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To Debrief or Not to Debrief Our Heroes: That is the Question

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Psychological debriefing was developed in the 1980s as an approach for use with people whose work exposes them to stressful incidents. It aims to help them to process the thoughts and emotions arising from their work. Subsequently, several randomized controlled trials tested truncated forms of debriefing in a different population: primary victims of unexpected trauma. These trials, and particularly two in which debriefing appeared to be harmful, led two major reviews to warn practitioners not to offer debriefing. Consequently, many organizations have stopped providing debriefing to employees who face trauma in their routine work. This paper argues that there are at least three reasons for the apparent failure of 'debriefing' in the two studies that reported adverse effects. First, the 'debriefing' did not follow protocol in terms of timing, length, and training and independence of the debriefer. Second, the patients who were 'debriefed' reported more severe initial symptoms than those who were not. Third, 'debriefing' was used with individuals for whom it was not originally intended. Psychological debriefing is intended to be used with groups of people who have been briefed together before going on to work together in stressful situations. Such groups have reported that they find psychological debriefing helpful, and research is emerging indicating that appropriate debriefing may indeed benefit these groups. We call for reviewers to recognize the limitations of debriefing research and not to overgeneralize their conclusions.

Key Practitioner Message:

- Warnings about the dangers of psychological debriefing are based on studies using an intervention that is very different from that used for disaster workers and military personnel.
- Evidence relating to primary victims of trauma has been overgeneralized to secondary victims.
- Psychological debriefing may harm if it is too short, too probing, conducted too soon or delivered by debriefers with insufficient training or experience.
- Research is urgently needed on appropriate debriefing for occupational groups briefed to work in stressful situations.

Keywords: Psychological Debriefing, Stress Debriefing, Crisis Intervention, Traumatic Stress, Trauma, Disaster Workers

BACKGROUND

Critical incident stress debriefing (CISD) is a crisis intervention technique formulated for teams of emergency service workers and disaster workers (Dyregrov, 1989; Mitchell, 1983; Mitchell & Everly, 1997). As a seven-phase process,[1] CISD offers a standardized, structured approach for discussing thoughts and emotions with skilled peers and mental health professionals following distressing incidents. The aims include normalizing common responses to trauma and providing information about coping strategies and future assistance if it is required.

Declaration of interest: Dr. Debbie Hawker is a strong believer in the value of high-quality randomized controlled trials (RCTs), evidence-based practice and cognitive behavioural therapy. She worked for 9 years as a therapist on RCTs at Oxford University Department of Psychiatry. She now provides training, resources and consultations for people working with NGOs, and she has written a manual on debriefing aid workers. Almost all of her current work is voluntary and any royalties from her manual go directly to the charity People In Aid. Dr. John Durkin is a trainer and consultant to fire, rescue and paramedic services. Dr. David Hawker is a voluntary debriefer for Tearfund, a non-governmental organization (NGO). The views expressed in this article are those of the authors and do not reflect the official policy or position of any institution with which the authors are affiliated.

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[1] Introduction, Facts, Thoughts, Reactions, Symptoms, Teaching and Re-entry.

The generic term 'debriefing' has been applied to a variety of interventions that diverge from CISD but which are apparently intended to achieve the same outcome. Debriefing became popular during the 1980s and 1990s as its benefits became evident to those whose occupations exposed them to traumatic stressors. Because efforts to establish empirical evidence for these benefits have seen mixed results, the use of psychological debriefing has become a subject of debate (e.g., Wessely & Deahl, 2003).

The Case Against Debriefing

The National Institute for Health and Clinical Excellence (NICE, 2005a) guidelines for the treatment of post-traumatic stress disorder (PTSD) identified seven randomized controlled trials (RCTs) comparing debriefing with a control group.[2] NICE reported that the RCTs showed no evidence of an effect of debriefing at 3- to 6-month follow-up and a limited effect favouring non-debriefed individuals at 13-month follow-up.

The Cochrane review of debriefing (Rose, Bisson, Churchill, & Wessely, 2006) identified 15 RCTs. Three of these found that debriefing was associated with a positive outcome, nine found no effect and two reported negative outcomes. The remaining study, lacking a non-debriefed group, found immediate debriefing to be more effective than delayed debriefing.

