Review Article

# PTSD and Psychological Debriefing

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Following a personal, community or national crisis or disaster there is a need to provide some form of early intervention and crisis support. The essential components of successful early interventions include planning, education, training and support for those affected. The goal of all early interventions should be to maximize the likelihood of a positive mental health outcome using the person's own adaptive coping mechanisms and support structures.
Psychological debriefing (PD) has been described as an intervention conducted by trained professionals shortly after a catastrophe, allowing victims to talk about their experience and receive information on "normal" types of reactions to such an event. Psychological debriefing has been developed and has been at the centre of significant levels of controversy during the past 15 years. Talking through traumatic or stressful events may help the psychological recovery of those who have suffered psychological insults.

**Key words:**
*Natural disaster, Post-Traumatic Stress Disorder, Psychological techniques*

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Since its development as an early post-trauma intervention, psychological debriefing has become common within organizations and following large-scale disasters. Within the diagnostic literature, Post-Traumatic Stress Disorder (PTSD) has been defined by: (a) the experience of a traumatic event; (b) persistent re-experiencing of the traumatic event; (c) persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness; (d) persistent symptoms of increased arousal; (e) more than one month duration of the disturbance; (f) significant distress or impairment in social, occupational, or other impairment areas of functioning (1).
The relationship between children's symptoms and parental symptoms has received some attention (2-4).
Over the past 15 years psychological debriefing has been developed and has been at the centre of a significant level of controversy during these years. Some people feel strongly that talking through traumatic or stressful events may help the psychological recovery of those who have suffered from psychological wounds (5). There is an increasing need for a review of psychological debriefing literature. This article describes the history, methods and development of psychological debriefing following exposure to a traumatic event.

## What is debriefing?

Psychological debriefing (PD) has been described as an intervention conducted by trained professionals shortly after a catastrophe, allowing victims to talk about their experience and receive information on "normal" types of reactions to such an event (6). This has been widely advocated for routine use following a range of major traumatic events.
Several methods of PD have been described, although most workers consider a PD to be a single-session, semi-structured crisis intervention has been designed to reduce and prevent adverse psychological responses to the traumatic event (7). In the past, claims have been made that the use of psychological debriefing may prevent the onset of more long-term psychological problems (8). PD was initially described as a group intervention for emergency workers (9) and seen as a part of a comprehensive, systematic, multi-component approach to the management of traumatic stress (9), but it has also been used with individuals (10) and as a stand-alone intervention. Bisson et al. (7) describe the purpose of PD as a provision for survivors of a traumatic experience to review their impressions and reactions to the trauma in an atmosphere where psychiatric 'labeling' is avoided. Participants are assured that they are normal people who have experienced an abnormal event.

## When did debriefing begin?

The current models of PD have been developed from a number of different approaches trying to mitigate the negative impact of exposure to traumatic events. One of the first approaches emerged in World War I and was described by Kardiner and Spiegel (11). This model was based on the three principles of proximity, immediacy and expectancy (PIE). The approach promoted the idea that soldiers would recover more quickly from their

combat experience if they were treated close to the battlefield, provided with immediate treatment and there was a strong expectation of a return to active service. Later the additional principle of brevity was introduced, which stated that treatment should last no longer than 10 days (12). During World War II the chief historian of the US Army, Brigadier General Samuel Marshall collected primary source data from group discussions with troops. On these occasions, details of each battle were elucidated in depth. Marshall estimated that seven hours were needed to debrief a single fighting day. In his book *Island Victory* (13) the minutiae of the battle were recorded vividly and the method and development of the debriefing outlined. Almost coincidentally, he noted that the emotional effects of the debriefing were 'spiritually purging.' The experience of traumatic events is not unique to war. Disasters involving earthquake, fires, floods and transportation can also affect large numbers of civilians. Those working with victims of disasters found that certain responses, essential to the protection of life at the time of danger, continued well after the danger and their usefulness (14).

