

Review: a brief psychological intervention (debriefing) is ineffective in preventing post-traumatic stress disorder

Wessely S, Rose S, Bisson J. A systematic review of brief psychological interventions ("debriefing") for the treatment of immediate trauma related symptoms and the prevention of post traumatic stress disorder. (Cochrane Review, latest version 25 Nov 97). In: *The Cochrane Library*. Oxford: Update Software.

Question

In persons who have had recent psychological trauma, does one session of debriefing reduce psychological distress and prevent post-traumatic stress disorder (PTSD)?

Data sources

Studies were identified using Medline, EMBASE/Excerpta Medica, PsycLIT, Social SciSearch, Sociological Abstracts, BIOSIS Previews, Occupational Safety and Health, PASCAL, the Register of Trials in the Cochrane Library, handsearches of key journals, and by contacting experts.

Study selection

Studies were selected if they were randomised controlled trials of brief psychological interventions involving a single session of debriefing delivered shortly after the trauma occurred. Studies were excluded if the participants were psychiatric patients, research participants such as psychology students, or children; the trauma involved perinatal grief or bereavement; the study was about treatment of PTSD; or the study had an n of 1 or crossover design.

Data extraction

Data were extracted on patient characteristics, setting, sample size, method of randomisation, time interval between trauma and debriefing, and methodological quality. Outcomes measured were rates of PTSD, psychological morbidity, depression, and anxiety.

Main results

6 trials met the inclusion criteria; data from the 2 oldest trials (both 1979) could not be synthesised. 2 trials provided dichotomous data for comparing debriefing with a control intervention

for development of PTSD. The data are inconclusive for short term follow up (2 to 5 mo), [p=0.28]* (table). 1 study provided long term data (>12 mo) that showed a harmful effect of debriefing [p=0.03]* (table). 1 trial provided dichotomous data for depression and anxiety. The results showed no effect of debriefing on either outcome. Trauma related symptoms were measured in the 4 most recent studies by the Impact of Events scale and all 4 studies had substantial variance; in only 1 study was the mean score > 1.6 times the standard deviation. In this study the mean score at 4 months was 26.7 in the debriefed group compared with 29.6 in the control group. The difference was not statistically significant.

Conclusion

One session of psychological debriefing after recent trauma does not reduce psychological distress or prevent the development of post-traumatic stress disorder.

*p values calculated from data in article.

Psychological debriefing v control for prevention of post-traumatic stress disorder (PTSD)†

	Debriefing	Control	RRI (95% CI)	NNH (CI)
Short term PTSD‡	16%	11%	43% (-26 to 177)	Not significant
Long term PTSD	21%	7%	190% (10 to 701)	7 (4 to 67)

†Abbreviations defined in glossary; RRI, NNH, and CI calculated from data in article; event rates are weighted.

Sources of funding: NHS Management Executive and King's College School of Medicine Strategy Fund.

For correspondence: Dr S Wessely, Institute of Psychiatry, Department of Psychological Medicine, King's College Hospital, London SE5 9RS, UK. Fax +44 (0)171 740 5129.

Commentary

For some mental health professionals, the doubts raised by Wessely *et al* regarding the efficacy of psychological debriefing might be considered heretical. The popularity of this intervention over recent years has been supported by anecdotal and written reports. One stated aim of debriefing has been the prevention of PTSD. However, the lack of empirical evidence and randomised controlled trials has been highlighted. Concerns have also been expressed that debriefing may have a negative effect in some cases.¹

However, it is an important contribution because it addresses the effectiveness of debriefing by reviewing controlled studies. It definitely confirms the need for further research, not only on the efficacy and outcome of debriefing but also on the

process in terms of how and whom it might help.

For clinicians it is important to be aware of the issues and implications raised by this study. In particular, the possibility that debriefing may cause further harm. Care is needed when organising and facilitating a debrief, and consideration should be given to the closer assessment and screening of incidents and individual needs. This may mean advising that a debrief is not appropriate or is contraindicated on occasion.

The claims that debriefing will reduce the risk for developing PTSD do not appear to be proved. However, this review only examines single session debriefing of people who are actually admitted to a general hospital after trauma. This does not mean that debriefing has no positive value

as 1 aspect of a critical incident stress management strategy. It may be that psychological debriefing should not be described as a treatment approach but is best perceived in the context of post-incident education and support.

I would certainly agree that compulsory debriefing for trauma victims should not be practised in any organisation. Participants should always have a choice as to whether they attend or not.

Gerard Bailes, M App Sci, C Psychol
Norvic Clinic
Norwich, UK

1 Raphael B, *et al*. In: van der Kolk BA, McFarlane AC, Weisaeth L, editors. *Traumatic stress: the effects of overwhelming experience on mind, body, and society*. New York: Guilford Press, 1996.