Even though only two of the 15 independent studies identified by the NICE and/or Cochrane reviews showed adverse effects, most attention has been paid to these. Yet it is rarely mentioned that in both of these studies (Bisson, Jenkins, Alexander, & Bannister, 1997; Mayou, Ehlers, & Hobbs, 2000) the debriefed patients had been more severely injured than the patients who were not debriefed. When initial trauma symptoms and severity of injury were controlled for, the negative effect of debriefing on later trauma symptoms was reduced to marginal significance ($p < 0.07$, Mayou et al., 2000) or disappeared, with the initial symptoms being the only variable that predicted trauma symptoms at follow-up (Bisson et al., 1997). Furthermore, the 'debriefing' offered in both studies was markedly different from that described by Mitchell (1983), as we will discuss later. Mayou et al. (2000, p. 592) noted that their intervention 'had limited internal structure'. Despite this, there is a widespread belief that these two studies prove that debriefing is harmful.

[2]The NICE guidelines do not make it clear that only six of the seven RCTs they identified were independent, as Mayou et al. (2000) is a follow-up of Hobbs, Mayou, Harrison and Worlock (1996). We regard these two papers as a single study and refer mainly to the later paper as it is important to consider the longer-term follow-up. The Cochrane review of debriefing included the earlier paper only, but then referred to the three-year follow-up that is described in the later paper.

Published Recommendations

The Cochrane review recommended that, 'compulsory debriefing of victims of trauma should cease' (p. 2 of Abstract), in both military and civilian life, although it recognized that this may not apply to group debriefing, debriefing after mass trauma or debriefing of emergency workers. The NICE guidelines (2005a) stated that:

> *For individuals who have experienced a traumatic event, the systematic provision to that individual alone of brief, single-session interventions (often referred to as debriefing) that focus on the traumatic event should not be routine practice when delivering services.* (p. 128)

In the Quick Reference Guide (which is more likely to be read by professionals than the full guideline), this sounds more like a command than a guideline:

> *For individuals who have experienced a traumatic event,* ***do not*** *routinely offer brief, single-session interventions (debriefing) that focus on the traumatic incident to that individual alone.* (NICE, 2005b, p. 12)

Curiously, NICE made this a Grade A recommendation, a grade reserved for RCTs 'as part of a body of literature of overall good quality and consistency' (p. 47). This is a surprising grading, given that the Department of Health's (2001) guidelines on evidence-based practice acknowledged concerns over the quality of the RCTs, and that the Cochrane reviewers (who included two co-authors of two of the studies) accepted that the quality of the studies was generally poor. Nevertheless, the full recommendations are carefully worded and nuanced. Their common interpretations are not.

For example, after the first edition of the Cochrane review was published, the American Psychological Association published an open letter from 11 eminent psychologists cautioning against debriefing following the mass trauma of 11 September 2001 (Goldstein et al., 2001). The World Health Organization discouraged the use of debriefing (van Ommeren, Saxena, & Saraceno, 2005). Articles and editorials appeared with titles such as 'Psychological debriefing is a waste of time' (Wessely & Deahl, 2003), 'The current status of psychological debriefing: It may do more harm than good' (Kenardy, 2000) and 'Psychological debriefing for acute trauma—a welcome demise?' (Conlon & Fahy, 2001). The *Oxford Textbook of Psychotherapy* says, 'it is now clear that single-session debriefing immediately after exposure to a traumatic event is ineffective' (Parry, Roth, & Kerr, 2007, p. 514).

Recommendations similar to NICE's have been accepted worldwide by people who have read the summaries without being aware of the limited evidence on which they are based. In a highly influential paper, Lilienfeld (2007, p. 58) cited CISD as a 'harmful' therapy, without

considering precisely what it was about the two negative studies that may have made them 'harmful'. Some clinicians are now so afraid that they might do harm, that they avoid asking any questions about traumatic events during assessments of clients known to have experienced trauma.

Shaky Foundations to the Tower of Evidence

In 2002, a review of debriefing commissioned by the British Psychological Society (BPS) concluded that appropriate RCTs 'are difficult to achieve ethically in the real world of crises and disasters' and called instead for 'a blend of qualitative and quantitative experimental designs' to evaluate debriefing (BPS, 2002, p. 74). The RCTs conducted on 'debriefing' so far seem to involve an intervention far removed from that offered by most trained providers of psychological debriefing.

The RCTs focused mainly on the question of whether or not 'debriefing' reduces symptoms of PTSD and related symptoms. Several other benefits of debriefing, reported by studies using different research methods, have not yet been assessed by RCTs. These include improved coping skills, increased morale and staff retention, reduced sick leave and compensation payments, and reduced usage of mental health services in the 12 months following the incident (Mitchell & Everly, 1997; Robinson, Mitchell, & Murdoch, 1995). Moreover, numerous studies suggest that the vast majority of people who receive psychological debriefing report it to have been beneficial (Arendt & Elklit, 2001; Mitchell & Everly, 1997; Wessely & Deahl, 2003).

