Dealing with disasters: does psychological debriefing work?

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SUMMARY

The psychological aftermath of disaster causes significant long-term psychiatric disability and suffering to victims and rescuers alike. This paper examines the effectiveness of psychological debriefing (PD), an early intervention that is widely used and claimed to reduce long-term psychiatric morbidity in the wake of disaster. Numerous factors hamper the design of methodologically sound research in this field and there is a lack of controlled studies supporting the efficacy of PD. Further research is needed to demonstrate the effectiveness of any immediate psychological intervention before significant resources are allocated to their routine provision.

Key words: counselling, disasters, psychological debriefing

INTRODUCTION

Serious and potentially disabling psychological and psychiatric symptoms are well recognized in accident and emergency (A&E) personnel, rescue workers and members of the emergency services involved in the aftermath of accidents and disasters. Most A&E staff experience some features of traumatic stress after intense and distressing emergency situations. Psychological symptoms include fatigue, sadness, dysphoria and poor concentration, heightened arousal and anxiety, guilt, anger and feelings of helplessness, identification with victims and intrusive thoughts which interfere with work. Although many of these symptoms are self-limiting, a number of subjects will go on to develop more serious acute stress reactions, diverse adjustment disorders and post-traumatic stress disorder. The prevalence of post-traumatic stress disorder may be as high as 30% or more in victims, emergency workers and rescuers alike after serious accidents and disasters. Serious psychological distress may also occur in ‘second-line’ support workers such as administrators, control room and reception staff, switchboard operators, hospital ancillary and volunteer workers and the families of emergency service staff.

A variety of individual and situational factors predispose staff to the effects of traumatic stress. Individual vulnerability factors include fatigue and sleep loss, poor physical health, a personal history of psychiatric disorder and a ‘neurotic’, anxiety-prone personality as well as a lack of supportive and confiding relationships. Adverse reactions are more likely to occur in staff subject to intense and prolonged exposure to distressing events. Other situational factors which predispose to stress include a lack of adequate training, low morale, working in dangerous conditions and a poor sense of identity and ‘belonging’ to a close-knit cohesive team. Staff who identify with victims — for example, those who handle personal effects — are particularly vulnerable. Infant deaths, child abuse, victims of sexual assault, mass casualties and body handling and identification are particularly associated with subsequent psychological morbidity and recognized as stressors that ‘can make victims of rescuers’.

Attempts to prevent or minimize morbidity after traumatic events have resulted in calls for the routine provision of early psychological intervention for the victims of trauma and the emergence of a ‘disaster industry’ lead by a variety of professional groups, including lay counsellors, psychologists, social workers and psychiatrists, who have all sought to establish a role for themselves after traumatic incidents. In a survey of senior officers of UK emergency services, 72% reported some critical incident stress provision within their local service, although only 28% felt that sufficient attention was paid to this aspect of staff welfare. Early interventions are intuitively appealing and a response to perceived need, but do they work?
This paper focuses on the evidence for the effectiveness of psychological debriefing (PD), which is probably the most widely advocated preventative intervention at present.

WHAT IS PSYCHOLOGICAL DEBRIEFING?

Mitchell, an American psychologist, initially described ‘critical incident stress debriefing’ with ambulance staff in 1983. Critical incident stress debriefing has been modified and expanded by others, including Dyregrov, who first used the term PD. It is aimed at all those involved in traumatic events, including victims, rescuers, emergency service workers and the providers of psychological aftercare.

A PD is a structured intervention designed to promote the emotional processing of traumatic events through the ventilation and normalization of reactions and preparation for possible future experiences. Although initially designed for use in groups, it has also been used with individuals, couples and families. A typical PD takes place 48–72 h after the trauma as a single group meeting lasting about 2 h.

Seven stages are passed through during PD. A brief introduction stressing the focus of the intervention and its confidentiality is followed by consideration of the facts of what happened from the varied perspectives of all those attending. The expectations, thoughts and impressions of those involved are then discussed. By this stage of the PD a detailed reconstruction of what happened will have occurred, and, at least in theory, led to the open expression of associated emotions, including guilt and anger. These are considered in depth and normalized as far as is reasonably possible. Group processes such as universality and peer support are mobilized during group PD, which helps with the acceptance of experienced emotions. The emphasis remains on normalization throughout and this is discussed formally towards the end of the PD. In conclusion, the debriefer(s) prepares the participants for future symptoms and reactions, should they occur, and gives guidelines as to when further help should be sought and where it can be found. These points are often reinforced with written information distributed to the participants before they leave.

HOW DOES PSYCHOLOGICAL DEBRIEFING WORK?

Trauma psychology suggests that most victims of severe trauma will endure some distressing symptoms as they assimilate their experience. Horowitz’s information processing model predicts alternating intrusive symptoms (e.g. nightmares and flashbacks) and avoidant symptoms (e.g. denial and avoidance of cues). These diminish in intensity with time and form an integral part of the normal stress response. Such symptoms are only considered pathological when they become excessive in frequency, magnitude or duration.

HOW EFFECTIVE IS PSYCHOLOGICAL DEBRIEFING?

The chaos and unpredictability of disasters and accidents alike makes research difficult and the vast majority of published data suffers from serious methodological difficulties. The most common shortcomings are summarized in Table 1.

