Debriefing: care and sympathy are not enough

Psychological first aid after traumatic events does not prevent later psychological disorders

IN THIS ISSUE OF THE Journal, Priest and colleagues report a further study showing the lack of effectiveness of "debriefing" after a traumatic event in preventing psychological disorders — in this case, in women after childbirth.[1] Their use of debriefing for this purpose indicates how widely the enthusiasm for this intervention has spread in the past decade. On superficial examination, early interventions are an appealing and inexpensive approach to dealing with events that can be followed by predictable psychiatric morbidity.[2] This negative study adds to the now substantial evidence that psychological debriefing has no value in prevention.[3,4]

The failure to establish the effectiveness of debriefing means that more expensive, longer term programs need to be evaluated. The challenge is only too apparent, with the recent publication of the Australian Gulf War Veterans' Health Study, which found that 31% of service personnel returning from the 1990–1991 Gulf War developed a psychiatric disorder in the subsequent decade, and that the veterans of the current conflict in Iraq are likely to be at similar risk.[5]

The community-driven imperative for early care and support was highlighted by the Bali bombing in October 2002 and the Canberra bushfires in January 2003. Similarly, the September 11 terrorist attack in New York provoked a demand for action and posed an enormous challenge because of the large number of people exposed to the collapse of the World Trade Center. The call for action after such events is spurred by the articulated policy that prevention should be a primary aim of mental health services.[6] The public health principle is that people who have had a toxic exposure are at risk, and that the predicted morbidity should be prevented if possible. However, a brief examination of the history of debriefing reveals some of the reasons for its ineffectiveness.

Debriefing began to be advocated when the impact of traumatic events became more generally recognised in the 1980s.[7] Debriefing is an adaptation of the PIES approach ("proximity, immediacy, expectancy and simplicity"[8]), which was developed to treat acute combat stress reactions in World War II. As a consequence of the effectiveness of this approach in combat, crisis intervention was embraced in the postwar period for patients presenting after a range of adversities. There was a belief that groups with repeated traumatic exposures, such as emergency service personnel, would benefit from psycho-education and articulation of the details and emotions associated with an event.[7] Subsequent research has concluded that this approach has no benefit.[3,4] The logical error is the assumption that a treatment that works for acute stress disorder will necessarily keep people healthy in the longer term.

The rationale for debriefing presumes that an individual reaction in the first days after an event is the critical determinant of the longer term outcome. However, while a substantial proportion of people with an acute stress disorder do develop post-traumatic stress disorder (PTSD), most people who develop PTSD have not had a severe acute reaction.[9] The latter group function effectively and are not highly distressed during the acute stress, and it is easy to assume they are not at risk. This group represent the major conceptual challenge in understanding the adverse effects of traumatic stress and how to prevent the longer term effects. The imperative for effective interventions is considerable, as the burden of disease attributable to PTSD is akin to that of depression,[10] which is ranked second to ischaemic heart disease in projections of disease burden for the year 2020 by the World Health Organization.[11]

The challenge from a public health perspective is how to minimise and manage predictable post-traumatic psychiatric morbidity. The evidence is that a long period of observa-

tion and intervention is necessary. The study of Priest and colleagues highlights the need for screening of postpartum women for psychological disorders over at least a year and provision of effective treatment.[1] In both the control and intervention groups, 18% of women were found to be suffering from depression at follow-up, despite almost certain contact with their general practitioners, providing opportunities for detection and treatment. Although this group of women showed themselves willing to receive a psychological intervention, they appeared not to have received effective treatment. However, it should be noted that normal pregnancy and delivery is not the type of stressful event that leads to PTSD, although difficult deliveries have been described as having this potential.[12] It is likely that the stress of childbirth accounts for only a small percentage of postpartum psychiatric morbidity.[3] Indeed, Priest and colleagues found a much lower prevalence of PTSD (0.8% and 0.6% in the control and intervention groups, respectively) than of depression in women postpartum.[1]

In developing evidence-based policy on traumatic events, it needs to be recognised that health services do not effectively deal with traumatised populations, and that PTSD is often missed in clinical settings.[13] Human suffering could be prevented and litigation reduced by instituting effective programs centred around diagnosis and early treatment of this disorder. This strategy depends on outreach and education in collaboration with the health services that patients customarily consult.

For those who develop an acute stress disorder, treatment informed by cognitive behavioural principles, rather than counselling, is effective.[14] Although there is a need to offer care and psychological first aid to survivors of traumatic events, we should not be fooled into believing this has any substantial long-term effect. However, contact soon after an event can provide a bridge for later screening and treatment, if required. Such interventions should be in the setting of ongoing evaluation and research, as many uncertainties remain. The groups who pose the greatest challenge for prevention are emergency service workers and service personnel, who seldom become unwell on their first traumatic exposure, but have repeated exposures. The challenge for demonstrating the value of better training, effective screening and early treatment are considerable, in a setting where most remain healthy with no intervention.

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