The fundamental problem is of overgeneralization from a poor evidence base. Two RCTs tested a variant of debriefing unrecognizable to skilled debriefers. The negative effect of debriefing vanished when other variables were held constant. Subsequently, the message has spread that debriefing is harmful. Numerous appeals to the small print of the recommendations have been ignored, as the headlines have been more influential. It is time to look systematically at the evidence of the two key RCTs and to consider more parsimonious interpretations.

LESSONS LEARNED FROM THE TWO RCTs REPORTING ADVERSE EFFECTS

Do not Offer Debriefing Too Soon after a Traumatic Event

In Mayou et al.'s (2000) study, which is probably the study most frequently cited to support the claim that 'debriefing' is harmful, people admitted to hospital were 'debriefed' 'within 24 hours of the accident or as soon as they were physically fit to be seen' (p. 589). Although convenient for data collection, this choice of time frame disregarded Mitchell's recommendation that debriefing should not occur within the first 24 hours following a traumatic incident or when someone is in severe pain (Mitchell, 1983). At such times, avoiding thinking about the trauma can assist coping. Forcing someone to speak about their trauma soon after it has occurred may encode it more vividly into memory and impede recovery (Ehlers, 1998) and reinforce feelings of helplessness (Everstine & Everstine, 1993). Debriefing should not cause the patient to 'relive' their experience of trauma, but forced reliving may occur if it happens too soon or when too much detail is requested (Ehlers, 1998). The authors of the RCT suggest that, 'rapid discharge from hospital necessitated very early intervention and some patients were still too numbed or distressed to be receptive' (Hobbs et al., 1996, p. 1439).

In the other RCT that reported a negative effect, Bisson et al. (1997) studied burns victims and observed that the sooner 'debriefing' was provided, the worse the outcome. For burns patients, the trauma generally continues for a considerable time after the injury. Treatment and scarring may cause more distress than the initial trauma. One benefit of debriefing may be the realization that the trauma is over, and the process of discriminating between 'then' and 'now' may aid recovery (Ehlers & Clark, 2000). Undertaking debriefing while the trauma is continuing is likely to be of very little benefit.

Mitchell and Everly (1996) caution that debriefing should not take place unless the participant is receptive to it and ready for it:

> *People have to be ready for help before it becomes useful to them. Providing help too early usually sets the stage for the rejection of the help and failure of the effort . . . hold off on the formal debriefings (CISD) until things settle down a little.* (pp. 189–190)

And again:

> *That which ultimately dictates appropriateness is not how many hours/days have passed since the trauma, but rather is how psychologically receptive the victim is to the help being offered.* (p. 208)

Do not Offer Debriefing Lasting 1 Hour or Less

The mean duration of 'debriefing' in the Bisson et al. (1997) study was 44 minutes; in the Mayou et al. (2000) study, it was 'approximately one hour'. Incidentally, all the other RCTs reviewed by Cochrane and NICE reported 'debriefing' lasting 15–60 minutes. Experts find that adequate psychological debriefing takes a minimum of 2 hours and usually lasts longer, with at least one follow-up contact (Dyregrov, 1989; Mitchell & Everly, 1996; Parkinson, 2001; Turnbull, Busuttil, & Pittman, 1997). Because of the lack of time, it is

unlikely that a full package of CISD was followed adequately in the RCTs, nor were any follow-up sessions offered. Rushed 'debriefing' can make matters worse (Lovell-Hawker, 2010) possibly because it risks exposure to anxiety without sufficient time for habituation (Hacker Hughes & Thompson, 1994; Rose et al., 2006). Giving enough time for debriefing reduces that risk.

Although Bisson et al. (1997) report that longer 'debriefing' was associated with poorer outcome, a clinically plausible reason (acknowledged by Bisson et al.) is that more distressed participants received longer 'debriefings', with debriefers naturally finding it harder to end the session. Moreover, with a mean duration of 44 minutes and a standard deviation of 17.4, approximately 56 of the 57 Bisson et al. debriefings would have lasted less than 80 minutes, a whole 40 minutes short of the adequate minimum. This suggests that length was inadequate in virtually all cases.

