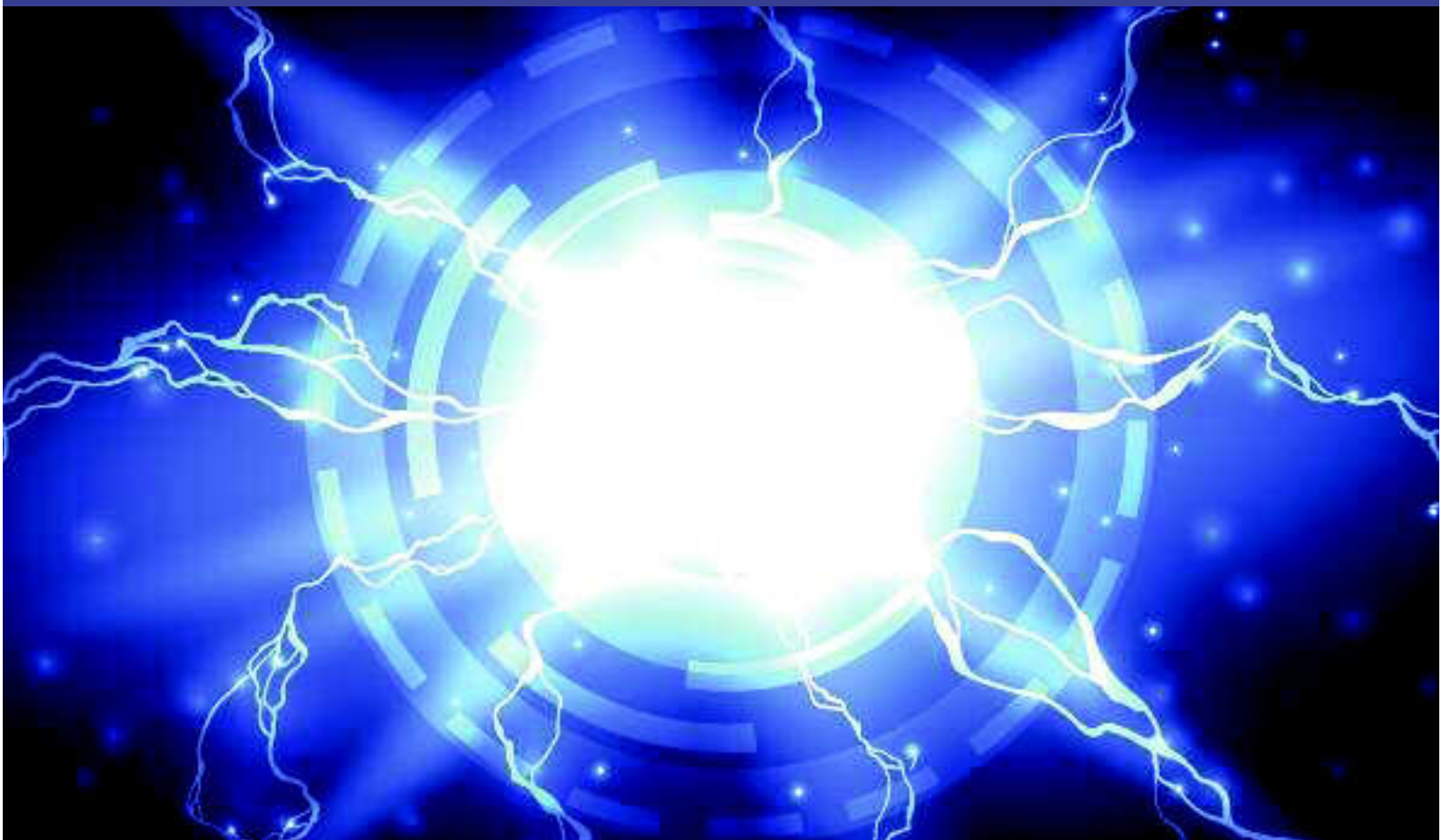




**The British
Psychological Society**

Crisis, Disaster & Trauma
Psychology Section

Early interventions for trauma



Proceedings from symposia held on:
25 November 2014 and 8 January 2015

June 2015

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ISBN: 978-1-85433-735-1

Printed and published by the British Psychological Society.

