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The Role Of Debriefing In Treating Victims Of Trauma.

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Abstract

The application of psychological debriefing has become an expected and widespread intervention following exposure to trauma. This article assesses the wisdom of such an approach and reports upon expert consensus regarding its use. Meta-analytic and narrative reviews are summarised and areas of agreement and disagreement are outlined. In sum, it was concluded that the majority of people do not become traumatised from stressful events; that generic psychological debriefing, when applied to individuals, appears to have little impact on functioning; that a specific form of debriefing called Critical Incident Stress Debriefing or Critical Incident Stress Management holds the possibility of noxious effects for some participants and that those most deleteriously affected by debriefing appear to be those most distressed by the initial trauma; that there is no randomised controlled trial evidence to support and differentiate impact from group debriefing approaches; and that early intervention using Cognitive Behavioural techniques for those with clinically significant presentations appears the most promising approach. A generic set of guidelines for intervention following trauma is provided.

Introduction

Authorities frequently default to orchestrating “debriefing” services following traumatic incidents, with the intent to both help mitigate the psychological consequences of these incidents and, in organisational contexts, to meet duty of care requirements under workplace health and safety laws. Critical Incident Stress Debriefing (CISD), a specific form of Psychological Debriefing (PD), gained widespread acceptance and implementation rapidly following its initial proposal in a trade magazine for emergency medical providers (Mitchell, 1983). There has, however, been increasing doubt cast on both the generic and specific practice of psychological debriefing, clouded by confusion regarding the terminology used, the outcomes to be measured, the consistency of application, and a range of similar issues. This article explores the claims frequently made by proponents regarding the efficacy and impact of CISD, counterclaims of ineffectiveness by its detractors, and an evolving general consensus regarding its specific use and the use of more generic psychological debriefing. We have argued elsewhere (Devilley & Cotton, in press) that the recently expanded context built to surround CISD, and called Critical Incident Stress Management (CISM) stands poorly defined and relatively indistinct in the treatment-outcome literature and should, unless reliable evidence to the contrary emerges from objective and independent study, be treated similarly to its signature intervention (debriefing and debriefing-styled exercises). Current expert consensus and meta-analytic reviews suggest that CISD is possibly noxious, that generic psychological debriefing is probably inert, and that more emphasis should be placed on screening for and providing early intervention to those who develop pathological reactions. Currently available empirical data raise serious questions regarding the wisdom of providing such services using existing models of intervention. We recommend instead a set of preliminary guidelines for clinical and organisational interventions that we argue to be more likely to meet the standards of empirically supported practice. This summary is predominantly based upon our previous work in Gist and Devilly (2002), Devilly and Cotton (in press), and Devilly, Gist and Cotton (in submission).

Reactions to Trauma

Traumatic events are endemic to psychiatric populations and have been reported to increase the likelihood of psychological dysfunction, and those who develop post traumatic stress disorder (PTSD) show high rates of comorbidity and utilise health

care services more than those without disorders (e.g., Brickman, Garrity, & Shaw, 2002; Kessler Sonnega, Bromet, Hughes, & Nelson, 1995). Kessler et al. (1995) estimated the lifetime prevalence rate for experience of traumatic events (e.g. rape, assault, natural disaster, witnessing murder, etc) to be 60.7% for men and 51.2% for women, and estimated the lifetime prevalence of PTSD (using DSM-III-R criteria) at 7.8%. Clinical case conversion clearly falls far below the rate of exposure - indeed, epidemiologic data following the 2001 terrorist attacks in New York City found symptoms consistent with PTSD in less 7.5% of those exposed, though that rate was nearly threefold for those in greatest proximity to the Twin Towers (Galea, Ahern, Resnick, Kilpatrick, Bucuvalas, Gold, & Vlahov, 2002); that incidence had resolved by about two-thirds within 4-6 months following the first wave of data collection (Galea, Boscarino, Resnik, & Vlahov, in press). It is evident, then, that exposure alone is insufficient to yield PTSD in a substantial majority of cases, and that many early manifestations spontaneously resolve without orchestrated intervention.

