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The Debate over Psychological Debriefing for PTSD

Injae Choe, M.A.,[1]

Introdction

Psychological Debriefing (PD) is an early intervention administered to trauma victims in order to prevent the onset of posttraumatic stress disorder (PTSD). The method has been considered a "mandatory" intervention and has long been endorsed by the American Red Cross and several relief agencies around the globe (Litz, Gray, Bryant & Adler, 2002), yet it has also incited warnings of contraindication from 20 renowned trauma experts shortly after 9/11 (Herbert, Lilienfeld, Kline, Montgomery, Lohr, Brandsma et al., 2001) in an APA Monitor open letter and from the World Health Organization (van Ommeren, 2002). Given that lifetime exposure to potentially traumatic events in the general population is extremely high-over 60% (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995) any measures to prevent PTSD deserves ongoing in-depth evaluation. Fortunately, the vast majority of these trauma-exposed people do not go on to develop

1: Department of Psychology, The New School for Social Research, New York, USA.

Address correspondence to Injae Choe, injae.choe@gmail.com

an acute, chronic, or delayed onset PTSD, attesting to the protective resiliency prevalent in the normal population. This fact alone immediately raises the question of whether any type of early psychological intervention should continue to be administered, especially if there is mounting empirical evidence to suggest that certain forms of intervention such as PD may either be inert or can even exacerbate and solidify the very symptoms of PTSD that mental health professionals and relief workers set out to prevent in the first place.

A History of Psychological Debriefing and Its Variants

Psychological debriefing (PD), rather than psychotherapy in the conventional sense, is usually considered a type of crisis intervention delivered within hours to a few days of a trauma and is designed to mitigate acute symptoms of stress and to prevent the emergence of posttraumatic psychopathology. Many of the PD techniques used were first developed by the military in World War I, mainly to speed the return of temporarily distressed soldiers to the frontline (Litz et al., 2002). After battle, commanders often met with groups of their troops on a routine basis to boost morale by encouraging the sharing of stories of engagement. Over time, some researchers and practitioners have successfully expanded applications of PD to the general population. In particular, Mitchell (1983) created the most widely used form of PD, called "critical incident stress debriefing" (CISD), that was originally designed for emergency service personnel but later administered to both primary and secondary victims of trauma. With this development, debriefings are now often given to traumatized individuals in various social and occupational health environments, and are not limited to firefighters, police officers, and emergency medical technicians.

Raphael and Wilson (2000) point out that PD in practice often involves a single session that lasts a few hours, and is delivered

to either an individual or a group up to a few days after trauma. A session leader creates a supportive and nonjudgmental setting to encourage participants to ventilate their emotions. Psychoeducation is also given about temporary and normal acute reactions. PD has been used with several populations, including survivors of crime, motor vehicle accidents, and major disasters, natural or otherwise. Studies of PD and its variants to date include the role of PD after the World Trade Center attack (Hammond & Brooks, 2001; Foa, Cahill, Boscarino, Hobfoll, Lahad, McNally, et al., 2005), "critical incident stress management" (CISM, see Everly & Mitchell, 1999), outreach with Pentagon staff after the attack (Rowan, 2002), early mental health intervention after the missile attack on the USS Stark (Sokol, 1989), and a prospective study of debriefing with brief group psychotherapy in a homogeneous group of non-injured victims of a terrorist attack in Scandinavia (Amir, Weil, Kaplan, Tocker & Witzum, 1998).

Another related term, "psychological first aid," referring to most emergency aid provided besides food, supplies, and physical healthcare, has had much overlap with PD. Wilson, Raphael, Meldrum, Bedosky and Sigman (2000) and Watson and Shalev (2005) discuss psychological first aid in conjunction with acute assessment and triage. Meanwhile, Pynoos and Nader (1988) have focused on psychological first aid to children exposed to community violence; they recommend identifying the degree of exposure (e.g., witnessing injury or death) in addition to assessing individual response that is out of proportion to the degree of exposure, indicating the need for evaluation of other risk factors.

Key Characteristics of PTSD Revisited

To fully grasp why much debate has surfaced over PD against such a backdrop of the various forms of early intervention, it would be worthwhile to reiterate the key characteristics of PTSD.