First published June 2015.

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Incorporated by Royal Charter Registered Charity No 229642

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Introduction

The high incidence of traumatic exposure and the negative consequences for survivors and society highlight the need for effective and appropriate early interventions.

The Crisis, Disaster and Trauma section organised two symposia which brought together a group of internationally recognised psychologists who have worked on the front line in supporting adults, young people and children exposed to war, natural and technological disasters and other traumatic events. The two days were designed to provide opportunities for all the participants to engage with the topic and to grapple with some of the issues that surround the provision of early interventions following traumatic exposure.

The day was opened by Professor William Yule and chaired by Professor Jamie Hacker Hughes (BPS President Elect). Professor Hacker Hughes also co-ordinated and supported the discussion groups which examined the central themes of the day. The resultant presentations have been captured and are included in this document together with a statement of intent for the application of early post-trauma interventions.

The proceedings were then brought to the Crisis, Disaster and Trauma Committee where approval has been given for publication.

I am most grateful to Noreen Tehrani for all the work she did in putting this symposium together, to Noreen Tehrani and Jamie Hacker Hughes for editing and to Sarita Jane Robinson for proof reading and copy editing the final publication.

Professor William Yule

Chair of Crisis, Disaster and Trauma Section

Speakers and Contributors

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What can be learnt from the debriefing controversy?

Dr Debbie Hawker and Dr David Hawker

Introduction

Critical Incident Stress Debriefing (CISD) is a crisis intervention technique formulated for teams of emergency service workers, following distressing incidents (Dyregrov, 1989; Mitchell, 1983; Mitchell & Everly, 1997). CISD offers a standardised, structured approach for emergency workers to discuss thoughts and emotions with skilled peers and mental health professionals. The aims include normalising common responses to trauma, providing information about coping strategies, and future assistance if it is required. Mitchell and Everly (1996) have described a seven-step process of CISD, as illustrated in Figure 1.

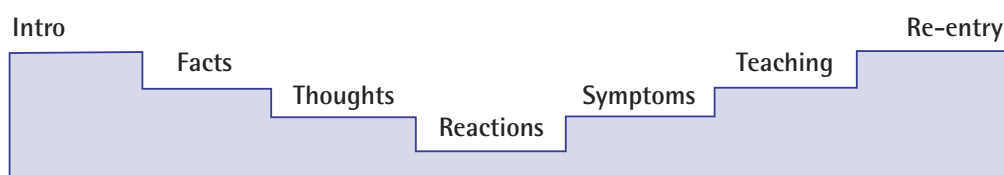


Figure 1: Seven steps of CISD

The case against debriefing

The latest update of the Cochrane review of debriefing (Rose et al., 2009) identified 15 Randomised Controlled Trials (RCTs) of debriefing. Three of these found that debriefing was associated with a positive outcome, nine found no effect and two indicated negative outcomes*. The review concluded, ‘There is no evidence that single session individual psychological debriefing is a useful treatment for the prevention of post traumatic stress disorder after traumatic incidents. Compulsory debriefing of victims of trauma should cease’ (Rose et al., 2009, p.4).

Similarly, the National Institute for Health and Care Excellence (NICE) guidance for the management of post-traumatic stress disorder (PTSD) recommends that single-session CISD ‘should **not** be routine practice’ (NICE, 2005, p.4). NICE identified seven RCTs of debriefing, two of which report the same study. Of the six different studies, four found debriefing to have no effect on the measures used, and two suggested it might have a negative effect: these are the same negative studies identified by the Cochrane review.

Declaration of interest: The author’s background

The first author came to the issue of debriefing as someone who is very much in favour of evidence-based interventions, and RCTs. She worked from 1997–2006 as a research psychologist conducting RCTs to treat eating disorders at Oxford University Department of Psychiatry. The team she was part of contributed to NICE guidance. She was keen to not only put into practice NICE guidance, but also to train other people to do so.

