Psychological Debriefing for children

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Abstract

Psychological debriefing has been the focus of contradictory reports in literature, raising controversies about optimal modality, time frame and efficacy. Psychological intervention for children in crisis settings is an area where literature are relatively lacking giving a less clear image of what should be practiced, when, how and why? For this particular age group taking in consideration their cognitive structure, reaction to stress and the particularity of a stressful event affecting a developing brain whether on neurobiological as well as psychological perspectives.

INTRODUCTION

Much of the early work examining the effects of critical life-threatening events on children and young people was descriptive and concerned with identifying and detailing symptomatology . Researchers have now turned their attention to prevention and treatment and a range of incident related psychological interventions have been described.[1]

Wraith emphasizes that as with adults, the debriefing model is intended to assist with stress but that traumatized children require a specially focused and individualized approach. The model suggested is composed of two parts: psychological first aid and clinical debriefing. Wraith questions the appropriateness of debriefing for children and emphasizes the vital role of parents, their needs and responses, particularly for younger children.[2]

Because children usually have so little previous experience of critical incidents and coping with these it is even more important that no harm is done –either by interventions that may override natural healing and recovery processes , or by the introduction of a clinical framework that thereafter dominates the response to the inevitable challenges of life. Despite the vital importance of working through traumatic experiences in childhood for the child's development and mental health, there is a gross lack of empirical data to underpin a prevention model in this area.[2]

Most of the debriefing practices currently provided for children are replications or derivatives of the adult models and are given a range of names, including creative debriefing , group treatments , classroom interventions … Debriefing models described include a variety of individual formats, group interventions , classroom activities or family engagement.[3]

It would seem that often the strategies and programmes developed do not arise out of assessment of the individual child's needs , but out of the adult's anxiety and counter transference , including the desire/need to be protective or healing , and not infrequently in response to the impact of the event on themselves being displaced onto the child.[4]

DEVELOPMENTAL CONSIDERATIONS

While children and young people are equally affected by traumatic events, the specific manifestations of their symptomatology occur among a developmental perspective .The cognitive development of preschool children (less than 5 years) is more limited. Their thinking is concrete and egotistical and they are unable to imagine ways in which the trauma could be prevented or altered. They may appear withdrawn or subdued and re-enact the trauma in a very factual and descriptive way through their play. Parents may notice the loss of previously acquired developmental skills, particularly toileting. Resulting in soiling and wetting accidents. Disturbed sleep is common and young children may be troubled by recurrent and distressing dreams or appear fearful about going to bed. Finally they may become very clingy, refusing to be left alone at play group or nursery, wanting instead to sit with their parents during the day and to sleep with them at night.[5]

The school-age child (over5 years) has a larger repertoire of cognitive responses and can imagine the traumatic event ,

having a range of possible outcomes, rather than re-enacting the trauma, school age children may talk about or act out different endings in which that may fantasize about executing revenge or prevent fatal or serious injury. Like younger children, their emotions are often reflected in their behavior and they can present with a wide range of reactions from apparent indifference to extreme irritability, anger and defiance. Their physical and verbal anger is often projected onto their parents or friends, which in turn may have a detrimental effect upon these important relationships. [5]

Young people reach a stage of cognitive maturity in which they are able to understand and conceptualize more abstract issues such as accountability, survivor guilt and alternative action. They are able to create and explore a range of possible trauma scenarios that may emphasize and be critical of, their own action or inaction. Young people are very aware of their own limitation and highly sensitive to the view of others. Often these critical thoughts remain private and are seldom shared, although their anger is expressed in more extreme and noticeable ways. This may be directed outwards in the form of truancy, substance abuse, rebelliousness or delinquency, or inwardly as manifested by deliberate self harm, eating disorders or depression. [5]

According to Piaget (1950) , conceptual development progresses through a number of key stages during which the child's thinking is qualitatively different. Older children aged 11 to 14 years are able to handle more abstract concepts and will be more aware of hypothetical issues surrounding the critical event, such as potential danger, threat to life, the role of fate and survivor guilt. Children aged 7 to 11 years are more concerned with factual information and observable behavior. They find it difficult to conceptualize and explore abstract issues but can begin to consider alternative scenarios and understand the irreversibility of death. [6]

Younger children aged 2 to 7 years function at the preoperational stage and have an egotistical magical belief that they are somehow responsible for what occurs. The developmental nature of conceptual thinking may therefore have an effect upon the content, formation and/or perpetuation of intrusive traumatic thoughts, which in turn may influence the overall effectiveness and individual value of the specific components of psychological debriefing. [6]

In term of content, traumatic imagery can take many forms. The imagery could be factually descriptive or result in the generation of alternative scenarios in which the survivor imagines and cognitively rehearses other courses of action or outcomes to the trauma. The conceptual development of children would suggest that the traumatic imagery of adolescents and young children may be different. Younger children have a more limited comprehension and it is probable that they experience more factual and descriptive imagery. Adolescents are able to undertake a more abstract and complex exploration of the trauma and are able to imagine alternative actions and other possible outcomes. [6]