In a separate evaluation of debriefing, one person who had received a 45-minute debriefing reported:

> *I was conscious of the time limit right from the start. It made me feel 'unrelaxed' and all I could think of was 'how can I fit in all I'd like to tell someone?' . . . I came out of it feeling like it was open heart surgery without time to be stitched back up, and I was left to pick up the pieces afterwards . . . If I was in the same situation again, I would prefer to not have a debriefing at all than to be debriefed in 45 minutes – it just is not possible.* (Lovell-Hawker, 2010, p. 7)

One review has noted that debriefings lasting less than 1 hour tend to have a neutral or negative effect, while longer debriefings generally have a positive effect (Arendt & Elklit, 2001).

Do Not Use Insufficiently Trained or Inappropriate Debriefers

Inexperienced debriefers may be unhelpful. In the Mayou et al. (2000) study, experienced clinicians were too busy to conduct debriefings, so 'regrettably . . . the interventions were undertaken instead by the research assistant' (Hobbs & Adshead, 1997, pp. 166–167). It has been reported that the 'debriefers' in the Bisson et al. (1997) study received only a half day's training in debriefing (Parkinson, 2001).

In contrast, Mitchell and Everly (1996) recommend that debriefing be conducted by a mental health worker (the team leader) and a peer debriefer (co-leader) working together (pp. 97–98). They urged 'all mental health professionals to become familiar with the emergency services "culture" before providing any service to those personnel' (p. 97), so participants can relate to them. Fawcett (1999) states: 'Debriefer credibility is an important issue. Credibility may be a function of several factors. Probably the most important is the "me too" factor—the notion that the debriefer knows what is being talked about because of their own personal experience' (p. 63).

Mitchell and Everly (1996) recommend that in addition to their professional training, debriefers attend an entry-level Basic CISD course (2 days minimum) and then progress to an Advanced CISD course (2 days) (pp. 267–268).

Research suggests that debriefing tends to be beneficial only when led by a trained, experienced debriefer (Arendt & Elklit, 2001; Dyregrov, 1999; Mitchell & Everly, 1996) who can answer questions about the traumatic experience (Lee, Slade, & Lygo, 1996).

The debriefer should also be independent, and not associated with inflicting the trauma. Many of the debriefings in Bisson et al.'s (1997) study were conducted by nurses who were associated with painful medical procedures. This may have influenced the patients' willingness to talk freely with them. The debriefings were delivered in busy trauma wards, which the authors note was not ideal.

DEBRIEFING FOR THE BRIEFED

Debriefing Is Not for Everyone

CISD was originally devised as part of a package for emergency workers who had experienced critical incident stress as part of their work. It was specifically designed for selected psychologically resilient personnel who are trained to cope with expected pressure during their routine work in stressful situations. These are teams of people who have trained together and been briefed together before working together.

CISD might not be expected to work so well with people not meeting these criteria. Yet both of the RCTs that reported negative outcomes focused on hospitalized medical patients (Everly, 2002) who experienced unexpected traumatic events. In a review of debriefing studies, Arendt and Elklit (2001) reported that debriefing 'is generally found to have some preventative effect when used with professional helpers, but the method seems to be far less effective, or even to have a negative effect, when used with other victims of trauma' (p. 430). Similarly, in another review, Jacobs, Horne-Moyer and Jones (2004) concluded: 'CISD is an effective method of reducing risks for PTSD-related symptoms in emergency service personnel. However, when debriefings are conducted with primary victims of traumatic events . . . the results are much less promising' (p. 5).

The Demise of Debriefing and Its Impact

The primary principle of medical ethics is to do no harm. This has been seen as the main reason to withdraw debriefing. However, a factor that has been overlooked is the harm done by withdrawing an intervention from occupational groups who (for over 20 years) have come to rely on it to help them cope with working in extremely

stressful circumstances. This is exactly what has happened. For example, concerning all UK military personnel, the Surgeon General's Policy Letter of 20 January 2006 (paragraph 4) stated of CISD: 'the medical evidence demonstrates no value and therefore [CISD] is **not** recommended by DMSD' (Defence Medical Services Department) (Ministry of Defence, 2006). To the knowledge of one of us (JD), West Midlands police followed other forces in requiring their CISD team to disband and stop offering debriefing because of the NICE guidelines. One of the UK's major travel health clinics, used by approximately 300 aid and mission organizations, cites adherence to the NICE guidelines as their reason for no longer offering psychological debriefing (Hargrave, 2006).