The likelihood of developing psychological reactions such as post traumatic stress disorder is, in part, moderated by trauma specific variables such as personal involvement in the traumatic episode; event characteristics, such as whether the event was naturally occurring or man-made; and the degree of exposure to the event and its sequelae. The likelihood of pathological outcome is also affected by person specific details such as socio-economic status, coping styles, and both the level and quality of perceived social support (Norris, Kaniasty, & Thompson, 1997). Current evidence is inconsistent regarding which coping styles (e.g. practical vs. emotional) may prove most advantageous at particular intervals following traumatisation, although Norris (2002) notes that minimizing (or distancing) the event appears to be an adaptive coping strategy while avoidance coping strategies and the assignment of blame were consistently related to poorer outcomes.

Kessler et al. (1995) noted that the rate of PTSD was higher amongst women (10.4%) than amongst men (5.0%), and was also higher amongst the previously married. Australian data (Creamer et al., 2001) recently replicated the finding regarding marital status yet found a much smaller difference regarding gender in a 12 month prevalence study. Interestingly, Australia also appears to show a lower 12 month prevalence rate of PTSD overall (1.33%) when compared to the American study (3.9%; Kessler et al., 1999).

PTSD is not the only, or even the most likely, pathological outcome following traumatic events. Studies have further indicated that a history of trauma may itself be a risk factor for depression, with one study (Lopez, Piffaut, & Seguin, 1992) reporting that 71% of raped women suffered from major depression whilst 37.5% developed chronic PTSD that lasted from 1-3 yrs. Raphael (1986) went so far as to estimate that 30-40% of those who experience a significant stressful event would go on to develop a significantly distressing reaction by one year postimpact. Of course, one would have to say that this estimation would be dependent upon the severity of the stressor and the definition of 'significantly distressing'.

Efforts to mitigate this potentially chronic and debilitating course have commanded both colloquial and professional concern. Early commentators argued for the use of psychological interventions immediately following virtually any traumatic event (cf. Mitchell, 1983, et seq.) as a prophylactic preventive measure and the use of psychological debriefing services following disasters resultingly became a widespread practice. Employers, governments and public policy makers rallied to calls for reasoned and humane support of those potentially affected, receiving much concerted lobbying to do so and hearing essentially no arguments to the contrary.

Only recently have controversies and questions simmering in the literature of academic research risen to general awareness. In marked contrast to the early and consistent proclamations of intervention advocates and marketers that such treatments were uncommonly efficacious in preventing PTSD, essentially devoid of iatrogenic risk, and represented the only responsible avenue for competent and compassionate response (cf. Mitchell, 1992), reports emerging from the refereed scientific literature of the psychological disciplines have increasingly suggested that the practice be approached with caution (Bledsoe, 2003), limited (Bisson, McFarlane, & Rose, 2000; Raphael, 1999), or even contraindicated (Parry, 2001; NATO, 2002) and curtailed (Rose, Wessely, & Bisson, 2001; Mayou, Ehlers, & Hobbs, 2000). Accordingly, those charged with marshalling assistance in the aftermath of potentially traumatising events can find neither clear nor unbiased direction as to the wisdom of providing such interventions, finding themselves instead lost in a cross-fire of data and assertions that prove difficult for a reasonable laity to decipher. The current dilemmas are well illustrated by a comparative evaluation of two recent metanalytic reviews of the psychological debriefing literature which came to diametrically opposed conclusions. Before the research can be discussed, some terms require clarification.

What is Psychological Debriefing?

The area of trauma research has become fraught with domain specific jargon that is easily confused and often misused, especially by those outside the research arena. “Psychological debriefing” (PD) and “Critical Incident Stress Debriefing” (CISD), for example, are often used interchangeably. The former is best described as the generic term for immediate interventions following trauma (usually within 3 days) that seek to relieve stress with the hopeful goal of mediating or avoiding long term pathology through narrative reconstruction of the experience and cathartic ventilation of its distressing impacts. PD attempts to achieve normalisation of distress and to provide ‘psycho-education’ regarding presumed symptoms and methods for their amelioration.

