

## **Debriefing: An Option Rather Than an Unanswered Question?**

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### **Introduction**

A recent study by Hawker, Durkin and Hawker (2010), "To Debrief or Not to Debrief Our Heroes: That is the Question," provided an enlightened view pertaining to the controversy that has plagued debriefing since the 1990's Cochrane Review. The article implores reviewers of debriefing to "recognise the limitations of debriefing research and not to overgeneralise their conclusions."

Developed in the 1980s, psychological debriefing was employed for our world's heroes and heroines, people who work in stressful fields and situations, such as the military, emergency services and humanitarian aid. Debriefing was used to help workers process their thoughts and emotions with the aim of reducing long-term stress and sick leave while helping to boost both employee coping skills and workplace retention. The Cochrane Review (Rose, Bisson, Churchill, and Wessely, 2006) and NICE (National Institute for Health and Clinical Excellence, 2005) identified two out of fifteen Randomised Controlled Trial (RCT) studies on debriefing that were negative. This changed the use and perception of debriefing, perhaps to the detriment of those who need it most. With a clear view on debriefing standards and the interpretation of these studies, it is imperative that more research and insight – and less overgeneralisation – is now needed to better understand the process and potential benefits of debriefing.

### **Background**

Known as critical incident stress debriefing (CISD), debriefing was codified as a seven-phase process to help emergency services and disaster workers in times of crisis by Dr. Jeff Mitchell. This structured debriefing process was created to help people discuss, understand and cope with trying situations with the assistance of trained mental health professionals and/or peers. Debriefing grew in usage and acceptance in the 1980s and 1990s.

However, following the Cochrane Review, a case against debriefing was made regarding two of fifteen independent studies that identified some negative effects resulting from the espoused debriefing process. The Review stated that "compulsory debriefing of victims of trauma should cease," however, it actually "recognised that this may not apply to group debriefing, debriefing after mass trauma, or debriefing of emergency workers." Since this edict, findings on debriefing have been overgeneralised and later interpreted in the NICE Quick Reference Guidelines to indicate "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."

A great deal of attention was paid to this Review and in particular, these two studies, which led to a recommendation that debriefing essentially be halted in the field of emergency services, and scant research on debriefing has been conducted since. This is in spite of the fact that the negative studies were flawed in several distinct ways and that, anecdotally, emergency workers still report a need for such services. Emergency workers once offered debriefing services now often find that they're no longer available. Sadly, as a result some organizations have even forbidden the intervention, citing possible harm.

### **Debriefing Research**

Of the 15 randomized controlled trials (RCTs) on debriefing featured in the Cochrane Review, three were associated with a positive outcome, nine found no effect and two were linked with

negative outcomes. In fact, the last study did not include a non-debriefed control group. Yet it was still found that immediate debriefing was more effective than delayed debriefing.

The two studies that have garnered so much attention failed to follow standard protocol in terms of timing, length and training for debriefers. For instance, many people debriefed too soon – within 24 hours of the incident – which is convenient in terms of data collection, yet may be too traumatic for the people who just experienced an extremely stressful incident. The Mitchell model encourages debriefing when the person is ready and not within 24–48 hours or while the trauma is ongoing. Moreover, Mitchell promotes debriefing sessions that last two to three hours. Interestingly the majority of negative studies of “debriefing” lasted between 15–60 minutes. Lastly, a debriefing session should always involve a mental health worker and/or a trained peer worker debriefing together. The two studies in question included a research assistant and those with only a half day of training, and in others nursing staff involved with the person’s physical treatment. Some debriefings were actually conducted on the hospital ward, rather than in a private setting, which is contra to debriefing standards.

Significantly, the “debriefing” in these studies was used for groups that it wasn’t intended for, such as hospitalized medical patients. Studies utilized in the review involved non-emergency personnel, such as motor vehicle accident victims, emergency room patients from house fires, falls or other traumas, mothers following difficult pregnancies, and burns, sexual assault and dog bite victims. This is a very different population than was initially espoused by Mitchell, who indicated debriefing is suited for groups of people who have already been briefed together prior to working together in stressful situations, which may be a key to the overall success of the process. In addition, while the debriefed patients did report more severe symptoms than the control group in these two studies, when the initial symptoms and injury severity were controlled for, the reported negative effect of debriefing was reduced to marginal significance. This fact, however, has not been widely reported.