*The remaining study, lacking a non-debriefed group, found immediate debriefing more effective than delayed debriefing

At the same time she worked on a voluntary basis with a large non-government organisation (NGO). This NGO offered CISD to their humanitarian workers following traumatic incidents. Having heard about the first systematic review of ‘debriefing’ (undertaken in 1997 and first published as a Cochrane Review in 1998), she set out to persuade this NGO to discontinue the process of debriefing. To do this, she felt that she would need to conduct research on the NGO’s staff, as the existing studies (of primary victims of trauma, such as burns victims and people in road traffic accidents) may not have generalised to humanitarian workers.

This comparison audit (which was not a RCT) found that only 7 per cent of debriefed aid workers experienced clinically significant levels of intrusive thoughts or avoidance at 14-month follow-up, compared with 24 per cent of non-debriefed aid workers. None reported a negative effect of debriefing. Over 80 per cent reported finding it helpful, with 40 per cent identifying a specific positive change which they attributed to the debriefing (Lovell, 1999). Levels of mild depression were similar for the two groups (around 25 per cent of each group at follow-up). No group differences other than the presence of the CISD intervention could explain the results. We were surprised to find that CISD appeared to have a beneficial effect, in contrast to what we had understood from the NICE guidance. This led us to look at the evidence-base in more detail.

Questioning the recommendation against debriefing

Because of the two RCTs which found that the debriefed group appeared to be coping less well at follow-up than those who were not debriefed, it has been widely claimed that debriefing is harmful, and should not be offered (e.g. Goldstein et al., 2001; Kenardy, 2000; Lilienfeld, 2007). Yet it is rarely mentioned that in both of these studies (Bisson et al., 1997; Mayou et al., 2000) the debriefed patients had been more severely injured than the patients who were not debriefed. When initial trauma symptoms and severity of injury were controlled for, the negative effect of debriefing on later trauma symptoms was reduced to marginal significance, (Mayou et al., 2000) or disappeared, with the initial symptoms being the only variable which predicted trauma symptoms at follow-up (Bisson et al., 1997). In addition, neither of these studies offered debriefing as it is provided in practice with occupational groups. Instead, they used a truncated version of debriefing, offered too soon, by inexperienced debriefers. Table 1 compares debriefing as devised by Mitchell, with the intervention used in the studies which suggest that debriefing might be negative.

The authors of the Cochrane review, who themselves conducted some of the RCTs, acknowledge that the quality of the RCTs ‘was generally poor’. The Department of Health (2001) evidence-based practice guidelines have also acknowledged concerns over the quality of the studies. Thus there is no reliable evidence that CISD is harmful. In the ‘negative’ studies, the negative effect was explained by initial severity. So, a more parsimonious conclusion from the Cochrane studies would be that three RCTs found a positive effect of debriefing, and 11 found no effect.

We shouldn’t waste resources on an intervention that has no effect. Is there any evidence that CISD could be beneficial, or that withdrawing it could be harmful?

In addition to the three RCTs which found a positive outcome of debriefing, there is considerable empirical evidence from less well-controlled studies in favour of debriefing.

For example, the vast majority of people who receive debriefing rate it favourably (Arendt & Elklit, 2001; Greenberg et al., 2003; Lovell, 1999; Mitchell & Everly, 1997; Wesseley & Deahl, 2003).

Some people view CISD as a lifeline. For example, one humanitarian worker who observed horrific acts of genocide during the Balkans war said:

I haven't been able to talk to anyone about this. I can't tell my wife, because then she would feel traumatised too. I couldn't tell my colleagues, because they had all seen similar atrocities and were already coping with too much. The thing which kept me going was knowing I would be able to talk about it during this debriefing. That saved me from going under. (Hawker, 2014, p.14).

Another humanitarian worker said:

I was desperate to talk to someone who I knew would be able to handle extremely traumatic experiences. I had shared some of it with others, but most people could not cope, which left me worse off. (Hawker, 2014, p.14).

