**Psychological debriefing is a waste of time**

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Edited and introduced by Mary Cannon, Kwame McKenzie and Andrew Sims.

**INTRODUCTION**

People who experience serious traumatic events may become distressed and are at risk of developing psychological illness. Because of the perceived need to ease the distress and to prevent chronicity, various forms of psychological therapy have been deployed. One such therapy is psychological debriefing. Some claim that it is helpful, others claim it may not do any good but at least it does no harm, but still others claim that it increases the risk of people developing long-term psychological symptoms following a traumatic event. Statutory agencies, charities and commercial organisations offer their services to victims following traumatic events. Fearing litigation, some companies require their employees to undergo debriefing following certain incidents. But is psychological debriefing the right treatment? Is it cost-effective? And what of the concerns that it may lead to long-term problems? Could litigation be joined because of exposure to psychological debriefing? We asked two experts who have published widely on the subject – Professor Simon Wessely and Professor Martin Deahl – to debate the proposition that psychological debriefing is a waste of time.

**FOR**

Bad things happen to people. Sometimes these bad things cause long-standing psychological damage. The desire to reduce that impact is one of the laudable aspects of human nature. So it would be good news to report that not only do we in the mental health professions have the desire to prevent psychiatric disorder emerging in the aftermath of trauma, but we also have the ability to do so. Sadly we do not.

I take ‘debriefing’ to refer to some short, usually single-session, intervention that is performed with as many of those caught up in a traumatic event as possible, and involves some variation on the theme of going over the traumatic incident, linked with education about the expected emotional responses and assurances that these are normal. The rationale is to reduce acute emotional distress and prevent the onset of post-traumatic psychiatric disorder.

Debriefing is exceptionally popular – in a recent systematic review we identified over 50 different indications or uses, all of them involving trauma in some shape or form (Wessely et al, 2000). Many organisations offer debriefing as part of the organisational response to untoward incidents – such as police officers involved in firearms incidents, or bank staff who have been witness to robberies. In some such examples, interventions are compulsory – perhaps out of a desire to reduce psychological distress, but also from a belief that this will reduce exposure to subsequent litigation.

There are many reasons why debriefing has flourished in recent years. When facing disasters, all of us must feel a need to do something. That talking about trauma must be better than ‘repressing’ or ‘bottling-up’ accords with a long and distinguished tradition in psychological treatment – ‘better out than in’ – and has face validity.

Many people who have been debriefed report the experience in a positive fashion.

For some the virtues of debriefing are as obvious as the benefits of penicillin, and there has been resistance to submitting the process to what remains the only reliable method we have of knowing whether a treatment does more good than harm – the randomised controlled trial (RCT). However, others, including many of those who were firm advocates of the procedure, have organised such studies and deserve considerable credit for so doing. The results of these studies have been summarised in several systematic reviews (e.g. Wessely et al, 2000).

These studies provide no evidence for any benefit of the intervention. All the modern studies fail to show any advantage to debriefing. But perhaps the most worrying findings come from the two trials scoring highest on the quality ratings, and with the longest follow-up times. The first reported the 18-month outcome of patients admitted to a Cardiff burns unit randomised to debriefing or no treatment (Bisson et al, 1997). There was a significant increase in the rates of post-traumatic stress disorder (PTSD) in those who had received the intervention. A persistent adverse effect of debriefing is also reported from the Oxford trial of debriefing of road traffic accident victims (Mayou et al, 2000).

Until these trials had been published, even to question the benefits of debriefing was difficult. However, armed with these results, we can now start to consider what might be going wrong. Perhaps the process of debriefing, part of the function of which is to warn participants of emotional reactions that might be expected to develop over weeks and months, actually increases the occurrence of these symptoms. Perhaps for some not talking is indeed appropriate – defence mechanisms may serve a purpose, and it is not always ‘better out than in’. Talking to a stranger, whom one has never met before and will not meet again, may impede the normal processes of recovery that utilise one’s own social networks – family, friends, general practitioner and others who may be better able to place the trauma in the context of one’s own life. Perhaps debriefing acts to professionalise distress, part of the general process of the professionalisation of adversity across society.

Not everyone will accept these findings. It is inevitable that when a cherished belief is challenged, various counterclaims are
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The 2002 Cochrane review included 11 studies comparing psychological debriefing with ‘no-intervention’ controls and concluded that psychological debriefing was of no value in preventing PTSD. Indeed, two trials found that it actually made subjects symptomatically worse (Rose et al., 2002). The studies on which these conclusions were based, however, have little to do with psychological debriefing in the real world and comprised single-session ‘one-off’ debriefing of single subjects (not selected from epidemiological samples) who were medically ill (or obstetric patients). Symptomatology of PTSD was generally employed as the sole outcome measure, although it is recognised that PTSD is but one of a number of post-traumatic syndromes. None of the studies assessed the impact of psychological debriefing on other important consequences of trauma such as alcohol and substance misuse, or its effect on social or occupational functioning.

The observation that psychological debriefing worsens symptoms is frequently cited by its opponents. They fail to mention, however, that the two RCTs that suggest that psychological debriefing may be harmful both failed to achieve equivalent group membership at pre-test (debriefed groups had more severe injuries in both studies) (Hobbs et al., 1996; Bisson et al., 1997). These pre-test differences may well have influenced post-intervention outcomes. Moreover, the deterioration in psychopathology of the debriefed group in one of these studies, although statistically significant, was so slight as to be clinically irrelevant (Hobbs et al., 1996).

Interestingly, the Cochrane review explicitly excluded a further 19 studies because of ‘methodological shortcomings’, principally concerning problems of randomisation. These included RCTs of group debriefing in the naturalistic settings for which psychological debriefing was
subjectively helpful at the time (although this is another outcome that has not been properly studied). Under these circumstances can it, therefore, be ethically justifiable to employ non-intervention controls, denying individuals short-term support, whatever the long-term outcome? For an operational commander on the battlefield or at a disaster site, ‘feeling better’ at the time may be a desirable outcome irrespective of any longer-term benefits.

Although it seems clear at this point that there is insufficient evidence to recommend offering one-off single-session debriefing or crisis counselling to medical patients, this finding has very little to do with the task of addressing the mental health needs of victims in the wake of a mass disaster. Whatever its intrinsic benefit, psychological debriefing provides an opportunity to focus on the psychological welfare of trauma victims. It has an important educational role and allows an opportunity to identify individuals suffering from acute stress reactions (who are at greater risk of developing longer-term disorders). Single-session psychological debriefing may well do harm, not by any direct effect on mental state but rather by fostering an air of complacency (in assuming that an individual who has had debriefing will be immune from subsequent disorder). It may also damage and make secondary victims of the ‘debriefers’ who themselves require adequate support and supervision. Psychological debriefing was never intended to be a stand-alone intervention – rather it should be but one part of a comprehensive stress management package that enables individuals to receive follow-up, an assessment of individual need and practical support, as well as allowing the early detection and prompt treatment of established PTSD and other disorders. Abandoning psychological debriefing sends out the dangerous message that doing nothing for individuals following traumatic events is acceptable.

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Access the most recent version at DOI: 10.1192/bjp.183.1.12

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