The traumatic images will be accompanied by a range of attributions as the individual attempts to explain why the trauma occurred. These vary along a developmental perspective and evolve from the magical and egocentric to more concrete factual explanations until multiple and more abstract concepts can be considered. The importance of these causal attributions in the development and maintenance of PTSD has been highlighted, one of the dimensions receiving most attention being that of internal-external controllability. [7]

Finally, considering traumatic reactions within a developmental perspective would suggest that psychological debriefing should be more closely tailored to the developmental level to the child. A greater emphasis upon the factual stage of the debriefing may be particularly helpful for younger children. This would enable them to realize that they had not caused the critical event and would correct any factual misunderstanding that has occurred. [5]

Older children, as reported by Casswell may be more interested in exploring abstract issues that challenge their internal cognitive schema and causal attributions. Debriefing with this age group may need to focus more upon the cognitive and emotional stages thereby allowing causal attributions to be reappraised. [8]

DEBRIEFING AS A PROCESS AND A TECHNIQUE

The technique and the process of debriefing may be conducted within the group, family or individual contexts depending on the age of the child, the needs of the child and the particular set of circumstances present at the time. Each require specific consideration but there is also considerable overlap.

If debriefing is considered as a process it can be seen to have two steps. Stage 1 constitutes psychological first aid , and stage2 is clinical group debriefing. Beyond this, children and their families may require treatment interventions if reactions are severe or entrenched or other vulnerabilities are present. [9]

PSYCHOLOGICAL FIRST AID

As with physical assault and damage, psychological first-line care through short-term measures that aim to contain any damaging impacts and also to prevent secondary damage. It is provided in the moments and immediate hours following the focus incident and is directed to addressing the sequelae of that incident.

For the child it has the primary requirement to establish a general experience of safety and containment, orientation to the event and the opportunity for emotional release. Reunion and engagement with significant others is imperative and needs to be addressed and managed sensitively. [10]

This stage needs to be overseen by sensitive, clear-headed and responsible leaders who are able to observe the multiplicity of needs of the children and parents and facilitate the meeting of them in what is often a chaotic and personally challenging context. It is important that homeostasis is attained through psychological first aid before formal group debriefing is embarked upon. [9]

CLINICAL DEBRIEFING

It is a more focused cognitive format where increased understanding of factual data of the common experience is possible, with illumination and understanding of one's own and other issues and reactions.

The child can be assisted to identify management options in the present and for the near future. [9,10]

Brooks & Siegel described a four-step model that includes preparation of the leaders as step 1, having the children tell the story and share reactions as steps 2 and 3 , and survival and recovery as the final step. A time frame is outlined for each stage. [11]

Hendricks and colleagues have developed a framework for individual intervention in which the child tells his or her story through language or play. The story is then explored in detail including associated fantasies and feelings and is followed by closure, which includes the child's transition back into school and everyday life. [12]

As the emotional meaning of the event is embedded in details of the experience as well as the personal and subjective impact, children may need to use a range of modalities to recreate the original context, which for adults is more readily recalled and communicated through language. Children use play, drawing, dramatization and relationships with others, as well as language, to communicate their experiences. They may use any number of these modalities to express segments of the event, and skill is required to work with the child to piece together the fragments communicated within the different modalities into a correct and coherent whole. [9]

The format may be variable depending on the age of the child and the level at which the regressive pull has settled. Therefore a debrief for a child may be facilitated through discussion and the verbal medium, through play, drawing, drama or a combination of the modalities. In some circumstances, the work of debriefing the child, especially the young child, may be achieved within the child-parent relationship if appropriate support and debriefing opportunities are made available to the parents. [9]

THE GROUP DEBRIEFING PROCESS

For children and young people the debriefing session typically adopts a standard structure. The debriefing start with an introduction, during which the purpose and format of the meeting is explained. The children are encouraged to talk about the critical life event in order to understand what happened and how they and others feel and might react. The rules of the session are highlighted during this stage. What occur within the session is private and is not to be shared with others who did not attend the meeting. Nobody should be teased or criticized for what they say and how they react. No one has to talk if they do not want to but if they do each child is to talk for him or herself, not for others. [13]

The second stage of the meeting is the fact phase in which the facilitator helps to build up a picture of what actually happened. The event is reconstructed from beginning to end thereby enabling all involved to gain a common understanding and to correct any misunderstandings. The third stage of the debriefing, which is concerned with the children's thoughts about the trauma. They are encouraged to describe their initial thoughts about the event at the time when they realized that something was wrong. This subjective appraisal is fairly soon followed by a discussion about the emotional impact of the trauma both during and immediately after the event and how children are currently feeling. [13]

Dyregrov (1991) suggested that direct attempts to elicit feelings should be avoided but that indirect methods should be used to encourage children to talk. They could be asked to talk about the worst thing that happened during the event, encouraged to draw pictures or complete unfinished

sentences. The facilitator encourages others to join in and share their experience, thereby helping the children to recognize that others have similar feelings. The thought and reaction stage will occupy the majority of the debriefing. The emotional release and opportunity for children to discuss thoughts of blame, guilt, helplessness and anger are seen as a major part of the process. [13]

The fifth stage is the information phase, during which the facilitator attempt to draw out similarities between the children thoughts and feelings. These are clearly explained as normal reactions to a highly unusual event. The normalization of these reactions helps the children to recognize that they are neither unusual nor going out of their minds. Information is provided about the range of possible reactions that follow such critical life events and the children are warned that these may persist for some weeks. General advice as to how they can cope with their thoughts and feelings such as encouraging them to talk, write them down, etc.. is provided.