Table 1: Comparison of Mitchell's CISD with potentially 'harmful' intervention (from Hawker, Durkin & Hawker, 2011)

Intervention feature	Original debriefing model	Inadequate debriefing	
Model	Mitchell & Everly (1996)	Bisson et al. (1997)	Mayou et al. (2000)
Population	Healthy emergency service and disaster workers	Medically hospitalised and unexpected trauma	Medically hospitalised primary victims of isolated and unexpected trauma
Timing of debriefing	When recipient is ready, not within first 24 hours or while trauma ongoing	While still undergoing treatment in hospital 2–19 days after burn	Within 24 hours of trauma or as soon as physically fit to be seen
Duration	Approximately 2–3 hours	Mean 44 minutes (SD 17.4)	Approximately one hour
Content and emotional expression: was there probing for vivid details?	Don't probe for detail, outline briefly what happened, put it behind you, expect normal recovery, look to the future	Attempted to adhere to Mitchell's structure (1983), but interpreted this to include 'intense imaginal exposure' (p.80)	'A detailed review of the accident, the encouragement of appropriate emotional expression' (p.590) 'Our debriefing intervention... contrasted in significant ways with the models of psychological debriefing described by Mitchell ... it is possible that the instructions led patients to ruminate excessively about the accident rather than putting it behind them' (p.592)

Intervention feature	Original debriefing model	Inadequate debriefing	
Model	Mitchell & Everly (1996)	Bisson et al. (1997)	Mayou et al. (2000)
Location	A private, quiet, comfortable room without interruptions	Hospital	Hospital. 'There were practical difficulties in delivering an intervention in busy trauma wards' (p.593)
Debriefers	A mental health worker and a trained peer debrief together	Reportedly had only half day training. Five were nurses also involved with medical procedures	Research assistant
Context	Debrief whole group together	Patient debriefed alone. Partners attended in 16 cases	Patient debriefed alone
Follow-up	Always at least one follow-up contact. Debriefing as part of a package of Critical Incident Stress Management	No follow-up (except research questionnaires). Debriefing as a standalone intervention.	

Naturally, the NICE management guidelines for PTSD focused on debriefing as a treatment for PTSD, but CISD for emergency workers has other relevant outcomes not considered by NICE. In a series of RCTs, Deahl and colleagues (Deahl et al., 2000; Deahl et al., 2001) found the use of CISD was associated with a significant reduction of alcohol misuse amongst British soldiers returning from peacekeeping operations. Mitchell and colleagues have found that benefits of debriefing include improved coping skills, increased morale and staff retention, reduced sick leave and compensation payments and reduced usage of mental health services in the 12 months following the incident (Mitchell & Everly, 1997; Robinson et al., 1995).

Our experience has been that CISD is used as an occupational rather than a clinical intervention. For emergency workers who experience trauma during the course of their work, CISD is offered as an intervention to help them return to work. It is a form of staff support.

Emergency workers tend to avoid therapy because of stigma. They are keen to receive an intervention which is provided by peers and seen to be a normal part of their work, as CISD is. But debriefing has been withdrawn as an option for many disaster workers and military personnel. They are now left without a form of support which was previously valued.

What can we learn from the debriefing controversy?

Lesson 1: What happens when you say 'do not do'?

Because guidelines have advised against the routine use of single-session CISD, some organisations have withdrawn debriefing. For example, concerning all UK military personnel, the Surgeon General's Policy Letter of 20 January 2006 (paragraph 4) stated of CISD: 'the medical evidence demonstrates no value and therefore [CISD] is **not** recommended by DMSD' (Defence Medical Services Department). One of the UK's major travel health clinics, used by approximately 300 aid and mission organisations, cites adherence to the NICE guidelines as their reason for no longer offering psychological debriefing (Hargrave, 2006).

One colleague was told, '*The debriefing you do is all right, but what other people do is harmful*'. Some of our colleagues have admitted being so afraid of being accused of debriefing that they no longer ask about traumatic events when assessing patients who are known to have experienced trauma.

