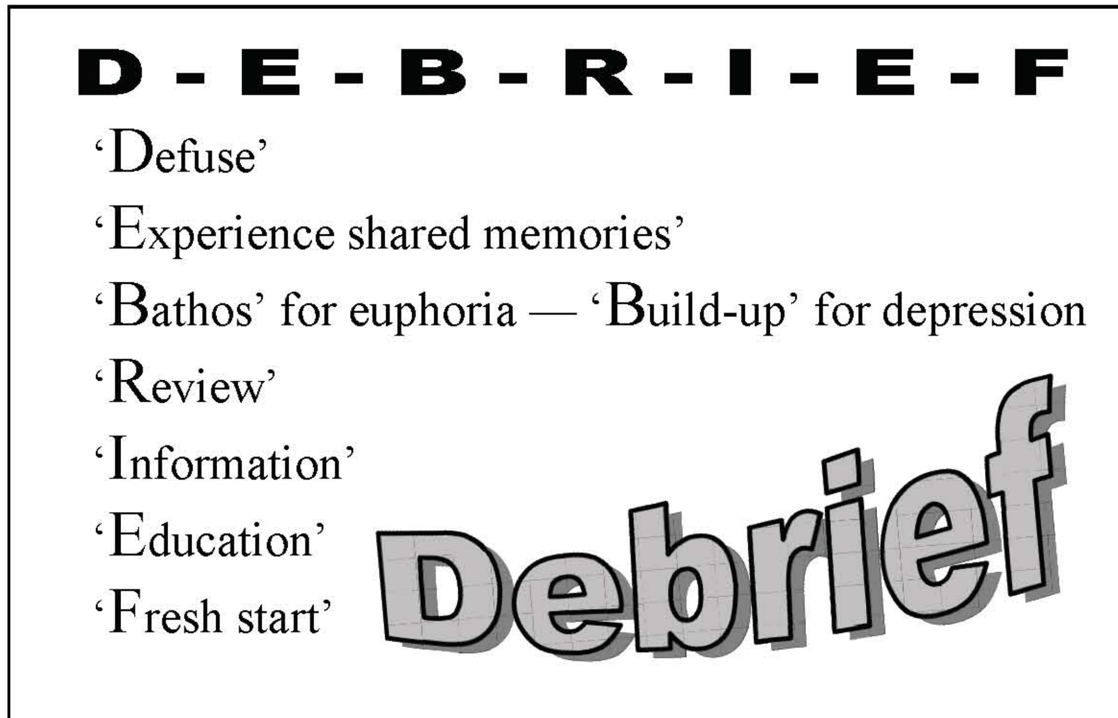
and Self medication

Which is the taking of pills or other drugs, excessive tobacco usage, and drinking alcoholic and caffeine beverages excessively in an attempt to deal with stress, distress, or intrusive memories.

* taking pills and other drugs, drinking alcoholic and caffeine beverages excessively to deal with stress, distress, or intrusive memories

Exposure to some or all of these effects of loss may create in the counsellor a need for debriefing.

Maybe the easiest way to explain debriefing is to use the word 'debrief' as an acronymn.



Again, let's look at these, one at a time.

1 D - Defusing

In the case of exposure to a critical incident, defusing preferably needs to take place within 24 hours of the exposure to the incident. This should really be a process preceding debriefing, although it may be included in a debriefing session if it has not been experienced earlier. Debriefing should take place within 24 to 72 hours of a critical incident exposure and at least weekly for full-time counsellors in regular practice. Part-time counsellors may either need less frequent debriefing or, as is often the case, the opportunity for more extensive defusing after each shift.

2. E - Experience shared memories.

One of the goals of debriefing is to help people to unload an experience and to learn from the shared experiences of others.

Those being debriefed are seen together as a group and ideally should include as many of the team as can possibly be together at the one time.

There is no shame in nor should there be any stigma attached to attending or feeling the need to attend a debriefing session.

Naturally Christian counsellors will choose to include God as one of their number in debriefing sessions, with a prayer and brief inspirational devotional segment.

Typically a session will take 2- 3 hours and commence with sharing information the group and setting its own rules about confidentiality and conduct. Examples of such rules may be

'Attack the issue and not each other; the problem not the person',

'One person to speak at a time without interruption' or

'We must not condemn repetition'.

Facilitators who carry out debriefing should ideally be specially trained professionals who are knowledgeable about debriefing processes, group dynamics, stress management, and reactions to trauma and loss.

People are encouraged to present their experiences and usually one or two specific shared experiences will emerge.

Thoughts, feelings, and reactions are discussed and may be

ventilated. (This is what we mean by disencumberancing.) I stress, though, that there should be no demand that ventilation need occur.

3. B - Bathos for euphoria; Build-up for depression

In a way debriefing allows for group telling of similar experiences.