During the ending phase, the facilitator summarizes the meeting, attempts to help the children plan what to do next and addresses any unanswered questions. The children are informed about what they should do if their distress persists and the facilitator follows up any who appear particularly affected. [13,14]

INDIVIDUAL DEBRIEFING

The interview is designed to be used with children fairly soon after a trauma and aims to help them to understand what has happened and how they are feeling. The first stage is the opening, during which the child is informed that the facilitator has met many children who have “gone through what you have gone through “. [15]

The young person is encouraged to draw a picture about anything as long as they can tell a story about it. The facilitator probes the child's drawing and story and starts to identify the traumatic references. These are used to lead into the second stage of the interview, which is concerned with relieving the traumatic experience by systematically reconstructing events. Within a supportive holding relationship, the child is encouraged to describe what they saw. Actual event is discussed in detail, the accompanying sensory experience described, and the worst moment for the child explored. Common feelings and emotional reactions including guilt, accountability and anger are discussed. [5]

The interview then moves into the final stage of closure, during which the facilitator reviews and summarizes the session. Children are reassured that feeling of helplessness and fear are common and alerted to the possible future course of their reactions. Finally, the child is invited to contact the facilitator if they wish to talk again. The interview is used by the facilitator as a way of screening the child to identify whether any further intervention is required. [5]

INVOLVEMENT OF PARENTS

The younger the child the more the parents automatically and appropriately regard themselves as integral to the life experiences, survival, health and welfare of their child. Management strategies must take the parental role into account. [14]

Developmental imperative require support for the child –parent bond, elucidation of the child experience in fact and in fantasy, the development of a range of modalities to express the experience, validation of the experience, opportunities for emotional relief and for expression of thoughts, ideas and questions .These need to be engaged in the realm of the shared common experience with the parents. [9]

Parents also need the facts of the events, information about their child's and their own reactions and management strategies in the present and the future. Therefore parents need to be engaged independly to support reconciliation of their own issues and to help them understand their own and each others' responses. Parent parallel groups and information sessions provide these opportunities. [9]

GROUP VERSUS INDIVIDUAL DEBRIEFING

It cannot be assumed that all children, particularly after a difficult experience, are functioning at the required level in each area to enable them to engage productively in a language based group debriefing event. [4]

The child who is functioning below four years of age is not readily able to symbolize and engage in representational thought, nor maintain memory interactions, and thus is not able to reflect and re-examine self and general knowledge. These attributes are requisites for group debriefing. [9]

Immaturity means the child has a weaker ego structure than adult and also less consolidated defense mechanisms. The limited repertoire of established successful coping skills , and the wide range of immature coping skills and defense mechanism in children need to be taken into account when one consider the appropriateness of group debriefing for an

individual child in a specific set of circumstances.

It may be appropriate for children to experience, in an individual context, the kind of support that debriefing is assumed to provide for adults. Another dimension is the role the peer group which will be of greater significance for the preadolescent than the younger child. [9]

Identification with the experience of peers in the context of an immaturely established sense of self may lead to contagious engagement with the experience within the group setting and possibly secondary traumatization by it. It is only when children move to late adolescence that they have the psychological maturity to maintain confidentiality of emotionally and psychologically significant issues without it causing further stress or traumatization. [9]

OPTIMUM TIMING

There are temporal variations in the way debriefing is provided .Casswell(1997) provided one debriefing session and a six-week follow up, Stallard & Law (1993) two debriefing session one week apart, while yule& Udwin (1991) provided one debriefing session, although they offered subsequent monthly group session. [15,16]

With regard of timing, psychological debriefing was originally conceived of as a form of crisis intervention to occur within two to three days of a traumatic event. Other argue that children and young people may be too numbed to benefit from a debriefing so soon and suggest an optimal post – disaster time of 7 to 14 days. When the sense of safety is engaged, physiological and psychological reactions can begin to abate and the child's own developmentally appropriate coping skills can begin to emerge. It is only at this point that the debriefing technique may be considered, if required at all. The issue of psychological readiness is important in determining the optimum time for conducting debriefing. The optimum time for debriefing children and adolescents remains to be established. It is , however, questionable whether psychological debriefing provided more than four weeks after a critical event can be conceived of as a crisis or preventative intervention. [5]

CONCLUSION

Psychological debriefing in children is still in need of further assessment and clinical research to optimize the expected outcome.

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