The current diagnosis of posttraumatic stress disorder in DSM-IV is unique in that it goes beyond simply listing reliable criteria. That is, it explicitly identifies a causal factor in its definition-a specific etiology is assigned to a "traumatic event" which poses a threat of death or serious injury, or a threat of harm to physical integrity of the self or others (American Psychiatric Association, 1994). Unfortunately, its apparent specificity in causation identification is deceptive since the definition of trauma can technically cover a broad range of unrelated tragedies, from events that affect an entire population such as terrorist attacks and earthquakes to individual trauma such as childhood sexual abuse and motor vehicle accidents afflicting the individual, whether single or repeated incidents, involving intentional violence or accidents. As long as the criteria for other symptom clusters, including reexperiencing, avoidance or emotional numbing, and hyperarousal are also met, a patient will be diagnosed with PTSD.

While some researchers may question the inherent, over-inclusive appraisal of a traumatic event in the diagnosis of PTSD (e.g., Shalev, 2000; McNally, 2003), the fact that this diagnosis links such a diverse set of external triggers to a wide spectrum of symptomatology can provide uncommon fertile ground for multidimensional empirical studies. In the context of PD, such studies will better inform the appropriate use or disuse of certain intervention techniques meant to prevent chronic PTSD, despite how popular or intuitively sensible some of these long-standing techniques might seem. Furthermore, because disparate events can qualify as clinically traumatic, it hardly means that these different trigger events must all follow the same psychobiologic pathways leading to similar subsequent symptomatology. Therefore, any hastily applied "one size fits all" approach to early psychological intervention will probably fail to address the most relevant risk factors for developing PTSD.

Empirical Evidence For and Against Psychological Debriefing

Carlier, Voerman, and Gersons (2000) indicate that most people who receive debriefing find it helpful. However, their findings say little about whether PD itself was the cause behind these perceived salutary effects. Individuals exposed to trauma do not necessarily develop PTSD. In fact, after initial adverse reactions, most individuals undergo a natural recovery process over a period of up to three months (McNally, Bryant & Ehlers, 2003). One danger resulting from such PD is that inappropriate intervention delivered at the wrong time may not only be unhelpful but may even impede this natural recovery process. In the absence of a better evaluation alternative, all evidence presented to support or counter the effectiveness of PD should be held to conventional empirical standards.

What is the evidence cited by PD advocates to support their application of early intervention? First, and perhaps most importantly, is the work of the strongest advocate, J. T. Mitchell, who founded the PD processes of CISD and CISM. In a landmark research summary, Mitchell presents the key points and findings of 65 outcome articles that examine the positive effects of early intervention (Mitchell, 2003). One of the many studies he cites (Campfield & Hills, 2001) uses a random assignment of robbery victims to either an immediate (within 10 hours) or a delayed (after more than 48 hours) debriefing group. There is a significant decline in PTSD symptoms resulting in the first group only. While this study purportedly endorses very early PD, it is missing a no-treatment control group. One extreme possibility is that some other selected group of robbery victims having received no treatment at all could have shown even less PTSD symptomatology than either of the randomized groups in this study. Other studies cited in Mitchell's review either lack randomization or a control group, or use unstandardized anecdotal accounts as the

only dependent variables (e.g., Burns & Harm, 1993). In addition, studies that are randomized suffer from several confounding factors (e.g., all nurses were female in Nurmi, 1999) or from treatment-type conflation variables (e.g., the use of six group psychotherapy sessions in addition to CISD in Amir et al., 1998). These are just some of the shortcomings noticeable in all the studies reviewed by Mitchell. Additional factors include the use of too few participants, a lack of pre-debriefing symptom measures, and a hypocritical disregard for the principle of delivering intervention early, such as allowing months to elapse after the original trauma (see McNally et al., 2003).

Meanwhile, there has been mounting evidence showing that PD is ineffective for survivors of crime (Rose, Brewin, Andrews & Kirk, 1999), motor vehicle accidents (Conlon, Fahy & Conroy, 1999), volunteer firefighters (Hytten & Hasle, 1989), disaster workers following an earthquake (Kenardy, Webster, Lewin, Carr, Hazell & Carter, 1996), and police officers who worked at a plane crash disaster site (Carlier, Lamberts, van Uchelen & Gersons, 1998). Further, Bisson, Jenkins, Alexander and Bannister (1997) present findings of a randomized clinical trial study conducted on burn victims. Their research shows that debriefed patients, after 13 months, had significantly higher scores on self-report measures of PTSD, anxiety, and depression. Other studies exhibit some of the shortcomings similar to flaws in studies supporting PD. Overall, however, most research arguing against the use of PD seems to have been conducted by rigorous experimental psychologists whose objective is to warn against a widely practiced, yet potentially harmful, early intervention protocol.