CISD, on the other hand, is a proprietarily based PD that was originally articulated by Mitchell during the 1980’s (Mitchell, 1983, 1986, 1988) through trade magazines, trade conferences, and proprietary seminars. It encompasses seven stages: 1) the introductory phase (rules, process and goals outlined); 2) the fact phase (what the participants saw, did, heard etc); 3) the thoughts phase (what the participants’ first thoughts were / are); 4) the reaction phase (emotional reactions, feelings); 5) the symptoms phase (global assessment of physical or psychological symptoms); 6) the teaching / information phase (educating the participants about common, likely, or possible stress responses); 7) the re-entry phase (referral information provided). CISD sessions generally last one to three hours, are usually delivered to groups of individuals, and are intended to take place within 24 to 72 hours after the event, where “the process goal of CISD is psychological closure subsequent to the crisis” (Everly et al., 2000; p.26).

CISD centres around group-based interventions (though individual, or ‘one-on-one’ debriefings have always been advocated as an acceptable and expected variant), relies heavily on ventilation and normalisation, and is intended to adhere systematically and sequentially to its seven-step design. It is now said to be couched within an amalgam of self-help strategies collectively named “Critical Incident Stress Management” (CISM; Everly & Mitchell, 1997). Devilly and Cotton (in press) have argued that CISD and CISM have yet to be sufficiently differentiated to represent distinct interventions (to wit, not mutually dependent upon one another) that can be tested both independently and collectively, and no reliable evidence has been encountered to demonstrate that such conjunction improves the efficacy of any

component or mitigates the paradoxical impacts of the debriefing component. CISD advocates claim, nonetheless, that this intervention “mitigates the acute psychological distress associated with psychological crisis that may arise from violent acts, and to prevent or mitigate the intensity of adverse posttraumatic sequelae” (Everly, Flannery, & Mitchell, 2000; p. 23-24).

It is important to differentiate debriefing from early intervention for diagnosed pathological responses. Psychological debriefing most commonly involves wholesale prophylactic provision of professional services, often through private debriefing companies/psychologists, immediately following a traumatic event as a matter of course, under organisational aegis or even organisational mandate. Early intervention, on the other hand, is the provision of what could be called “restorative treatment” to individuals who request psychological help following trauma and have a clinically significant presentation (Deville, 2002). Recent evidence appears to back the use of early cognitive behavioural therapy (CBT) for those diagnosed with Acute Stress Disorder (ASD; e.g., Bryant, Harvey, Dang, Sackville, & Basten, 1998); CBT has been shown to be very efficacious in treating developed post traumatic stress reactions when utilized in short course interventions commencing 4-6 weeks following traumatic exposure (e.g., Foa, Riggs, Dancu, & Rothbaum, 1993; Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999).

Debriefing Review Studies

As part of the Cochrane Collaboration, Rose, et al. (2001) conducted a meta-analytic review of the psychological debriefing literature. Their inclusion criteria were that the studies utilised psychological debriefing (which employed normalisation and ventilation) that was administered as a single session within one month of the trauma and relied upon a randomised design. This elicited only eight studies in all, two of which had uninterpretable statistics. Unfortunately, the randomisation requirement, though scientifically rigorous and laudable, also meant that no group-based interventions were included in the review. This is problematic because group-based debriefing has been a principal method of delivery for this type of intervention. Nevertheless, of the six studies that were interpretable, all either found no benefit of PD or - and worryingly - that PD increased the likelihood of developing PTSD compared to no intervention. Rose et al. (2001) concluded that compulsory debriefings should cease immediately and that resources would be better utilised by focussing on those individuals who develop recognisable disorders.

The thrust of this sentiment was underscored in a recent meta-analysis by van Emmerik et al. (2002). These authors likewise conducted a literature search to find studies which had used debriefing within 1 month following a trauma, and where symptoms were assessed pre- and post-debriefing using psychometrically acceptable assessment instruments. Seven studies met their criteria, five of which used CISD as one intervention, six used no-intervention control conditions, and three used conditions of other PD interventions (i.e. “30 minute counselling”, “education”, and “historical group debriefing”). The results suggested that while people have a disposition to improve over time when they received no intervention (on both measures of PTSD and other trauma related domains), neither CISD nor non-CISD based interventions made a significant difference in the outcomes reported. The authors noted, however, that while confidence intervals overlapped, the effect size for nonintervention was moderate and for non-CISD interventions moderate to strong. The interval for CISD, unlike the other conditions, included zero and negative values, indicating no effect or a possible paradoxical impact on resolution. Put more directly, the provision of CISD would appear to inhibit or even reverse the normal inclination toward resilience and resolution while the provision of non-CISD interventions had no negative effect and may, to some degree, work at least somewhat to enhance it.