Bathos, from the Greek for 'depth', is the ability of the group to bring you 'down to earth' if you have unrealistic euphoria. This may be due to receiving only one side of a story and misinterpreting the implications, eg. The choice by a repeat counsellee to separate herself from the cause of her grievance. Unrealistic euphoria may also be due to an hysterical response by the counsellor to a particularly distressing counselling session -

The group discussion may help this counsellor to come down to reality and resume usefulness.

Build-up is a far more common role the group can perform for counsellors. Hearing depressing tales of woe for umpteen hours at a time may, in itself, be depressing.

Couple to that the frustration of realising that there are times when you feel powerless to help, at a loss for words of encouragement, 'out of your depth' in expertise or experience, or confronted with an unusually complicated scenario—little wonder depression causes so many casualties in counselling circles when debriefing doesn't occur either regularly enough or at all.

Sometimes debriefing sessions may need to include the dynamic of some other aspects of group tension relief such as progressive relaxation exercises, deep breathing, or physical games such as balloon or ball throwing or aerobic exercises.

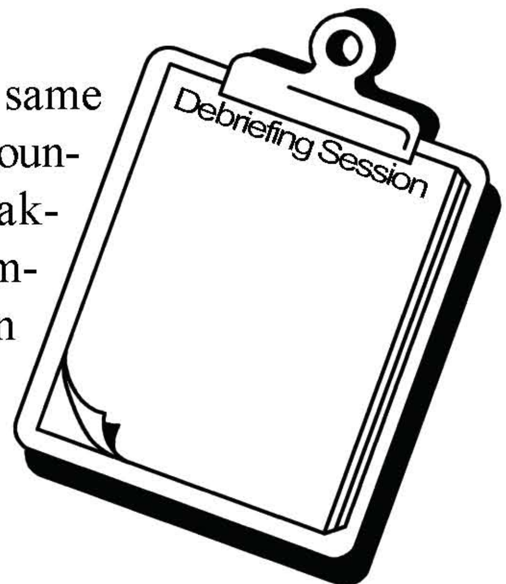
This may become appropriate when either a session is overly prolonged, when tensions are 'running hot' or when the facilitator senses the possibility of the session turning into what is colloquially called a 'gripe session'. Some debriefing group facilitators make team games a part of every debriefing session. However, it can be overdone.

4. R - Review

Despite the anxiety some counsellors feel about such things, reviewing a shared experience with role-play or dramatisation is both beneficial in disencumberancing and in educating.

It is through this review component that we experience a non-threatening shared mobilisation of support. Questions hidden in the recesses of the timid counsellor's mind are often answered by the more experienced.

Sharing different approaches to the same incident may both reveal and recognise counsellor's individual strengths and weaknesses, but a facilitator skilled in affirming, praising strengths and building on weaknesses will make this component most productive and non-threatening.



5. I - Information

We all need to gather statistics on the types of cases we are presented with both for our own use in planning, goal setting and budgeting, and as a requirement of management, Government and funding bodies.

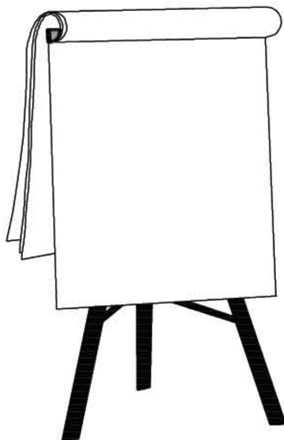
Debriefing sessions may provide an opportunity for these statistics to be gathered more representatively than the standard report forms many of us are used to.

For example, our reporting system may record that we, as a group, dealt with x number of cases of rape in the past so-many days. But the debriefing session may reveal that such-and-such a percentage of these were from a particular ethnic community or from workers at a motor assembly plant, for example.

However, the debriefing session must never take the place of your regular written reports and case-notes, etc.

6. E - Education

All debriefing sessions should include an education component. To some degree this is covered in earlier media such as role-play, but closing a debriefing session with specific training by a social or health professional in some relevant area can both relieve the tension of the session and provide valuable in-service training. Simply having a social or health professional at your debriefing session may be advantageous.



7. F - Fresh start

Professional debriefing has proved to be a useful and supportive process. Although because of its individuality, it has had little systematic evaluation in terms of outcome, it is perceived positively by most professionals.

Debriefing's acknowledgement of people's experiences is both a symbolic as well as a real aspect of its value.

Nevertheless there are significant numbers of counsellors for whom it will not be adequate.

It may not be at the right time.

It may not meet their needs.

It may be they felt no opportunity for self-expression.

It may be they feared exposing their vulnerability.

Perhaps they feared loosing control.

Studies have shown that some people will continue to be highly stressed despite professional clinical debriefing, and for many, although it is perceived as helpful, it may not lessen their symptoms of stress and distress.

Some may not be able to use debriefing because of shock or denial.

It is essential that debriefing not be seen as a cure-all, but is available as part of a safety net of back-up and support including further education, personal counselling, and rapid and effective professional intervention when problems arise.

Debriefing then is an avenue for counsellor growth and togetherness.

* (From 'Coming Together'
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