### Key Lessons

The key lessons learned from the two randomized controlled trials which reported adverse effects in regard to debriefing are significant and should guide research going forward in gaining a balanced and sound perspective on the efficacy of debriefing. Studies that are contrary to the standard Mitchell protocol for debriefing should be excluded from the research, otherwise it is akin to comparing two completely different entities. Mitchell’s model of critical incident stress debriefing espouses:

- 1) **Do not offer debriefing too soon after a traumatic event:** In one of the studies that reported adverse results, people admitted to a hospital were debriefed within 24 hours of the incident or accident (or as soon as they were fit to be seen). This is clearly too soon, since avoiding thoughts of the trauma can actually help in coping immediately after a traumatic event. In these studies, the sooner the debriefing took place, the worse the outcome. Therefore, any future studies should ensure that debriefing takes place when a person is ready and receptive and not so soon after the event.
- 2) **Do not offer debriefing sessions that are one hour or less:** In the two studies that supported the cessation of debriefing in traumatic events, debriefing was performed for 44 minutes and about an hour, on average (and for just 15 minutes in some cases). Experts encourage a minimum of two hours for an initial session with at least one follow-up debriefing session. This time is needed to follow all proper debriefing protocols. None of the studies cited post-debriefing follow-up.

- 3) **Do not use insufficiently trained or inappropriate debriefers:** This goes without saying, but is another key. If a debriefer has insufficient training, the process can certainly go awry. Debriefing should be conducted by a mental health professional and/or a trained peer debriefer who are both familiar with the workplace culture and have credibility (the “me too” factor). Any future studies should ensure that this protocol is carefully followed.

As previously mentioned, further research on debriefing is needed to determine additional key lessons for usage, efficacy and success in debriefing methods. Research should ensure that the above issues are no longer a factor in the outcome of the study.

### **First Do No Harm**

While the Hippocratic Oath implores physicians to “first do no harm,” withdrawing this intervention, as the authors suggest, from groups who came to rely on it over the 20 years it was employed and reported anecdotally that it was beneficial, can, in fact, be harmful.

It has been found that while many individuals who suffer a traumatic event can talk to friends, family and therapists to cope with their thoughts and feelings, many emergency service workers, military personnel and other professionals previously turned only to debriefing to cope with challenging issues. While these groups appreciate the opportunity to discuss the event during the debriefing process, many of them will not discuss incidents with family or therapists, whether due to occupational stigma or concern that it could affect their long-term career prospects, or as a result of confidentiality requirements. Furthermore, they feel that debriefers better understand their plight and circumstances than those outside their immediate circle of colleagues.

These heroes and heroines who once were offered debriefing as standard procedure may have been left to wonder why it is no longer available or has even been vilified. In a 2003 study by Thomas Greenberg et. al., two-thirds of peacekeepers returning from deployment were in favour of formal psychological debriefing. The ethics of withdrawing a standard practice that has been used to positive ends by many in occupational groups such as emergency services, humanitarian aid fields and the military is questionable.

### **Conclusion**

In summary, there essentially needs to be more research about debriefing, particularly that of a format that may be more realistic rather than based upon RCT, which may be impractical given the nature of debriefing. This is fundamentally why “to debrief or not to debrief” remains the question. This potentially valuable service for emergency workers should not be withdrawn based on flawed studies that did not follow standard protocols. It is imperative that researchers and practitioners refrain from overgeneralising the outcomes of the prior studies which are ultimately questionable.

While inadequate debriefing may be harmful and debriefing should never be mandatory (nor should it be espoused to treat post-traumatic stress disorder), many of our heroes are being denied a form of support that they both need and desire. Simply, if these occupational groups request debriefing, there is no reason they shouldn't have access to it, within the context of informed consent and appropriate debriefing protocols.

More high-quality research on debriefing in fields such as emergency services, the military and humanitarian aid work is warranted to determine the value, appropriate uses and implications of

debriefing for those who regularly work in stressful situations. Future research should incorporate Mitchell's critical incident stress debriefing protocols as part of its platform.

Our heroes and our heroines should, in fact, not be questioned when they request debriefing. To debrief or not to debrief should be an option rather than an unanswered question.

*(Reference: Hawker, D.M., Durkin, J. and Hawker, D.S.J. (2010) 'To Debrief or Not to Debrief Our Heroes: That is the Question', Clinical Psychology and Psychotherapy, John Wiley & Sons, Ltd.)*