## Who was debriefing designed for?

Against this historical background, together with the establishment of the formal diagnosis of post-traumatic stress disorder (PTSD) as a recognized psychiatric disorder (DSM-III), debriefing techniques began to be adapted for use with emergency service and the primary victims of major disasters. Some people began to believe strongly that talking through traumatic or stressful events could help the psychological recovery of those who suffered from psychological wounding (5, 15).

## Current popular models of debriefing

The increase in frequency of civilian disasters in the 1980s, coupled with research on the effect of the intensity and proximity of the traumatic stressor, led various mental health professionals to evolve psychological debriefing as a group intervention for workers involved with traumatic situations (16, 17). In this article, four current and popular models of group debriefing are described. These models are those of Mitchell, who terms the intervention 'critical incident stress debriefing' (CISD), Dyregrov (17) and Raphael (18), who both use the term 'psychological debriefing' (PD), and Armstrong et al.(19) who use the term 'multiple stressor debriefing model.' Although there are differences between the models, for the term 'psychological debriefing' (PD), the feature common to all the models is that they have a structured format and are essentially formal group meetings held shortly after the traumatic event.

### *Mitchell's model of debriefing*

The CISD protocol that Mitchell (9) describes is a group process of seven distinct phases. Prior to this Mitchell used a six-stage model (16). During the introductory phase confidentiality is emphasized and the outline of the CISD explained. Those attending are informed that the session is not psychotherapy but a discussion with psychological and educational elements. Participants are urged to talk although it is emphasized that they will not be forced to say more than is comfortable for them. The second phase is finding out the facts of what actually happened with standard questions such as 'What was your job?' and 'Who arrived first?' At this stage emotions are openly acknowledged and judged as normal.

The third phase is cognitive, with those attending being encouraged to talk about thoughts surrounding the trauma, introducing some of the personal meanings that the event had for them. The fourth phase is a discussion of the emotions and reactions (emotional, physical, and behavioral) associated with the event. This is usually the longest and deepest phase of the intervention.

A typical question the facilitator might ask is 'What was the worst thing about this event for you?' Participants are encouraged to speak openly and freely about their emotions, focusing on extreme fear or feelings that were unexpected or hard to accept. Feelings of impending death are often ventilated with visible catharsis. The fifth phase of the critical incident debriefing model is concerned with symptoms of distress both during and following the traumatic event, and typical questions could be 'How have you been since the incident?' Stress symptoms are reviewed as they arose at the scene and afterwards as they are at the time of interview. By this process the facilitator obtains three 'pictures' of distress and an idea of whether the symptoms are improving or worsening. These symptoms may be physical, cognitive, emotional or behavioral. The sixth phase of the debriefing is concerned with teaching. General information is given regarding the stress reactions and the 'normal' nature of these. Specific advice is given about diet, increased risk of accident, alcohol consumption, and effects on relationships and lack of libido. Information specific to the particular kind of catastrophe is also included where appropriate. Techniques designed to reduce acute stress symptoms, such as using social support, taking time for oneself to rest, are described. The seventh phase provides an opportunity to summarize all that has occurred and to raise further issues if necessary.

### *Dyregrov's model*

The Dyregrov (17) model of PD is based on Mitchell's work, although there are a number of significant differences. Mitchell begins his debriefing at the time of the trauma, whereas Dyregrov begins his just before the incident using questions such as 'How did you learn about this event?' Dyregrov then moves on to look at the individual's decision-making process during the cognitive stage with questions such as 'What made you decide to do that?' Dyregrov suggests that this form of

questioning enables participants to reduce tendencies to self-blame. Sensory information is also gathered about the incident with questions such as 'What do you see, hear, touch, smell or taste?' This level of sensory detail is missing from Mitchell's model. A high level of attention is given to the normalization of reactions both at the time of the incident and currently. Although the models of Dyregrov and Mitchell are similar, the model developed by Dyregrov places a greater emphasis on reactions and responses, which he suggests is safer for the participants (17).