Toward a Balanced View of the Evidence

Some advocates of PD continue to argue that over-insistence by PD opponents on the ubiquitous use of randomized clinical trial

studies (RCTs) is misguided and hypocritical, particularly when the wider field of psychotherapy itself in general relies heavily on case studies and quasi-experimental designs rather than RCTs. Everly and Mitchell (1999) and Mitchell (2002) maintain that their opponents have been measuring the wrong variables or misapplying their protocol. Specific arguments that Mitchell and Everly use to point out flaws in the negative studies of CISD include: 1) most of these studies tested individual rather than group debriefing, 2) debriefing is treated as a stand-alone technique only, 3) there is a reckless dismissal of all testimonials of PD participants; 4) other meaningful outcome variables such as adaptive function, reduced absenteeism at work, and reduced sick days, rather than PTSD symptom outcomes alone, should be measured, and 5) CISD has from its inception been geared mostly toward emergency workers rather than primary trauma victims (see McNally et al., 2003).

Despite their success in producing several negative studies, advocates of RCTs continue to face the burden of convincing the field that their methodology is indeed the most appropriate across all treatment and intervention studies. Although it would be difficult to find emperical methods that are more sound, the application of RCTs in the real world is almost always compromised on many fronts. As McNally et al. (2003) point out, investigators often fear the ethical ramifications of assigning trauma-exposed individuals to a no-treatment control group on the one hand and incorporating a treatment condition with possible adverse (side-)effects on the other, all so as to adhere to a strict experimental design. Further, pre-trauma assessments are rarely available (except perhaps in the military where such records are routinely kept) to take into account predispositional factors, psychiatric history, and comorbidity. Unique to the study of early interventions such as PD, empirical researchers in this domain are logistically unprepared to launch a well-designed study in the immediate aftermath of a sudden, unexpected calamity. Even

when such researchers have a system and protocol already in place, securing official approval for human subject testing will always take an unbearable amount of time also.

Finally, on a more theoretical level, RCTs are by definition not immune to some well-known imperfections and constraints. First, all group-comparison designs are implemented at the expense of potentially eye-opening in-depth information otherwise extractable about individual differences. Even if a pure RCT design somehow became fully viable in the study of PD for PTSD, the resulting findings would still require careful interpretation. That is, any experiment based on a group design will still reveal significant differences only on average. Said another way, whenever the PD treatment group shows a null or adverse effect, there is the possibility that a number of individuals did in fact show some measurable improvement, contrary to the opposite average result of the group as a whole.

Conclusion

Litz et al. (2002) propose that a number of factors must be considered in improving continued investigations of PTSD onset: 1) some potential confounds can be greatly reduced by aggressively controlling for initial symptom levels and pre-trauma clinical history, 2) more concerted efforts should be exerted on carrying out several follow-ups and post-hoc multivariate analyses so that predictors of change in symptom severity can potentially reveal useful clinical information on the detailed phenomenology of the individual, 3) the predominant alternative to PD, cognitive behavioral therapy is the one distinct treatment that consistently meets most of the basic empirical validation requirements in the prevention of PTSD, especially if an appropriate number of sessions are delivered within an optimal timeframe, and 4) certain key elements of CISD and other PD modalities whose effects are undetected or ignored altogether by RCTs may in fact prove use-

ful in improving trauma victims' overall adaptive coping (e.g., skills leading to reduced use of alcohol and a better understanding of normal posttraumatic reactions and their associated sequelae).

As the cumulative emperical knowledge base of all researchers continues to build, the various stakeholders drawn into the aftermath of trauma should become increasingly adept at negotiating practical demands with ethical imperatives. Hopefully, those who stand to benefit the most in the end will indeed turn out to be the future survivors of the diverse manifestations of trauma.

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