These findings and conclusions contrast dramatically with a review of CISD / CISM by Everly et al. (2000) and a statistical meta-analysis by Everly and Boyle (1997). The meta-analytic review stated that it included only studies that explicitly used CISD in a group debriefing format. They concluded that CISD achieved a treatment effect size of Cohen’s $d = 0.86$ (i.e., a large, positive effect). It must be noted, however, that the studies included in these analyses appeared in neither of the reviews outlined above (Rose et al., 2001; van Emmerik et al., 2002). It should also be stressed that none of the studies used a randomised, controlled design and some of the studies were unpublished and unavailable for inspection. Furthermore, of those that were available, Devilly et al. (in submission) were unable to independently derive the effect sizes reported by Everly and Boyle (1997) from the original data presented in two of the available three articles. The idiosyncratic and nonrepresentative nature of these reviews has been independently noted by other authors as well (Bledsoe, 2003; Fullerton et al., 2000; Litz et al., 2002; van Emmerik et al., 2002), who similarly discounted their conclusions.

The most conservative argument regarding group CISD would be that, since no randomly controlled trials of group CISD have been reported, its effectiveness remains undemonstrated. The consensus of randomised controlled trials to date, however, strongly suggests that individual debriefings using the CISD/M system are at best inert and quite possibly noxious, and hold no prophylactic effect. Since there is no evidence to suggest that this verdict is altered by changing formats or embedding the intervention with other untested self-help strategies, it is more prudent to argue that current evidence advocates avoiding this approach regardless of format until clear and convincing evidence of differential efficacy is produced.

Still, one must consider the replicated finding that people typically report high satisfaction ratings following involvement in PD. It has been argued that while this is one outcome domain, it is not necessarily the best upon which to make decisions regarding treatment implementation (Deville, 2002). These assessments are likely to represent a nonspecific “halo effect” stemming from appreciation of such palliative factors as presence, concern, and empathy for one’s distress - factors in no way exclusive to the debriefing format or necessarily resultant of that specific intervention. Indeed, the equal or greater effect sizes associated with other contrasted interventions (van Emmerik et al., 2002) would suggest that these effects may even be more potently delivered in other contexts.

So what do we really know about debriefing and what should a responsible practitioner do? The first task is to look at the areas where all parties seem to agree, seeking to find some general ‘consensus’ between research studies and expert opinion.

Areas of Agreement

The first area of agreement is that whilst no intervention should cause harm, there is a lack of accord between what has been reported in the refereed scientific literature and what has been general practice in the field. This is due, at least in part, to a paucity of controlled research compared to an abundance of marketing and advocacy in other, less constrained venues. Indeed, at a recent North Atlantic Treaty Organisation (NATO) - Russian workshop on terrorism the general agreement was that “there is still no consensus on the role, if any, of very acute interventions. Classic CISD debriefing can no longer be recommended” (NATO, 2002). None the less, there has not been a clear explication of an approach consistent with established

empirical findings that could be followed as an alternative to the now ubiquitous “debriefing” approaches.

Secondly, debriefed parties generally appreciate the gesture (Deville & Cotton, in press). Client satisfaction with the procedure has been widely reported as strong, but more critical assessment of satisfaction data sometimes reveal an endorsement that is less than overwhelming. Bunch and Wilson (2002), in a refereed fire service trade magazine, recently reported that “critical incident stress debriefing was considered to be helpful at some level by no less than 70% of Oklahoma City firefighter survey respondents” (p.48). When the data were examined directly, however, approximately 3 times as many had rated the intervention “not helpful” as had rated it “very helpful” and more than two-thirds had rated it below the midpoint of the four-point Likert scale they had been presented. While expectancy for change in people diagnosed with psychiatric disorders and attending treatment is sometimes related to actual change, high levels of satisfaction with debriefing are not necessarily reflected in positive outcomes.

