Post-trauma debriefing: the road too frequently travelled

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The meta-analysis by Arnold van Emmerik and colleagues in today's *Lancet* about the efficacy of post-trauma psychological debriefing stands among the more potent entries in an increasing litany of reports, reviews, and consensus statements. The latest report raises significant concerns about this ubiquitous intervention. Despite limitations from poor data-quality and uneven design in the studies assessed, the analysis is consistent with those of other researchers, indicating that debriefing: (1) yielded no demonstrable effect on subsequent resolution of traumatic exposure and may inhibit or delay resolution for some participants; (2) showed a smaller effect than calculated for non-intervention controls, suggesting that natural proclivities toward resilience may be more potent than this style of intervention and (3) yielded lower effect-sizes than alternative interventions against which it was compared, raising the strong likelihood that other approaches are more likely to help.

The findings echo and extend assessments of multiple randomised trials in Cochrane Collaboration reviews.[1] Although such meta-analyses have been criticised for lacking studies of group debriefing within the specific occupational settings in which the practice originated (rather than in traumatised individuals more generally), well-designed quasi-experimental field studies in those contexts have also yielded negative or equivocal findings,[2–4] which leaves the burden of proof about efficacy with proponents of debriefing.

The implications for practice are unequivocal. Calls for caution and restraint have been heard from many responsible scientists and practitioners,[5–9] and are underscored in conclusions from consensus panels[10] and empirically-based practice guidelines that have recommended limitation[11,12] or contraindication.[13,14] But despite direct and publicised warnings from well-established researchers in trauma response and intervention,[15,16] reports from New York City after the attacks on the World Trade Center indicated that more than 9000 purveyors of debriefing and other popularised interventions—more than three counsellors for every person believed to have died in the attack—swarmed there, advocating intervention for any person even remotely connected to the tragedy.[17]

Given the evidence, why should use of debriefing techniques not only persist but also seemingly flourish? Post-traumatic stress disorder is much debated.[18] Progressive dilution of both stressor and duration criteria has so broadened application that it can now prove difficult to diagnostically differentiate those who have personally endured stark and prolonged threat from those who have merely heard upsetting reports of calamities striking others. Moreover there are few systematic data about the normal course of resolution after traumatic exposure or the inherent variability of that course within and between individuals, a fact that leaves discernment between symptoms of arrested or abnormal processing and normal signs of sometimes profound but ultimately transient discomfiture a subject of speculation.

The problem is compounded further in practice, where the enterprise of debriefing has become dominated by a prolific and parochial subculture of secondary providers whose understanding of these highly complex and elusive issues is often limited to proprietary workshops, trade magazines, and paperback books rather than the peer-reviewed venues of empirically guided professional practice. This has, in turn, created entrenched enclaves of self-identified debriefers within various organisations—initially in public safety and military concerns, but now extending into schools, hospitals, and a widening range of other enterprises—who earnestly strive to help but stand severely hampered by the tools they have been sold.

Although immediate debriefing has yielded null or paradoxical outcomes, the value of contemporaneous instrumental assistance and support—those kinds of practical help often learned better from grandmothers than from graduate training—has increasingly been found to be useful in disaster response.[19] Structured interventions, however, may be better embedded in models of stepped care, where the nature and level of intervention is conservatively tailored to the needs, context, and course of individual resolution.[20,21] Preliminary epidemiological data from New York City have revealed levels of post-traumatic stress disorder that, whilst clearly significant, fell below even conservative early prognostications[22] and which had dropped by more than two-thirds within 4 months.[23] These findings underscore the counterproductive nature of offering a prophylaxis with no demonstrable effect, but demonstrated potential to complicate natural resolution, in a population in which limited case-conversion can be anticipated, strong natural supports exist, and spontaneous resolution is prevalent.

Promising approaches are emerging, with high sensitivity and specificity, allowing straightforward and relatively non-intrusive assessment to identify those at greatest risk of clinical progression to post-traumatic stress disorder.[24] These approaches are designed for implementation 2–4 weeks post-impact, when brief-series cognitive behavioural therapy has efficacy in treating post-traumatic stress disorder in high-risk populations.[21]

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