

Crisis debriefing: What helps, and what might not

Good intentions are admirable, but providing effective treatment contributes more

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Debriefing interventions have sprung from the understandable desire to reduce—if not eliminate—victims’ suffering after traumatic loss. Unfortunately, no compelling evidence has shown that an intervention given within a few days of a traumatic event can prevent significant psychological distress.

Evidence does suggest, however, that components of psychological debriefing discussed here may help you provide effective “first aid” to trauma



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Table 1

Clinical features of complicated grief

- **Constant longing**, yearning, or pining for the lost person
- **On edge** or jumpy
- **Trouble accepting** the loss
- **Difficulty trusting** others
- **Anger or bitterness** about the loss
- **Uneasiness** about moving on with life
- **Emotionally numb**
- **Trouble feeling connected** to others
- **Feeling as if there is no future** or that the future holds no meaning without the lost person

Source: Reference 3

Table 2

Clinical features of posttraumatic stress disorder

- **Exposure to traumatic event** characterized by actual or threatened death or serious injury OR threat to physical integrity of self or others
- **Peritraumatic response** must be characterized by intense fear, helplessness, or horror
- **Re-experiencing symptoms** (1 or more), such as intrusive distressing memories or nightmares
- **Avoidance and numbing symptoms** (3 or more), such as avoidance of trauma-reminiscent cues, contexts, or conversations
- **Hyperarousal symptoms** (2 or more), such as concentration difficulties, exaggerated startle response
- **Duration:** Symptoms must be present for at least 1 full month after the trauma and must be of sufficient severity to compromise functioning

Source: DSM-IV-TR

victims and identify persons at risk for chronic psychological problems.

COMPLICATED GRIEF REACTIONS

Death of a family member or close friend is among life's most painful losses. When death occurs unexpectedly—as from violence, accident, natural disaster, or suicide—survivors' emotional and psychological response can be pronounced.

Most survivors report great distress immediately after trauma or traumatic loss, but only an estimated 9% develop chronic psychopathology,¹ such as complicated grief (*Table 1*).^{2,3} If the death was violent, surviving loved ones may experience complicated grief and posttraumatic stress disorder (PTSD)⁴ (*Table 2*).

Complicated grief is associated with considerable morbidity and risk of physical illness.⁵ PTSD develops in approximately one-third of cases involving sudden, unexpected death of a close friend or relative¹ and can result in comorbid—but distinguishable—reactions to the loss (*Box*).⁶

Evidence-based secondary and tertiary intervention protocols have been developed for PTSD,⁷ but no practice guideline exists for treating or preventing complicated grief. Few controlled trials have been done.⁸

Early interventions. After traumatic events, the early interventions routinely offered by mental health professionals are forms of psychological debriefing—specifically critical incident stress debriefing (CISD). CISD is a variant of debriefing developed by Mitchell et al, whereas

psychological debriefing can take a variety of forms. However, all forms of debriefing (CISD or otherwise) typically consist of four components:

- educating individuals about stress reactions and how to cope with them
- instilling messages that stress reactions are normal
- helping affected persons process and share their emotions
- providing information about and opportunity for further intervention, if needed.

Typically, individuals exposed to potentially traumatic events are invited, within days, to participate in a 3- to 4-hour session in which the incident is reviewed. Participants are asked to describe the stressor, provide a factual account of the event, then describe their thoughts during the incident. Emotional reactions to the event also are shared, and the facilitator normalizes these reactions.

DOES DEBRIEFING WORK?

Debriefing is designed not to address the intense but transient emotional reactions that can be expected immediately following traumatic loss but to prevent protracted, incapacitating distress. For an early intervention to be considered effective, it must be associated with greater or more expedient symptom recovery compared with natural remission. Controlled clinical trials are necessary to determine if this is the case.⁹

Control groups are essential when studying treatment outcomes of early crisis interventions. Simply documenting improvement among treated individuals is insufficient because substantial symptom remission is the norm and chronic psychopathology is comparatively rare. Thus, early interventions studies should at least:

- include a treatment group and a no-treatment or wait-list control condition
- randomly assign participants to avoid self-selection biases.