Low satisfaction, such as with receiving no form of assistance or intervention, could conceivably correlate to higher end state functioning, particularly given the finding that debriefing individuals has been less potent than natural proclivities toward resilience and resolution and may, in fact, inhibit its progress (van Emmerik et al., 2002). While it is generally agreed that traumatized individuals both expect and appreciate some form of visible aid, not all forms of help turn out to be helpful (Gist, Lubin, & Redburn, 1999).

Thirdly, most researchers and clinicians would also agree that those who are distressed following a traumatic event should be denied neither practical nor emotional support, although the best method of delivering such support remains unclear. Everly et al. (2000) contended that CISD is the only proven debriefing intervention but, as made clear in the above discussion, individual CISD is a method of very questionable utility, particularly with those most distressed following a trauma (Mayou, Ehlers, & Hobbes, 2000). Rose et al. (2001) recommended, in the light of the absence of quality data regarding group debriefings and the possibly iatrogenic effects of individual debriefings, that resources should instead be focussed on identifying and treating those who develop recognisable disorders following trauma. These recommendations, though, fail to adequately address the needs and requirements of many organisations. Therefore, a more prudent approach for these instances is to

frame the assistance needed within an organisational context as opposed to less apt or useful clinical models.

Theoretical Impact of Debriefing Modules

There are several avenues of theory and research that lend both insight and direction to the emerging practice of organisational and community assistance in disaster, and which help to frame and potentially resolve the dilemma raised above. Their effective consideration, however, demands that we consider disaster as a developmental challenge rather than as a pathogenic threat. In order to determine what may be useful, we must first look at what might contribute to reported paradoxical impacts. Why is it that, in some studies, those who were debriefed were more likely to develop PTSD? What parts of the debriefing process might contribute to these inhibitions of natural resolution? Might some aspects hold the potential to iatrogenically accentuate distress? And, more importantly, if we removed these aspects would we still have an intervention with high satisfaction ratings which might also help to mitigate long term distress?

Serial Revivification - Most debriefing protocols encourage, through the maxim of catharsis, specific reporting of what one saw and heard during the event, moving from there to articulation what one was thinking and feeling - often specifically inquiring as to the worst moments and most intense emotions encountered. This may serve to intensify already disturbing reactions by reconnecting the individual with the sources of discomfort well before sufficient distancing has been achieved. In such cases, this revivification is unlikely to serve a cathartic end. Group applications of debriefing may further compound these issues. Social comparison under threat may prove a particularly salient consideration in understanding both successful adaptation and paradoxical impacts.

Perceived threat lends a unique urgency to the search for affiliation and social comparison, and these contacts follow particular patterns that underscore the perceived need for a specific and appropriate model. The models preferred by individuals are those seen to be similarly situated, and especially those offering clear indications of having evolved and sustained successful adaptation to similar demands (Taylor & Lobel, 1989). The more abrupt, unexpected, novel, or ambiguous the individual's experience however, the less likely that suitable models will be readily available. Serial revivification, therefore, could have at least two possible negative effects.

Firstly, in a group setting, some of the people may not have been aware of the level of danger to which they were exposed and this post-event process could lead to a re-appraisal of their memory of the event in a way which increases their subjective estimation of the danger to which they were exposed during the traumatic incident. Secondly, a single one hour session of revivification, delivered to people who might normally have gone on to process the information successfully unassisted, runs the risk of sensitising such persons to the stimuli involved at a time when desensitisation is vital to resolution. The processes of desensitisation necessary to address pathological elements inherent in PTSD require systematically graded exposure to defined stimuli and progressive habituation to those stimuli to extinguish the fear response; this clearly cannot be accomplished in a “one-off” prophylactic group encounter.