Most people who suffer from incidents such as a traffic accident or a burn (the traumas 'debriefed' in the RCTs) are able to talk with hospital staff, family, friends or others who have had similar experiences. They have not usually heard of debriefing, nor do they request it. If they have persistent symptoms of trauma, they find people to talk to, including therapists if required. In contrast, many emergency service workers, aid workers and military personnel feel that a debriefing is the only opportunity to talk about their experiences (Lovell-Hawker, 2010). They want to talk as part of a routine post-incident process, but they do not want to seek therapy, perhaps because of the stigma, or fear that this will have a detrimental effect on their career prospects. They report that few people can understand or relate to their experiences or want to listen to them. Some fear traumatizing others, or being regarded as unable to cope, if they talk about them in other circumstances without a debriefer to guide them. An aid worker who had observed horrific human rights abuses during genocide reported:

> *I haven't been able to talk to anyone about this. I can't tell my wife, because then she would feel traumatised too. . . . The thing which kept me going was knowing I would be able to talk about it during this debriefing. That saved me from going under.* (Lovell-Hawker, 2010, p. 12)

Many disaster workers make similar comments. Robinson (2000), in a report about emergency services personnel, observes:

> *There appears to be a fundamental need that many, if not all, humans have, namely to share frightening and distressing experiences with others who have at least some understanding of what has been experienced and who feel some caring or concern that this has occurred.* (p. 104)

Greenberg et al. (2003) studied 1202 peacekeepers on return from their deployment. Peacekeepers who spoke about their experiences reported less psychological distress than those who did not. Two-thirds were in favour of formal psychological debriefing. One-third had not spoken about their experiences, and it was these who were most in favour of formal debriefing. If debriefing is not available, they may feel unable to speak to anyone.

Debriefing has been an expected, normal procedure for disaster workers and military personnel. It has been as routine as briefing prior to an assignment. Some of those who expect to receive debriefing, including those who have appreciated it in the past, cannot understand why it is no longer available to them. We are often asked why debriefing is perceived by some to be harmful, and when it can be reinstated.

Is it ethical to withdraw an intervention valued by its recipients on the basis of the results of two RCTs that used a different intervention, on populations for whom the use of debriefing was never intended? Rose et al. (2006) freely acknowledge that the studies included in the Cochrane review may not be relevant for emergency workers, and state that research on 'the efficacy of debriefing in emergency workers' is 'a particular priority', as is research on the efficacy of group debriefing (p. 15). Yet in many instances emergency workers are now denied debriefing, as a result of the Cochrane and NICE recommendations and their catastrophic misinterpretation. Professionals speak about having to be 'NICE compliant'. They are afraid of being accused of professional misconduct if they offer psychological debriefing, even to those in occupational risk groups (e.g., Tobin, 2001).

Towards an Evidence Base

There is evidence suggesting that debriefing benefits briefed individuals who are at occupational risk of trauma. For example, Lovell (1999) found that only 7% of debriefed aid workers experienced significant levels of intrusive thoughts or avoidance at 14-month follow-up, compared with 24% of non-debriefed aid workers. None reported a negative effect of debriefing, while over 80% found it helpful, with 40% identifying a specific positive change, which they attributed to the debriefing. The use of CISD has also been associated with a significant reduction of alcohol misuse among British soldiers returning from peacekeeping operations in Bosnia (Deahl, Srinivasan, Jones, Neblett, & Jolly, 2001; Deahl et al. 2000). To the knowledge of one of the authors (JD), successful suicide prevention in the New York Police Department in the 1990s has been attributed to CISD and related peer-support techniques, and this persuaded the authorities to extend their use to police officers following the attacks on 11 September 2001. Training and peer-support programmes still persist with this group. Finally, in an RCT of 952 peacekeepers, Adler, Litz et al. (2008) randomly assigned platoons to debriefing, stress education or survey-only conditions. Group debriefing was minimally

associated with lower reports of post-traumatic symptoms for participants exposed to high levels of mission stresses.

It is interesting to note that some of the most promising findings are being achieved when the traditional seven-phase CISD method has been adapted to review a period of military service or humanitarian aid work, and to include discussion of return to life at home, rather than discussing a single traumatic incident in great detail (Adler, McGurk, Bliese, Hoge, & Castro, 2009; Lovell-Hawker, 2010). For example, Adler, Castro and McGurk (2008) describe a five-phase[3] 'battlemind psychological debriefing' procedure that has recently been introduced into the US military. This form of debriefing is receiving positive feedback from battlefield behavioural health providers in Iraq. In their 2009 study, Adler et al. describe how 2297 US soldiers who had completed a year-long deployment in Iraq were randomized by platoon to receive standard stress education, battlemind psychological debriefing, or small-group or large-group battlemind training (education about post-deployment transition). At four-month follow-up, the soldiers with high levels of combat exposure who had received battlemind psychological debriefing reported fewer post-traumatic stress symptoms, depression symptoms and sleep problems than those assigned to stress education.