However, many people still seek debriefing. Having considered the evidence, many organisations in the UK (and abroad) continue to use CISD openly. These include NHS foundation trusts, police services; NGOs and United Nations departments (Regel et al, 2014). Some professionals continue to offer CISD, but now use a different name for it, having been told they can do debriefing as long as they use another name such as Psychological First Aid (though there is no evidence that Psychological First Aid is any more effective; Dieltjens et al., 2014). Bisson et al. (2007), after arguing against CISD, described in positive terms an unnamed intervention, for a journalist who had been through trauma, which appeared to include the core components of CISD.

Lesson 2: A poor quality RCT is not gold standard

RCTs are often considered to be the gold standard for research. But some RCTs can be of poor quality, such as those which have been used to proscribe debriefing.

The RCTs included in the NICE and Cochrane reviews had methodological limitations including sampling bias; small samples; no intention to treat analyses; a high proportion lost to follow-up; poor quality randomisation; researchers not blind to treatment group; and analysing data while the trial was still in progress, then stopping the trial, risking type-1 error. Evidence provided by a poor quality RCT is probably not stronger than evidence from well-designed studies using other methods, and so should not carry more weight. There is a need to assess the quality of the evidence, and the population sampled.

NICE has its own system for ranking the quality of empirical evidence. NICE recognises RCTs (category 1b evidence), controlled studies without randomisation (IIa), other types of quasi-experimental studies (IIb), and non-experimental descriptive studies, such as comparison studies, correlation studies and case-control studies (III).

But in the case of debriefing, only RCTs were included and all other categories of evidence have been ignored. Given the undue influence of poor quality RCTs on NICE's conclusions, there is an urgent need for *all* the evidence to be assessed.

Lesson 3: How not to debrief

The NICE guidance and Cochrane review, and other research, are very helpful in helping us know what to avoid when debriefing.

a. Don't offer debriefing too soon after a traumatic event

In the study which is perhaps most frequently cited to support the claim that debriefing is harmful (Mayou et al., 2000), people admitted to hospital were debriefed 'within 24 hours of the accident or as soon as they were physically fit to be seen' (p.589). Although convenient for data collection, this choice of timeframe disregarded Mitchell's recommendation that debriefing should not occur within the first 24 hours following a traumatic incident or when someone is in severe pain (Mitchell, 1983). At such times, avoiding thinking about the trauma can assist coping. Forcing someone to speak about their trauma soon after it has occurred may encode it more vividly into memory and impede recovery (Ehlers, 1998) and reinforce feelings of helplessness (Everstine & Everstine, 1993). Debriefing should not cause the patient to 'relive' their experience of trauma, but forced reliving may occur if it happens too soon or when too much detail is requested (Ehlers, 1998). The authors of the RCT suggest that, 'rapid discharge from hospital necessitated very early intervention and some patients were still too numbed or distressed to be receptive' (Hobbs et al., 1996, p.1439).

In the other RCT which reported a negative effect, Bisson et al. (1997) studied burns victims and observed that the sooner 'debriefing' was provided, the worse the outcome. For burns patients, the trauma generally continues for a considerable time after the injury. Treatment and scarring may cause more distress than the initial trauma. One benefit of debriefing may be the realisation that the trauma is over, and the process of discriminating between 'then' and 'now' may aid recovery (Ehlers & Clark, 2000). Undertaking debriefing while the trauma is continuing is likely to be of very little benefit. Mitchell & Everly (1996) caution that debriefing should not take place unless the participant is receptive to it and ready for it:

'People have to be ready for help before it becomes useful to them. Providing help too early usually sets the stage for the rejection of the help and failure of the effort ... hold off on the formal debriefings (CISD) until things settle down a little' (p.189-190).