Education Regarding ‘Symptoms’. Another common aspect of debriefing is educating clients regarding expected reactions to trauma. The rhetorical reasoning for this approach is to ‘normalise’ people’s subjective reactions, and to achieve this debriefers frequently distribute lists of potential problem areas (e.g., increased irritability, avoiding reminders of the trauma, disturbed sleep, intrusive memories of the event, etc). However, there is a subtle but possibly very profound difference to be drawn between ‘normalising’ the fact that people are often distressed after these types of events and priming people to consider these discomfitures as pathological symptoms while labelling the event “traumatic.” Such attributions may dispose vulnerable individuals to interpret the inescapable disequilibrium of disruptive life events as pathological anxiety which becomes, in effect, a self-fulfilling prophecy of despair.

Modelling & Distancing. Charlton and Thompson (1996) found that only positive reappraisal and distancing to be coping strategies predictive of successful adaptation post-trauma, and these factors in particular may demand a very specific type of ‘upward contact’ to provide effective modelling and support. This type of contact is unlikely to be found in conjunction with persistent cathexis toward reprocessing those very events that should have been adequately distanced and reframed in the adaptive process. There is also the risk that ‘CISD teams’ may accommodate individuals whose prior exposure to trauma has left them with unresolved issues for which vicarious rumination may be sought. This can result in an unwitting dispatch of responders who serve as inadvertent ‘downward contacts’. Given the proliferation of

‘CISD teams’ seeking to intervene with emergency services personnel and at trauma scenes, this becomes a matter of substantial concern.

Overhelping. Perhaps the most salient cause for concern in ‘interventionism’ is captured in Gilbert and Silvera's (1996) concept of overhelping. They demonstrated that immediate and highly visible attempts to “help” an individual with processes that they would, in fact, have successfully executed without aid served to defeat perceptions of self-efficacy central both to personal and interpersonal assessments of mastery on the part of the individual. These assessments of self-efficacy, however, may be crucial to successful adjustment. Given the consistent finding that most individuals confronted with disaster resolve its impacts with or without intervention, the very essence of our current trend toward rapid, highly promoted, highly visible intervention may essentially be counterproductive for those we most intend to aid.

The Organisational Context. There is also evidence emerging in the work psychology and organisational behaviour literature that the organisational context may exert a much stronger influence on employee wellbeing outcomes than has hitherto been recognised. In a recent study Hart and Cotton (2003) found that low levels of positive affect (which they termed morale) was a much stronger determinant of police withdrawal behaviours (e.g., stress-related absenteeism and intention to submit a stress-related workers compensation claim) than levels of psychological distress. This line of research is important because it suggests that employers should accord priority to workplace strategies that maintain employee morale, and improve the quality of people management practices. It may be that these organisational interventions are more effective in mitigating the effects of exposure to critical incidents than traditional clinical strategies are likely to be.

Guidelines For Practice

Knowing what hurts usually aids us in forming opinions about what not to do. This said, how should organisations and professionals react to trauma? Many organisations are currently concerned of litigation for not providing debriefing, yet in light of the empirical evidence, are at the same time being warned that they could conceivably be sued for providing a noxious intervention that has been demonstrated to increase the risk of developing a pathological outcome for some employees. In addition to the recommendations made by Devilly & Cotton (in press) we are proposing below a set of general guidelines to help mitigate this ‘Catch 22’ for both

organisations and professionals until a fuller consensus is arrived at by both the legal and psychological communities:

Organisations

Validation and Sense of Care. Validation of a person's experiences and showing that the organisation cares about, and is concerned with, the physical and emotional well-being of employees increases morale (e.g., Hart & Cotton, 2002). It is in this context that an organisation may well contract a psychological expert in Employee Assistance. However, it is important that the contract with this expert does not specify 'psychological debriefing' but rather 'post-crisis care.' Moreover, this consultant needs to be knowledgeable about organisational issues and utilise workplace-oriented interventions that reinforce the sense of organisational support. Given current empirical findings, it may be advisable to specify debriefing as a contraindicated approach in the employment setting.

Pro-activity. Higher self-mastery and sense of control within organisational settings tends to predict less negative affect when people are faced with a stressful task (Hoffman, 2001). Increasing a sense of mastery is, of course, context specific. However, following a critical event, an organisation can promote pro-activity through negotiations with their staff asking such questions as "how would you like to respond to this event and what can we do, as your employers, to facilitate this?" Allowing employees a sense of control regarding interventions needs to be done overtly and with great sensitivity. Furthermore, this may need to be addressed at both group and individual levels. It is suggested that the psychological expert be involved in such processes to help guide the appropriateness of the organisational response.