Content of Occupational Group Debriefing

The debriefing models proposed by Adler et al. (2009) for the military and by Lovell-Hawker (2010) for aid workers focus on reviewing a whole period of occupational service (rather than a single traumatic incident), and on the transition back to normal life at home, and future plans. One of the criticisms of CISD has been that prolonged, vivid descriptions of a traumatic incident soon after it has occurred may increase the risk of developing PTSD (see Ehlers, 1998). Indeed, Bisson et al. (1997) suggest that one of the reasons why the intervention in their study may have been harmful was that it 'involves intense imaginal exposure to a traumatic incident shortly afterwards', and because their intervention was so short (mean 44 minutes), there was no time for habituation to occur (p. 80).

In Mitchell's model of debriefing for occupational groups (Mitchell & Everly, 1996), in contrast, participants are invited to outline 'briefly, what happened from your perspective' (p. 106). Mitchell and Everly (1996) warn explicitly that '*probing is out of place in CISD*' (p. 195, italics in original). They also allow adequate time to deal with any negative emotions, which may arise during the session, while warning debriefers, 'do not open any emotional issues that you cannot bring to a closure' (p. 208). Lovell-Hawker (2010) and Adler et al. (2009) also propose models that avoid probing for vivid details. These models aim to normalize symptoms; emphasise that the event is past; focus on the difference between 'then' and 'now', and encourage return to normal life and work. This is in keeping with Ehlers and Clark's findings (2000) on factors associated with reduced increase risk of PTSD.

Wessely (in Wessely & Deahl, 2003) wrote that the variant of debriefing would not make a difference: he could not see any difference between one variant and another, or why one should work when another failed. But in fact CISD as devised by Mitchell (Mitchell & Everly, 1996) is very different from the interventions provided in the two RCTs that suggested it might be 'harmful'. We will refer to the intervention in those studies as inadequate debriefing, in keeping with the conclusions drawn from them. We have focused on these two studies because they are the two that have received the most attention. They are the only two RCTs that indicated a possible negative effect of debriefing, albeit one which was eliminated when initial distress and injury were controlled for. All the other trials reported by Cochrane and NICE showed a favourable or neutral effect of debriefing. The differences between the original debriefing model and inadequate debriefing are summarized in Table 1.

In addition, in the Mayou et al. (2000) study, patients with no psychological symptoms were excluded (see Hobbs et al., 1996), which further limits how far the findings can be generalized.

It should be clear from Table 1 that inadequate debriefing (columns three and four) is not the same as CISD described by Mitchell and Everly for disaster workers (column two). Compared with the original model, inadequate debriefing was offered to the wrong people, too soon, in the wrong setting, too briefly, too intrusively, and without follow-up. In our fields of work, we are familiar with the debriefing as outlined in column two, but have never come across the intervention described in columns three and four. The differences between the original debriefing model and inadequate debriefing are not trivial. They might be seen to border on the contrast between competence and clinical negligence. Efficacy trials explore whether an intervention produces the desired result under ideal conditions. Effectiveness trials measure the effect in 'real world' clinical settings. The authors of the RCTs might argue that the studies were effectiveness trials. Perhaps the authors were concerned that looser forms of debriefing, similar to the inadequate debriefing they tested, were common practice in the past. Inadequate debriefing is certainly not like the debriefing for occupational groups that we have come across in real settings over the past 15 years. The trials seem more like inefficacy trials, exploring the effects of intervening in very poor conditions. Having said all of this, our aim is

[3]Introduction, Event, Reactions, Self and Buddy Aid, and Battlemind Focus.

Table 1. Comparison of Mitchell's critical incident stress debriefing with potentially 'harmful' intervention