And again:

'That which ultimately dictates appropriateness is not how many hours/ days have passed since the trauma, but rather is how psychologically receptive the victim is to the help being offered' (p.208).

b. Don't offer debriefing lasting one hour or less

The mean duration of 'debriefing' offered by Bisson et al. (1997) was 44 minutes; Mayou et al. (2000) allowed 'approximately one hour'. Incidentally, all the other RCTs reviewed by Cochrane and NICE reported 'debriefing' lasting 15-60 minutes. Experts find that adequate psychological debriefing takes a minimum of two hours, and usually lasts longer, with at least one follow-up contact (Dyregrov, 1989; Mitchell & Everly, 1996; Parkinson, 2001; Rick & Briner, 2000; Turnbull et al., 1997). Because of the lack of time, it is likely that full package of CISD was not followed adequately in the RCTs, nor were any follow-up sessions offered. Rushed inadequate 'debriefing' can make matters worse, possibly because it risks exposure to anxiety without sufficient time for habituation (Hacker et al., 1994; Rose et al., 2009). Giving enough time for debriefing reduces that risk.

Although Bisson et al. (1997) report that longer ‘debriefing’ was associated with poorer outcome, a clinically plausible reason that was acknowledged by these researchers was that more distressed participants received longer ‘debriefings’, with debriefers finding it harder to end the session. Moreover, the mean duration of the debriefings was 44 minutes and a standard deviation of 17.4, resulting in 56 of the 57 debriefings lasting less than 80 minutes, or 40 minutes short of the recommended minimum, suggesting that length of the debriefings were inadequate in almost all cases.

In a separate evaluation of debriefing, one person who had received a 45-minute debriefing reported:

I was conscious of the time limit right from the start. It made me feel ‘unrelaxed’ and all I could think of was ‘how can I fit in all I’d like to tell someone?’ ... I came out of it feeling like it was open heart surgery without time to be stitched back up, and I was left to pick up the pieces afterwards ... If I was in the same situation again, I would prefer to not have a debriefing at all than to be debriefed in 45 minutes – it just is not possible (Hawker, 2014, p.8).

One review has noted that debriefings lasting less than one hour tend to have a neutral or negative effect, while longer debriefings generally have a positive effect (Arendt & Elklit, 2001). CISD should allow adequate time to deal with any negative emotions which may arise during the session.

c. Don’t use insufficiently trained or inappropriate debriefers

Inexperienced debriefers may be unhelpful. In the Mayou et al. (2000) study, experienced clinicians were too busy to conduct debriefings, so ‘regrettably ... the interventions were undertaken instead by the research assistant’ (Hobbs & Adshead, 1997, p.166–167). It has been reported that the ‘debriefers’ in the Bisson et al. (1997) study received only a half day training in debriefing (Parkinson, 2001).

In contrast, Mitchell and Everly (1996) recommend that debriefing be conducted by a mental health worker (the team leader) and a peer debriefer (co-leader) working together (p.97–98). They urged ‘all mental health professionals to become familiar with the emergency services ‘culture’ before providing any service to those personnel’ (p.97), so participants can relate to them. Fawcett (1999) states: ‘Debriefer credibility is an important issue. Credibility may be a function of several factors. Probably the most important is the ‘me too’ factor – the notion that the debriefer knows what is being talked about because of their own personal experience’ (p.63).

Mitchell and Every (1996) recommend that in addition to their professional training, debriefers attend an entry-level Basic CISD course (two days minimum) and then progress to an Advanced CISD course (two days) (p.267–268).

Research suggests that debriefing tends to be beneficial only when led by a trained, experienced debriefer (Arendt & Elklit, 2001; Dyregrov, 1999; Mitchell & Everly 1996) who can answer questions about the traumatic experience (Lee et al., 1996).

The debriefer should also be independent, and not associated with inflicting the trauma. Many of the debriefings in Bisson et al.’s (1997) study were conducted by nurses who were associated with painful medical procedures. This may have influenced the patients’ willingness to talk freely with them. The debriefings were delivered in busy trauma wards, which the authors note was not ideal.

d. Don't probe too hard for details

One of the criticisms of CISD has been that prolonged, vivid descriptions of a traumatic incident soon after it has occurred may increase the risk of developing PTSD (see Ehlers, 1998). Indeed, Bisson et al. (1997) suggest that one of the reasons why the intervention in their study may have been harmful was that it 'involves intense imaginal exposure to a traumatic incident shortly afterwards', and because their intervention was so short, there was no time for habituation to occur (p.80).