The debriefing literature is difficult to inter-

Box

How complicated grief differs from posttraumatic stress disorder

Traumatic loss. Although complicated grief (CG) and posttraumatic stress disorder (PTSD) can both develop following the loss of a loved one from a traumatic event, CG also can develop after expected deaths from natural causes. PTSD is exceedingly uncommon if a loved one's death did not result from homicide, suicide, or accident, whereas CG can occur when the loss was not particularly violent or sudden.

Avoidance vs preoccupation. The fundamental difference between CG (*Table 1*) and PTSD (*Table 2*) symptoms is the degree that survivors avoid cues and contexts that remind them of their loss.

Those with PTSD go to great lengths to avoid thinking about the traumatic event and actively avoid situations that may remind them of it. This avoidance, paradoxically, exacerbates intrusive memories, as trying not to think about something increases the frequency of those thoughts.

Individuals with CG do not avoid reminders of the deceased. Quite the opposite, they seek out reminders (such as photos or recordings) and find solace in them. Reminders may contribute to their ongoing rumination or preoccupation, in which they retreat into memories of the deceased rather than engage in present life.

Hyperarousal symptoms that are required for PTSD diagnosis are largely absent in CG. Even when persons with CG experience arousal, it is not akin to scanning the environment for danger or threat, as is typical with PTSD. Persons with CG have a pronounced negative affect and bereavement-related depression, rather than an exaggerated startle response or heightened physiologic reactivity.

Source: Reference 3



pret because studies often are unclear about what intervention has been used (CISD or otherwise).

Debriefing for traumatic loss. Debriefing-based interventions have been used after mass violence and other large-scale traumatic events that may trigger complicated grief reactions.¹⁰ Most studies have not evaluated the impact of debriefing on complicated grief specifically but have focused on PTSD, anxiety, and depression. Typical published accounts of debriefing-based interventions for grief responses¹¹ have been anecdotal, qualitative, and uncontrolled.

One rare controlled study of debriefing¹² was designed to target emotional difficulties in women following early miscarriage. The one-half of participants who were debriefed 2 weeks after miscarriage perceived debriefing to be helpful. Despite significant improvement in early intrusion and avoidance scores, however, the women who were debriefed showed no greater improvement after 4 months than did a nondebriefed control group. The investigators concluded that debriefing did not influence post-loss adaptation.

A wider search. In the absence of randomized, controlled trials (RCTs) of debriefing-based interventions for traumatic loss, we turn to the larger debriefing literature. Nearly all debriefing studies have focused on PTSD symptoms rather than grief responses.

A number of peer-reviewed studies suggest that psychological debriefing is an effective intervention. These studies^{13,14} are characterized by dramatic symptom reductions following the intervention. Unfortunately, nearly all lack a control group, and the few that were controlled¹⁴ were not randomized. Studies reviewed by Everly et al¹⁵ also contain fundamental flaws, such as lack of random assignment, failure to assess individuals prior to

the intervention, and lack of control groups.

None of the few RCTs of psychological debriefing conducted in traumatized populations show that it accelerates recovery in treated persons compared with nontreated controls.¹⁶ All of the studies¹⁷⁻²² included untreated control conditions, and participants were randomly assigned. Without exception, debriefed participants did not show superior improvement, and in two studies they showed worse outcomes than did untreated controls.^{17,21}

An NIMH panel recommends offering trauma victims 'psychological first aid' when feasible

FOCUSED INTERVENTIONS

To provide optimal care to our patients, we must base our decisions on rigorous empirical study. In the case of debriefing, available well-controlled trials lead us to conclude that debriefings are inert.

To be clear, we are not philosophically opposed to early intervention for traumatic loss. We believe researchers must continue to develop and study interventions that can stave off chronic pathology among those at risk after traumatic loss.

Thus, clinicians and researchers face the same imperative: to accurately and efficiently identify persons at risk. Indiscriminately debriefing all persons who experience traumatic loss—without regard to risk—is not the most judicious use of clinical resources. Nor is it likely to advance our understanding of risk factors and resiliency in loss or of treatment efficacy.

Grief literature indicates that broadly applying interventions to anyone who has experienced loss does not help and may in fact exacerbate grief symptoms. Focused interventions for persons most at risk for complicated grief are more effective.²³

PRACTICE RECOMMENDATIONS

Given the limited evidence, the recommendations that follow are preliminary and based on

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the few early interventions for trauma that have produced superior outcomes compared with untreated controls.^{24,25} In general, these interventions used:

- cognitive-behavioral techniques (education, promotion of adaptive coping strategies)
- exposure exercises for survivors who were using maladaptive avoidant coping strategies
- homework to reinforce therapeutic activities initiated in session.

