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Does debriefing after psychological trauma work?

Time for randomised controlled trials

Some people believe strongly that talking through traumatic or stressful experiences may help the psychological recovery of those who have suffered psychological wounding. This belief has led to military psychiatrists providing immediate interventions at the front line that are intended to heal and return soldiers to activity,[1] and it has fuelled psychological debriefing methods such as Mitchell's critical incident stress debriefing.[2] Debriefing programmes have expanded rapidly, reflecting a powerful social movement that sees them as meeting the needs of workers in emergency services, victims of disasters, and those who have been affected by trauma and violence in wider society.[3-5] Yet, although military psychiatry has succeeded in returning troops to action, outcome studies suggest that soldiers who are repeatedly traumatised by returning to combat may suffer even higher rates of severe and chronic post-traumatic stress disorder in the longer term.[1]

The proponents of debriefing agree that it needs evaluation, yet there is a dearth of systematic evaluation and outcome studies. In one of the few systematic evaluations, many subjects reported two weeks after debriefing that they had found it helpful and felt less stressed.[6] Nevertheless, 41% of the group of chiefly female welfare workers (n=65) and almost 6% of the group of chiefly male emergency workers (n=102) reported the traumatic experience to be "still having considerable or great impact on them," with a high frequency of cognitive and other symptoms. Symptoms were not, however, assessed systematically with standard measures.

Randomised controlled trials of the effectiveness of debriefing have not been reported, although a few studies include comparison with a group that was not debriefed. A study of firefighters two weeks after they dealt with a hotel fire in Norway showed that most of those who attended debriefing reported that it had helped and increased their self confidence. Their scores for intrusive thoughts and avoidance behaviour measured by the impact of events scale[7] were no different from those of the group who had simply talked to their colleagues informally.[8]

Nearly half of a group of emergency workers surveyed one year after attending serious bus crashes still reported considerable symptoms, and 13% thought that they would probably not recover.[9] Those who had been debriefed (182 of 285) had significantly higher scores for morbidity and distress on the general health questionnaire[10] and the impact of events scale. These findings provide little evidence that the debriefing, even though perceived as helpful, was effective in preventing negative outcomes. The group with high distress might have been worse without it, but the study was unable to show this.

Similar findings were obtained in a longitudinal study of 195 people who had helped after an earthquake, of whom 62 had been debriefed and 133 had not.[11] Screening for degree of stressfulness, threat, and psychological exposure over the subsequent two years found a general decrease in symptoms, with less improvement over time among those who had been debriefed, even though 80% rated the debriefing as helpful. Clearly, neither perceived helpfulness nor experience of debriefing was associated with more positive outcomes. These studies were not controlled trials. The groups may not have been comparable, perhaps experiencing different stressors (loss rather than trauma), having uncertain roles, and having more welfare or counselling functions, for which the debriefing model was inappropriate, or perhaps being more distressed at the outset. But it is conceivable that debriefing may exaggerate the traumatic process[11 12] or even be associated with a delayed presentation. In addition, exposure to informational social support, which forms part of much debriefing, is associated with increased vulnerability to traumatic symptoms in trainee police officers (J Higgins *et al*, unpublished data).

A more recent report from Deahl and colleagues represents the nearest to a controlled study yet reported; it was conducted in war graves troops, who had to deal with enemy and allied dead during the Gulf war.[13] For operational reasons some troops were debriefed and others were not. Psychiatric symptoms were assessed nine months later and related to debriefing status and other relevant variables, such as training. Threat to life and history of psychological problems were correlated with post-traumatic morbidity and subsequent relationship problems. There was no evidence that the psychological debriefing had a positive effect on outcome—yet, again, the authors remained committed to the principle of debriefing and reported that many soldiers valued the opportunity to express feelings.

Who benefits?

Why is debriefing so successful as a social movement and so believed in as an ideology, given that there have been no adequate demonstrations of beneficial effects or prevention of post-traumatic morbidity? Debriefing may be perceived so

positively because it meets many needs: the need of those not directly affected to overcome their sense of helplessness and the guilt of surviving, to make restitution, and to experience and master vicariously the traumatic encounter with death; the needs of those directly affected to speak of what has happened, understand it, and gain control; and the symbolic need for workers and management to assist those who suffer and to show concern.

Debriefing may not work as it is currently implemented because it does not take account of subjects' levels of arousal, defensive styles and coping processes, cognitive impairments associated with acute trauma, dissociative phenomena relating to the traumatic experience, and other pathogenic influences such as past trauma, past psychological morbidity, and current and recent life stresses.[14] Debriefing has typically been used as though all the trauma comprised a single element—for instance, a threat to life—whereas loss, separation, and dislocation are separate stressors that probably need different interventions and timing. Only one debriefing format reflects this concept, but there have been no studies of its effectiveness.[15]

The possibility that debriefing may increase problems warrants further consideration. Perhaps debriefing focuses on the trauma to the exclusion of other important stressors that may be of greater relevance, such as organisational stress or personal life stresses. Debriefing may not be appropriate in timing or format for some people[5 12 16] and may even lead to secondary traumatisation.[17] It may also medicalise normal responses to stress: reactive processes are often described as "symptoms" in the educational aspects of debriefing. And complex aspects related to health and safety in the workplace, litigation, and other factors may complicate both process and outcome.

Debriefing is here to stay, at least for now, and meets some real and symbolic needs. But it is costly and possibly ineffective for many people, and its provision may seem to negate the need for more individualised and longer term programmes focusing on recovery and rehabilitation for those who have been traumatised. Given the very positive view of debriefing held by many of its recipients and the community's belief in the need for counselling after trauma, we should carefully consider the best form of intervention for particular groups and incidents. Existing programmes can no longer stand alone without randomised controlled trials of debriefing, with multiple outcome measures and assessments over time, as well as evaluation of more individualised counselling.

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New equities of information in an electronic age

The Third World needs First World information—how about the other way round?

The developing countries of the Third World are far from homogeneous. Nevertheless, as consumers of information the countries have a stark regularity of features that allows for convenient grouping: most of their medical libraries subscribe to fewer than 50 journals, less than one library in 10 has a computer or CD-ROM player; and budgets for new books, software, and online charges are tiny or non-existent. Telephone and telecommunications systems are sparse, unreliable, and expensive, so use of networks is rare. Where access to networks exists it is used mainly for simple communications rather than to scan health literature.

To add to this unpromising perspective it is now clear that the cost of information is overtaking the cost of information technology. As the price of computers drops and as countries invest in modernising their telecommunications the basic cost of content, reinforced by copyright protecting encryption and tagging systems, will become the principal economic barrier to the flow of information. The "information poor," particularly in developing countries, will remain worst off.

Many non-government organisations have been helping developing countries to acquire health literature and contemporary technology. But such well intentioned projects hardly ever include information from the Third World. Whatever the donors' intentions, Western information aid to the Third World usually serves as a vehicle for opening up markets in developing countries to Western information providers. The implicit assumption is that the information superhighway is a one way street from the First World to the Third.

One reason for this is the general perception that Third World information is not applicable in the First World. Certainly, developing countries often lack a sufficiently