Professionals

Practical And Social Support. Following a traumatic event, people's first need is invariably for information. Were loved ones injured / involved? Where can I sleep tonight? Which documents must I complete? Providing this type of pragmatic support minimises additional stress for the individual. Psychological professionals can bring a practiced voice of compassion to these practical, instrumental ministrations, but must be constantly vigilant to avoid any tendency to 'clinicalise' these more direct forms of aid.

Keeping abreast of the research. This field of research is in a particularly fast developing phase and there can be no substitute for the constant updating of knowledge. In addition to keeping up to date with research on debriefing there is also

a need to maintain professional development on emerging research on treatment for those who go on to develop ASD or PTSD, and to consider the emerging body of research on preventative measures for post-traumatic stress.

With respect to ASD and PTSD, the currently most replicated treatment result is that CBT (particularly techniques involving exposure to corrective information) evidence the best gains. Therefore, once someone has been identified who a few days to four weeks later is still experiencing inordinate distress due to the event, care should be taken to involve them in more structured, individual and individualised treatment.

Resilience is the natural human process of adapting well in the face of adversity, trauma, tragedy or stress. Individuals cope with trauma in varying ways and with varying degrees of success, however statistics consistently show us that the vast majority of individuals recover from a traumatic experience without experiencing significant psychopathology. It has been suggested that the lack of efficacy of psychological debriefing might be explained by its interference with the natural processing of a traumatic event, and by inadvertently leading victims to bypass the support of family, friends or other sources of social support - a primary factor in resilience - in favor of a misguided notion that professional help is more apt to aid their resolution (van Emmerik et al. 2002). Research is required to more effectively understand natural resilience and differential proclivities to process a traumatic experience and heal, so that preventative action may be taken to boost natural resilience in 'at risk' individuals before any trauma has occurred.

Naïve Enquiry. But what of the “debrief” and how does one go about identifying at risk individuals? Rather than serial revivification, it is suggested that the professional grasp the basic ‘facts’ of the case by asking open ended questions to those who are present. This also enables the professional to help identify those who are showing the greatest distress, either through their complete lack of engagement or their reliance upon it. This enquiry should also address at a very basic level people’s reactions, their intensity, and their persistence. Rather than focusing on the ‘signs’ or ‘symptoms’ of trauma, asking a general question as to how people have been elicits the means of progressing to increasing a sense of control and mastery through pro-activity.

Pro-activity. As with organisations, the promotion of pro-activity can increase a sense of mastery and self-efficacy. The focus here is first on what the individuals are doing to cope (e.g. talking with friends and family, keeping active, etc.) and secondly on

what the group as a whole is doing to cope (e.g. meeting as a group to problem solve any outstanding issues, possible group projects to help coping, discussion of how management can help, discussion of changes that might be proposed to management to offset a reoccurrence, etc).

Monitoring & Follow-up. If the trauma occurred in the workplace, using an appropriate model (e.g., experienced veteran) to act as a peer who can be consulted, at risk individuals (i.e., those showing signs of ASD or PTSD) may be followed-up by trained professionals (e.g. psychiatrist, clinical psychologist, etc). However, we recommend that these professionals be trained in CBT and have an expertise in treating trauma reactions.

Conclusion

Overall, there is evidence that the majority of people who witness or undergo a trauma demonstrate psychological resiliency and that distress tends to lessen over time. However, there is gathering evidence that indiscriminate debriefing of individuals using generic debriefing models has little or no effect on the long term functioning of people, that providing Critical Incident Stress Debriefing may impede recovery, and that those who are most distressed by the trauma are those most likely to be deleteriously affected by the intervention. To our knowledge there has never been a randomized controlled trial of group debriefing.

Early intervention for those who go on to develop clinically significant problems is showing great promise using Cognitive Behavioural Therapy, particularly techniques which promote the processing of information from the trauma and exposure to corrective information.

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