Intervention feature	Original debriefing model	Inadequate debriefing	
Model	Mitchell and Everly (1996)	Bisson, Jenkins, Alexander and Bannister (1997)	Mayou, Ehlers and Hobbs (2000)
Population	Healthy emergency service and disaster workers	Medically hospitalized primary victims of isolated and unexpected trauma Burns patients	Road traffic accident survivors
Timing of debriefing	When recipient is ready, not within first 24 hours or while trauma ongoing	While still undergoing treatment in hospital 2–9 days after burn	Within 24 hours of trauma or as soon as physically fit to be seen
Duration	Approximately 2–3 hours	Mean 44 minutes (standard deviation 17.4)	Approximately 1 hour
Content and emotional expression: was there probing for vivid details?	Do not probe for detail, outline briefly what happened, put it behind you, expect normal recovery, look to the future	Attempted to adhere to Mitchell's structure (1983), but interpreted this to include 'intense imaginal exposure' (p. 80)	'A detailed review of the accident, the encouragement of appropriate emotional expression' (p. 590) 'Our debriefing intervention . . . contrasted in significant ways with the models of psychological debriefing described by Mitchell . . . it is possible that the instructions led patients to ruminate excessively about the accident rather than putting it behind them' (p. 592)
Location	A private, quiet, comfortable room without interruptions	Hospital	Hospital. 'There were practical difficulties in delivering an intervention in busy trauma wards' (p. 593)
Debriefers	A mental health worker and a trained peer debrief together	Reportedly had only half day training. Five were nurses also involved with medical procedures	Research assistant
Context	Debrief whole group together	Patient debriefed alone. Partners attended in 16 cases	Patient debriefed alone
Follow-up	Always at least one follow-up contact	No follow-up (except research questionnaires)	

not to criticize the authors of the RCTs. It is extremely difficult to conduct RCTs with people who have experienced a recent trauma, hence they may have seen little option than to use patients in a hospital setting, and longer sessions might have proved impossible.

A final problem with Bisson et al.'s (1997) study is that the authors stopped recruiting participants 'when preliminary analysis of the data revealed possible adverse consequences for the intervention group' (p. 78). While this may seem a clinically compassionate response, it is not normally good practice in RCTs, where early data analysis can be misleading unless planned into the design. Unplanned analyses increase the risk of type 1 error (concluding that differences are due to the intervention when they are only random variations), especially if the sample size is not yet as large as that indicated by power analysis to be necessary to detect true difference. Bisson et al. (1997) acknowledge that, 'despite a sample size of greater than 100, the power of the results was below 60%' (p. 80).

Warranted Conclusions

The Cochrane and NICE reviewers, and the authors of the RCTs, have done a great service in highlighting potential mistakes which providers of debriefing should avoid. We agree that inadequate debriefing has a potential to have adverse effects. We agree with the Cochrane conclusion that 'compulsory debriefing should cease'. Debriefing should never be mandatory. Indeed, Mitchell and Everly (1996) cautioned: 'Forced companionship is as potentially traumatizing as the original trauma to some victims who need isolation and solitude at that particular point in time' (p. 209). We recommend that where debriefing is provided, participants should be allowed to opt out if they choose. We agree that debriefing is not a treatment for PTSD. We are not arguing for debriefing for primary victims who unexpectedly experienced an isolated trauma. And we are certainly not arguing for the type of 'debriefing' outlined in columns three and four of Table 1.

What troubles us is that overgeneralization from the NICE guidelines has meant that some emergency service workers, aid workers and military personnel who want to talk about their experiences in a debriefing setting, no longer have the opportunity to do so. We do not hold NICE or the researchers responsible for the overgeneralization, which may be an unintended consequence of well-intentioned guidance. Mayou et al. (2000) took particular care in stating: 'The findings are limited to individual trauma and cannot be extended to group debriefing or later intervention' (p. 593). Bisson et al. (1997) cautioned that their results may not apply to group debriefing or to trauma other than burns trauma. NICE (2005a, p. 84) state:

> *No trial on critical incident stress debriefing as it was originally conceived by Mitchell and colleagues (i.e. a group intervention for teams of emergency workers, military personnel or others who are used to working together) . . . met our inclusion criteria.*

Yet overgeneralization has occurred. In our opinion, these occupational groups should be allowed to receive personal debriefing if they want it, within the context of informed consent. They are now often denied debriefing even though neither we nor the Cochrane or NICE reviewers can cite any research which shows that it harms them.

WHAT'S IN A NAME?

While advising against debriefing, the NICE guidelines recommend offering about five sessions of trauma-focused cognitive–behavioural therapy (TF-CBT) to people with severe post-traumatic symptoms within a month of a trauma. Studies have found 4–5 sessions of TF-CBT to be beneficial in reducing symptoms (Bryant, Harvey, Dang, Sackville & Basten, 1998; Foa, Hearst-Ikeda, & Perry, 1995).