Sijbrandij et al. (2006) found that probing for detail and then not helping through normalisation and discussion of coping strategies might increase symptoms of distress among victims of trauma who were highly aroused (although this effect was only found in the short-term, and not at long-term follow-up).

In Mitchell's model of debriefing for occupational groups (Mitchell & Everly, 1996), in contrast, participants are invited to outline 'briefly, what happened from your perspective' (p.106). Mitchell & Everly (1996) warn explicitly that '*probing is out of place in CISD*' (p.195, italics in original). They also allow adequate time to deal with any negative emotions which may arise during the session, while warning debriefers, 'do not open any emotional issues that you cannot bring to a closure' (p.208). The CISD model aims to normalise symptoms; emphasise that the event is past; focus on the difference between 'then' and 'now', enhance coping strategies and encourage return to normal life and work. This is in keeping with Ehlers and Clark's findings (2000) on factors associated with reduced increase risk of PTSD. The aim is to reduce arousal (Dyregrov & Regel, 2012), rather than to increase it as may have happened in the negative studies.

Lesson 4: Debriefing is intended as a group intervention for briefed workers; they may receive more benefit from debriefing than victims of unexpected trauma debriefed as individuals

Debriefing is not intended for everyone. CISD was originally devised as part of a package for emergency workers who had experienced critical incident stress as part of their work. It was specifically designed for selected psychologically resilient personnel who are trained to cope with expected pressure during their routine work in stressful situations. These are teams of people who have trained together and been briefed together before working together.

CISD might not be expected to work so well with people not meeting these criteria. Yet both of the RCTs that reported negative outcomes focused on hospitalised medical patients who experienced unexpected traumatic events, and not on occupational groups of people briefed to expect trauma in the course of their work.

The NICE guidelines state, 'No trial on critical incident stress debriefing as it was originally conceived by Mitchell and colleagues (i.e. as a group intervention for teams of emergency workers, military personnel or others who are used to working together) or critical incident stress management (i.e. a multi-component programme of debriefing, follow-up and case management) met our methodological inclusion criteria. As a consequence we have a lack of evidence for practice in these situations' (NICE, 2005, p.84). Likewise, Rose et al. (2009) acknowledge that the studies included in the Cochrane review may not be relevant for emergency workers, and state that research on 'the efficacy of debriefing in emergency workers' is 'a particular priority' (p.12).

In one review of debriefing studies, Arendt & Elklit (2001) reported that debriefing 'is generally found to have some preventative effect when used with professional helpers,

but the method seems to be far less effective, or even to have a negative effect, when used with other victims of trauma' (p.430). Similarly, in another review Jacobs et al. (2004) concluded: 'CISD is an effective method of reducing risks for PTSD-related symptoms in emergency service personnel. However, when debriefings are conducted with primary victims of traumatic events ... the results are much less promising' (p.5).

CISD was intended as a group intervention, which aims to enhance social support following trauma. There is overwhelming evidence that social support is a major protective factor following trauma (Hobfoll et al., 2007). Debriefing occupational groups with their peers may be the most effective form of debriefing.

Lesson 5: Recent evidence suggests that debriefing groups of briefed workers may be favourable

Since the NICE and Cochrane reviews were last updated, there have been some promising results on debriefing occupational groups exposed to trauma, including some research of higher quality than the studies included in those reviews.

Tuckey & Scott (2013) conducted a RCT with emergency service personnel and found that CISD was associated with significantly lower alcohol use compared to screening only, and significantly greater post-intervention quality of life when compared with education only.

Using randomisation by platoon (necessary for a group intervention), Adler et al. (2009) found that soldiers with high levels of combat exposure who had received psychological debriefing reported fewer post-traumatic stress symptoms, depression symptoms and sleep problems than those assigned to stress education. Adler et al. (2008) randomly assigned platoons to debriefing, stress education or survey-only conditions. Group CISD was minimally associated with lower reports of post-traumatic symptoms and aggression (vs. stress management class), and higher perceived organizational support (vs. survey only) for participants exposed to high levels of mission stresses. The CISD group had a slightly higher alcohol intake than the other groups at both time points but the mean intake did not reach a harmful level.