Most importantly, these interventions were conducted specifically with trauma survivors who were at risk for chronic psychopathology, rather than with anyone exposed to trauma or traumatic loss. Also, these interventions usually were not given within hours or days of the trauma but several weeks later. Because most persons exposed to trauma are anxious, sad, grief-stricken, or otherwise upset, immediate attempts to identify those at risk for protracted difficulties will likely be futile.

'Psychological first aid.' Although immediate formal treatment is not recommended, a National Institute of Mental Health consensus conference²⁶ recommended offering trauma victims "psychological first aid" (Table 3) when feasible. Psychological first aid is not intended to prevent chronic psychopathology but to provide:

- immediate emotional and informational support
- psychoeducational materials that describe common sequelae of trauma
- information about how and where to get help, if desired.

Included is information about the potential benefits of discussing reactions to the loss with trusted friends, family members, or significant others when victims feel comfortable doing so.

Screening for risk factors. When victims seek your professional support or services immediately after

Table 3

Recommended components of 'psychological first aid'

- **Protect** survivors from further harm
- **Reduce** psychological arousal
- **Mobilize** support for those who are most distressed
- **Keep** families together and facilitate reunions of loved ones
- **Provide** information and foster communication and education
- **Use** effective risk communication techniques

Source: National Institute of Mental Health, reference 15

a traumatic event, screen for risk factors for complicated grief, PTSD, or other chronic difficulties. Complicated grief is a relatively new diagnosis, and research on its risk factors is preliminary. The literature suggests, however, that risk factors may include:

- childhood abuse and neglect
- childhood separation anxiety
- loss of a child
- excessive interpersonal dependency or insecure attachment styles.⁶

To assess for PTSD risk, ask about history of exposure to other traumatic events, pretraumatic

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Related resources

- ▶ Litz BT (ed). *Early intervention for trauma and traumatic loss*. New York: Guilford Press; 2004.
- ▶ **National Center for PTSD:**
Psychological first aid: field operations guide.
www.ncptsd.va.gov/pfa/PFA.html.
Links to self-report assessments to screen for PTSD.
www.ncptsd.va.gov/publications/assessment/adult_self_report.html.
- ▶ Shear K, Frank E, Houck PR, Reynolds CF 3rd. Treatment of complicated grief: a randomized controlled trial. *JAMA* 2005;293(21):2601-8.

DISCLOSURES

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psychological difficulties (especially anxiety disorders), inadequate social supports, and exposure to grotesque aspects of the current trauma (such as seeing mutilated or dismembered bodies).²⁷

In the weeks and months after the traumatic event, we recommend screening the most distressed victims for risk of developing chronic psychopathology. The National Center for PTSD offers self-report measures appropriate for various populations (such as children or adults) and trauma contexts (such as combat) (see *Related resources*). The Inventory of Complicated Grief²⁸ is useful for screening for CG.

Empirically informed CBT. Provide brief cognitive behavioral interventions only for persons at risk and only after sufficient time has passed to allow you to differentiate between normal grief and

abnormal responses. Early interventions that have shown promising outcomes typically have been delivered approximately 2 weeks after the traumatic exposure.^{24,25}

Brief, multi-session CBT given several days to a few weeks after the trauma has been associated with improved posttraumatic adjustment.^{24,25} Interventions that appear to be most promising for patients who meet criteria for CG combine:

- psychoeducation
- exposure therapy for those having difficulty grasping the reality of their loss
- and behavioral activation techniques.²⁹

Unlike most PTSD interventions, those for bereavement-related distress have been used several weeks (rather than days) after the patient's loss.

Focus psychoeducation on how maladaptive strategies (such as avoiding trauma cues) can prolong trauma-related distress. Structure early interventions to encourage home-based exercises (such as exposure). These may reduce victims' reliance on maladaptive strategies, accelerate therapeutic effects, and promote the generalization of treatment gains.²⁴⁻²⁵

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Empirical evidence does not support crisis debriefing for survivors immediately after a traumatic event. Emerging data endorse immediate psychological first aid, followed by cognitive behavioral interventions only for persons found to be at risk for chronic psychopathology.

BottomLine

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