TF-CBT may include asking participants to recount and focus on their experiences, education about trauma reactions and coping skills and cognitive restructuring. CISD with skilled debriefers contains similar components, facilitated by a mental health professional and a peer debriefer. When the time taken for introductory greetings is deducted from each session, 4–5 sessions of TF-CBT lasts around 3–4 hours—which is similar to the time for CISD including follow-up. Thus, in content and total duration of intervention, CISD is more similar to TF-CBT (which is recommended) than to inadequate debriefing.

Since NICE made its recommendations, debriefing has continued in some services under a new name (in some emergency services and chaplaincies, for example; see Placer County Law Enforcement Chaplaincy, 2007). The United Nations Department of Safety and Security has reportedly endorsed CISD, using the term powerful event group support (PEGS) which is seen as less controversial (Everly & Mitchell, 2008; Mitchell, 2009). The UK military services have moved to the use of trauma risk management ('TRiM'), which itself developed from and has become a substitute for CISD. In other services (e.g., some emergency services and aid organizations) debriefing has been withdrawn totally. Often nothing is offered in its place, as these professionals do not wish to receive therapy. The vast majority are in favour of formal debriefing, which does not carry the stigma of therapy or imply that their response is abnormal (Adler, Litz et al., 2008; Greenberg et al, 2003; Lovell-Hawker, 2010). They prefer to receive CISD with their peers (Durkin & Bekerian, 2003; Ørner, 2003).

CONCLUSIONS

We are concerned that so many people have interpreted two negative outcome 'debriefing' studies as a warning that all debriefing is harmful. We can understand how decisions came to be taken by a number of organizations to withdraw psychological debriefing based on the results of these studies. However, in this paper we have argued that the premises that lay behind these decisions were flawed. We saw several plausible alternative explanations for negative outcomes that had not been adequately considered or tested.

1. The 'debriefed' patients had been more severely injured than those who were not debriefed. Negative outcomes were eliminated when initial distress and injury were statistically controlled.
2. The 'debriefing' used was generally too short to adhere adequately to the accepted model of debriefing and is likely to have occurred too soon, while the patient was still in shock or pain or undergoing treatment.
3. Some of the 'debriefers' lacked adequate training, experience or independence.
4. 'Debriefing' in busy hospital wards denied patients sufficient privacy and confidentiality.
5. The 'debriefed' patients were primary victims of trauma among the general public, rather than professionals who had been selected for their resilience and briefed to cope with traumatic stress as an occupational hazard—the group for whom the intervention was devised.

We agree that such inadequate 'debriefing' may well be harmful. We also agree that caution is necessary and that debriefing should never be mandatory. However, to proscribe all debriefing on the basis of such research might be compared to banning Caesarean sections because a few studies find them to be harmful when inexperienced surgeons are given 15 minutes to perform them on women during the first 12 weeks of pregnancy.

As mental health professionals active in the military, emergency service and humanitarian aid fields, we are aware that the personnel we work with often request debriefing, and speak of its benefit for them. Yet these self-sacrificial professionals (whom some refer to as heroes and heroines) are now being denied a valued form of support on the basis of the studies described. Research designs that use convenience samples in hospital settings are unlikely to reflect the psychosocial complexities with which we are familiar in our respective fields. We hope that those who undertake such research would hold back from making generalizations from their samples unless they can identify what those tested have in common with those in the field.

Debriefees' belief that debriefing is effective counts for little if RCT results suggest otherwise (Wessely & Deahl, 2003). We are sometimes asked to produce RCT evidence that debriefing is beneficial for the groups we work with. The findings of Adler et al. (2009) and Deahl et al. (2000; 2001) are a step in this direction. Unfortunately, aside from the practical difficulties in arranging such research, ethical approval and funding for such research are now very difficult to obtain, owing to the widespread belief that any intervention that includes the word 'debriefing' is harmful. We have been told that the case against debriefing is proven and the debate is closed. We disagree. Instead, we agree with the Cochrane reviewers that further research is necessary, especially research on group debriefing for teams who have been briefed. RCTs should ideally stratify for initial trauma impact and avoid the methodological and statistical limitations of the RCTs that have been published so far, including those that reported neutral outcomes. It is beyond the scope of this paper to list all these limitations, but they include among several of the studies: failure to perform intention-to-treat analysis; a high proportion of sample lost to follow-up; sampling bias; small samples; poor quality randomization and unsatisfactory or unclear allocation concealment. With such poor quality RCTs, it would not be out of place to pay more attention to high-quality research that has used other methods. We predict that appropriate psychological debriefing will be shown to have benefits for secondary victims of trauma who have been briefed together and who have worked together through traumatic events. Research into these uses of debriefing should be encouraged and supported.

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