In a controlled study without randomisation, Ruck et al. (2013) found that prison staff who chose to be debriefed showed a significant reduction in their traumatic stress, anxiety and depression scores. There was no significant change in symptoms of the non-debriefed group.

The balance of evidence may now be swinging in favour of CISD, at least for groups of emergency personnel and the military.

Lesson 6: Evidence-based guidelines risk becoming faith-based dogma

Despite evidence in favour of debriefing, there seems to be a tendency in influential academic papers to repeat what has become almost like a faith-based creed, 'I believe that debriefing is harmful' (see Lilienfeld, 2007). However, when challenged, they cannot point to any evidence of harm. A true evidence-based practitioner is one who looks behind the evidence base and is willing to ask questions.

Lesson 7: The debate is not over

When we submitted a paper on debriefing to a journal some years ago, it was rejected and we were told that the debate is over. When we submitted the paper to be published elsewhere (Hawker et al., 2011), the Ministry of Defence required two other co-authors

(Jamie Hacker Hughes and Mike Srinivasan) to remove their names from the paper, as they were not permitted to re-open the debate on debriefing.

But the debate is not over. We agree with the Cochrane reviewers that further research is necessary, especially research on group debriefing for teams who have been briefed. RCTs should ideally stratify for initial trauma impact and avoid the methodological and statistical limitations of the early RCTs.

The findings of Tuckey & Scott (2013), Adler et al. (2008, 2009) and Deahl et al. (2001, 2002) are a step in the direction of providing RCT evidence that debriefing is beneficial for occupational groups. Unfortunately, aside from the practical difficulties of arranging further research, ethical approval and funding for such research are now very difficult to obtain, owing to the widespread belief that any intervention that includes the word 'debriefing' is harmful.

Summary

The Cochrane and NICE reviewers, and the authors of the RCTs, have done a great service in highlighting potential mistakes which providers of debriefing should avoid. We agree that inadequate debriefing has a potential to have adverse effects. We agree with the Cochrane conclusion that 'compulsory debriefing should cease'. Debriefing should never be mandatory. We recommend that where debriefing is provided, participants should be allowed to opt out if they choose. Debriefing is not the only form of early intervention; there are alternatives. Any intervention offered should be culturally appropriate (Hawker, 2014). We agree that debriefing is not a treatment for PTSD. We are not arguing for debriefing for primary victims who unexpectedly experienced an isolated trauma. And we are certainly not arguing for the type of inadequate 'debriefing' outlined in columns three and four of Table 1.

What troubles us is that over-generalisation from the NICE guidelines has meant that some emergency service workers, aid workers and military personnel, who want to talk about their experiences in a debriefing setting, no longer have the opportunity to do so. We do not hold NICE or the researchers responsible for the over-generalisation, which may be an unintended consequence of well-intentioned guidance. Mayou et al. (2000) took particular care in stating: 'The findings are limited to individual trauma and cannot be extended to group debriefing or later intervention' (p.593). Bisson et al. (1997) cautioned that their results may not apply to group debriefing or to trauma other than burns trauma. Yet over-generalisation has occurred.

Personnel in the military, emergency service and humanitarian aid fields often request debriefing, and speak of its benefit for them. Yet many of these self-sacrificial professionals are now being refused a valued form of support on the basis of the studies described. There is no evidence that debriefing is harmful when used with such groups. These groups report finding debriefing beneficial and recent RCTs have supported this. Therefore, we believe that it is time to stop saying that debriefing is harmful for occupational groups, and to allow those who want to receive debriefing to be offered it, within the context of informed consent. The debriefing must be of a high standard and follow accepted guidelines (Hawker et al., 2011). If we do not use an intervention in the way it was intended, we should not be surprised if it does not work.

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