Anecdotal reports supporting the effectiveness of PD are plentiful and have fuelled its increasing use. McFarlane examined the course of post-traumatic morbidity in 469 firefighters exposed to a bushfire disaster over 25 months. He found that individuals who were not debriefed afterwards were more likely to develop an acute post-traumatic stress reaction than those who were. However, the effectiveness of the debriefing process was thrown into doubt by his finding that those individuals who developed a delayed onset post-traumatic stress reaction were more likely to have attended a debriefing than individuals who had remained well throughout the follow-up period.

Sixty per cent of 172 emergency workers who had received PD after various traumatic incidents

Table 1. Common methodological shortcomings in PD research

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<th>Shortcomings</th>
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<tr>
<td>Not prospective</td>
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<tr>
<td>Small sample size</td>
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<tr>
<td>Absence of control group</td>
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<tr>
<td>Varying degrees of trauma</td>
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<tr>
<td>Absence of random allocation</td>
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<td>Other confounding variables ignored</td>
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<td>Low response rates</td>
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<td>Sampling bias</td>
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<tr>
<td>Lack of uniformity of PD</td>
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<td>Timing variance</td>
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<td>Questionnaire versus interview results</td>
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Psychological debriefing in Australia completed questionnaires two weeks after the PD. Most found the PD useful and felt it had helped to reduce their symptoms of stress. Unfortunately, the absence of a control group, lack of more objective data, a short follow-up period and low completion rate limit the value of these findings.

Two other studies supporting PD suffer from similar methodological problems. One study that does boast a control group is that of Bunn and Clarke, who assessed the use of a 20 min supportive interview with a psychologist as opposed to no intervention in the relatives of severely ill or injured patients admitted to an emergency ward. The subject group were less anxious immediately after the interview, but no follow-up data was collected.

In a questionnaire study looking at the effectiveness of PD in 74 British Gulf War veterans, no demonstrable difference was found in psychological morbidity at 9 months between those who had been debriefed and those who had not. Similarly, a study comparing two groups of Norwegian firefighters exposed to dead bodies found no difference in psychological symptoms 2 weeks later between those formally debriefed and those who had talked with colleagues. Both of these studies have their weaknesses, but, importantly, do include comparison groups, which, given the lack of knowledge on the natural history of post-traumatic stress reactions is essential.

More complex preventive interventions after traumatic events have been more convincingly shown to have a positive effect in better designed studies. However, one reported intervention showed no difference at 1 and 6 month follow-up between a group of road traffic accident victims who received a preventive counselling programme and those who did not. Interestingly, in common with Robinson and Mitchell's findings, those who received the intervention said they found it useful.

Psychological debriefing is not without its own risks. Mandatory attendance at a PD has, not surprisingly, been associated with passive participation and resentment and it is widely accepted that debriefers themselves may become 'secondary victims'. McFarlane voiced concern that over-enthusiasm for primary preventative methods might delay the diagnosis and effective treatment of those who do suffer psychological sequelae. He argued that 'clear definition of the limitations of the crisis intervention approach and the point at which more formal treatment is required' is needed. His concerns were fuelled by the finding that many individuals with psychiatric disorders as a result of the Australian bushfires presented late due to other professionals’ fears that labelling on referral to a psychiatrist would occur.

CONCLUSIONS

The effectiveness of PD is far from proved, even though it appears to be popular with the consumer. The data available from methodologically flawed studies suggests that at best PD affords some protection against later sequelae and, at worst, makes no difference. It is already apparent that individuals receiving PD are not immune to subsequent psychological morbidity. Therefore if PD is used after traumatic events, formal follow-up to facilitate the identification of individuals who do go on to develop serious psychological sequelae is vital.

The current body of knowledge suggests that the presence or absence of other factors, — for example, an acute stress reaction, — personality, past psychiatric history and adequate social support are likely to affect the psychological outcome of individuals involved in traumatic events more than a presence or absence of PD — factors which should perhaps should receive greater attention when recruiting emergency service staff. Indeed, when individuals have an adequate support network and do not have other vulnerability factors, a PD may be redundant.

Despite a lack of adequate data supporting PD, clinical experience suggests that many individuals value the opportunity to express feelings of anger and guilt and derive comfort from the realization that these are a normal emotional response to trauma. Many of the feelings expressed during PD are intensely personal and disaster workers and victims often experience difficulty in confiding in, and tend to be suspicious of, 'outsiders', especially mental health professionals. If PD is to be effective, it should be a team responsibility taking place within groups of emergency workers carried out as locally and rapidly as possible. The role of mental health professionals should be directed towards educating these groups rather than trying to provide a service themselves.

If PD or any other professional psychological intervention is to be made available to large numbers of individuals, considerable resources will be required. At present PD falls into that group of psychological interventions discussed by Fahy and Wesseley as urgently requiring proper evaluation. It is essential, therefore, that the efficacy of PD is properly evaluated using prospective controlled study designs and random allocation to PD or non-intervention groups. Attention must also be paid to adequate measurement.
of the dimensions of trauma as well as other variables that may affect outcome and both pre- and post-treatment assessment. This should give a clearer indication as to whether PD should be routinely offered to everyone involved in traumatic events, restricted to ‘high risk’ individuals, or abandoned. Whatever the outcome of such research, McFarlane’s warning that overenthusiasm for primary preventative methods might delay the institution of diagnosis and effective treatment for those who do suffer psychological sequelae\textsuperscript{27} must not be allowed to become a reality.

REFERENCES


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doi: 10.1136/emj.12.4.255

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