Psychological Debriefing Does Not Prevent Posttraumatic Stress Disorder

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Individuals exposed to horrifying, life-threatening events are at heightened risk for posttraumatic stress disorder. Given the substantial personal and societal costs of chronic PTSD, mental health care professionals have developed early intervention methods designed to mitigate acute emotional distress and prevent the emergence of posttraumatic psychopathology.

The method most widely used throughout the world is psychological debriefing. Psychological debriefing is a brief crisis intervention usually administered within days of a traumatic event (Raphael and Wilson, 2000). A debriefing session, especially if done with a group of individuals (e.g., firefighters), usually lasts about three to four hours. By helping the trauma-exposed individual "talk about his feelings and reactions to the critical incident" (Mitchell, 1983), the debriefing facilitator aims "to reduce the incidence, duration, and severity of, or impairment from, traumatic stress" (Everly and Mitchell, 1999). The most popular model, Critical Incident Stress Debriefing (CISD), has seven phases (Mitchell, 1983; Mitchell and Everly, 2001) (Figure). The facilitator begins by explaining that debriefing is not psychotherapy, but rather a method for alleviating common stress reactions triggered by critical events (introduction). The facilitator then asks each participant, in turn, to describe what happened during the trauma in order "to make the whole incident come to life again in the CISD room" (fact phase) (Mitchell, 1983). After each participant has done so, the facilitator asks group members to describe their thoughts as the traumatic event was unfolding (thought phase). The facilitator then moves to the phase designed to foster emotional processing of the experience (feeling phase). Operating under the assumption that "everyone has feelings which need to be shared and accepted" (Mitchell, 1983), the facilitator asks questions such as "What was the worst part of the incident for you personally?" (Everly and Mitchell, 1999). The assumption is that participants will benefit by ventilating and reliving the emotions provoked by the trauma in a public gathering. After this phase, the facilitator then asks each participant whether they are experiencing any psychological or physical stress reactions that might be shared with the group (reaction phase). The facilitator then conceptualizes these reactions as nonpathological responses to terrible events and provides stress management tips (strategy phase). Finally, the facilitator summarizes what has occurred during the session and assesses whether any participants require referral for further assistance (re-entry phase).

According to Mitchell (1983), a single debriefing session "will generally alleviate the acute stress responses which appear at the scene and immediately afterwards and will eliminate, or at least inhibit, delayed stress reactions." Everly and Mitchell (1999) recommended that debriefing should be offered to anyone exposed to a critical incident, regardless of whether the person is experiencing stress-related symptoms. Although individuals exposed to trauma often receive debriefing on a
one-on-one basis, according to Everly and Mitchell, debriefing is best suited for groups of people exposed to the same critical incident. Developed originally for firefighters, police officers and other emergency service personnel, debriefing has become standard practice in diverse settings where adverse events sometimes occur, such as businesses, schools, hospitals and the military (Everly and Mitchell, 1999). Indeed, an entire debriefing industry has emerged to meet this need. Hence, Mitchell and Everly's International Critical Incident Stress Foundation trains approximately 40,000 individuals each year to provide debriefing and related services to those exposed to trauma. Moreover, Everly and Mitchell (1999) have argued that businesses may be at risk for lawsuits should they fail to provide services such as debriefing for employees exposed to critical incidents.

**Does It Work?**

According to Mitchell and Everly (2001), research on their debriefing methods "proves their clinical effectiveness far beyond reasonable doubt." Other scholars, however, have drawn drastically different conclusions. After conducting a meta-analysis of randomized, controlled trials (RCTs) on debriefing, Rose et al. (2001) concluded,

There is no current evidence that ... psychological debriefing is a useful treatment for the prevention of post traumatic stress disorder after traumatic incidents. Compulsory debriefing of victims of trauma should cease.

Another meta-analysis revealed that individuals exposed to Mitchell's version of debriefing failed to experience symptomatic relief, whereas individuals who were not exposed to CISD did show improvement (van Emmerik et al., 2002).

Although most studies have failed to uncover any beneficial effect of debriefing, two have shown that it can impede natural recovery from trauma. Bisson et al. (1997) randomly assigned hospitalized burn victims to either a debriefing session or to a no-treatment (assessment-only) condition. Burn victims in the treatment condition received a single one-on-one debriefing session that lasted between 30 and 120 minutes, occurring from two to 19 days after the burn accident. In some cases a partner (usually a spouse) attended the session. The debriefer followed Mitchell's protocol. There were no significant differences between the groups at the initial assessment on questionnaire measures of depression, anxiety and posttraumatic stress. At the three-month follow-up assessment, the rate of PTSD assessed via clinical interview was non-significantly higher in the debriefed group than in the control group (21% versus 15%). At the 13-month assessment, the rate of PTSD was significantly higher in the debriefed group than in the control group (26% versus 9%). Moreover, the debriefed group scored significantly higher on questionnaire measures of depression, anxiety and PTSD relative to the control group. Bisson et al. concluded that even if debriefing is merely inert, rather than toxic, "its routine use should be discontinued."

In another study, Hobbs et al. (1996) assessed victims of road traffic accidents who had been randomly assigned to either a one-on-one debriefing session or to a no-treatment (assessment-only) condition. Individuals assigned to the debriefing condition received a single one-hour session between 24 and 48 hours after their accidents. Four months later, neither the debriefed nor the control group reported a reduction on measures of PTSD, anxiety or depression (Hobbs et al., 1996). Three years later, the debriefed group reported significantly more PTSD symptoms, general psychiatric symptoms and fear of traveling as a passenger in an automobile than did the non-debriefed group (Mayou et al., 2000). Additional analyses revealed that participants who had initially scored high on a self-report measure of PTSD symptoms and who were not debriefed improved markedly by the three-year follow-up assessment, whereas high-scorers who were debriefed remained markedly symptomatic three years later. The authors concluded, "Psychological debriefing is ineffective and has adverse long-term effects. It is not an appropriate treatment for trauma victims" (Mayou et al., 2000).

**Debriefing Advocates Respond**

In response to these findings, debriefing advocates have issued two responses (Everly and Mitchell,
1999; Mitchell, 2003). First, they have cited other studies that they believe confirm the efficacy of debriefing. Unfortunately, every one of these studies (none RCTs) is methodologically flawed, and most of them are so weak as to render their findings uninterpretable (for a review, see McNally et al. [2003]).

Second, they have argued that the negative studies lack probative import and are irrelevant to how debriefing is conducted in actual practice. The main critiques against the negative studies are:

- They use one-on-one debriefing, not group debriefing;
- Inappropriate measures have been used to evaluate the efficacy of debriefing;
- People directly exposed to trauma (primary victims) have been studied, rather than the emergency service personnel for whom CISD was originally developed;
- Negative studies depart from approved protocol in ways that render the findings irrelevant; and
- Critical Incident Stress Debriefing must not be evaluated on its own but only in the context of a comprehensive Critical Incident Stress Management (CISM) program.

Each of these specious critiques is devoid of merit, and each has been rebutted in detail elsewhere (for a review, see McNally et al. [2003]). Although debriefing advocates often complain that researchers fail to follow protocol precisely in studies showing null or toxic effects, these advocates must first demonstrate that their method actually works. Then their complaints about protocol departures may be warranted--only after they have furnished convincing evidence of the efficacy of their method.

**Conclusions**

Despite repeated attempts to document that psychological debriefing can prevent posttraumatic psychopathology, there is no convincing evidence that it does so. Even if the procedure is not harmful, its continued implementation may delay the development of truly effective crisis interventions, while wasting time, money and resources on a method that is, at best, inert.

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**References**

**References**


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