***Raphael's model***

Raphael's (18) model is again quite similar although perhaps not as prescriptive as that of Mitchell and Dyregrov. Like Dyregrov, Raphael begins the debriefing before the incident and asks participants about the level of preparation or training that they had received prior to this experience. She suggests areas of inquiry that may beuseful during the psychological debriefing. These can include:

- Disaster stressors personally experienced such as death encounter, survivor conflict, loss and dislocation;
- Roles held: feelings, both positive and negative;
- The victims and their problems;
- The stresses of empathy and identification;
- Frustrations and stresses of the task, such as inadequate skills or resources, or uncertain goals and responsibilities;
- Special relationships with friends and colleagues, and others who have been through the experience;
- The 'special' nature of the disaster work;
- Personal and individualistic responses, such as anger, anxiety and guilt;
- Difficulties in transferring both clients and self back to the non-disaster setting.

Raphael suggests that these topics should be reviewed in a careful and systematic way in order to facilitate working through the material emotionally (18). Questions are asked about the experience at the disaster, for example 'Was your life threatened?' or 'Did you lose anyone close to you?' Although this type of information may emerge from the Mitchell or Dyregrov model, Raphael is much more direct in her questioning. She also emphasizes positive aspects of being involved with the catastrophe and asks questions such as 'Did you feel good about anything you did' and 'Did you have a sense of fulfillment?' Raphael also suggests looking at the feelings of other victims; this idea is not found in either of the other two models. In the final stage Raphael focuses on what has been learnt from the experience and discusses transferring back to working in a non-disaster setting, including the problems that this can create. This aspect is not apparent in the other models discussed.

***The Multiple Stressor Debriefing Model***

The Multiple Stressor Debriefing Model (MSD) was described by Armstrong et al (19). The MSD model is made up of four main stages. In the first stage the purpose of the debriefing and the rules are outlined. The participants are then asked to describe in detail the aspects of the disaster that are most troubling. The second stage of the debriefing involves asking the participants to describe their feelings and reactions to the incidents they experienced. In the third stage the emphasis moves to coping strategies and the participants are provided with information on the normal and abnormal responses to stress. The participants are encouraged to describe how they coped with stress in the past and how they are currently coping. Wherever possible the debriefer uses the practical coping strategies identified within the group rather than introducing new coping styles. In the final stage the participants are asked how they feel about leaving the disaster site.

The emphasis then changes to saying goodbye to co-workers and preparing for returning to home and other responsibilities. Before leaving the debriefing room a discussion is held on what has been accomplished, with an emphasis placed on the continuing need to talk to partners and colleagues. At the end of the debriefing any remaining questions are answered and referrals are made where necessary. One of the main differences between this model and the other models is the emphasis placed on past reactions to stressors and coping styles. The MSD model recognizes the effect on the other stressors on the participants including the need to leave colleagues and return home. The MSD model emphasizes the importance of discussing past reactions to stressors and coping styles in the debriefing**.**

***Individual debriefing models***

The models outlined here were designed as group interventions but perhaps, not surprisingly, increasingly PD has been used with adult individuals following trauma. An individual debriefing model was developed in the British Post Office (10) to support lone employees affected by physical violence, threats of physical violence, hijacking or being taken hostage. This model involves five stages, introduction, facts, thoughts, feelings and a closing.

The introduction sets the rules of the debriefing including what will happen, how it might help and how long it will last. The second stage deals with the facts during this stage. Detailed sensory memories relating to the traumatic experience will be identified. In the thought phase of the debriefing the sensory and factual experiences are used to establish positive and negative thinking related to the sensory experiences. Finally, the emotions or feelings related to the thoughts and sensory accounts are identified. The closing phase of the debriefing allows time for summarizing the incident and for undertaking education on the normal symptoms of trauma and discussing the use of existing and new coping skills. Dyregrov (20) describes using a debriefing approach with individual family members following the death of a child.

## An alternative view on debriefing

A number of workers suggest that the current models of debriefing are unhelpful and may even be harmful to trauma victims (21, 22). These workers believe that most models of debriefing place too great an emphasis on re-exposure to the traumatic event, which results in emotional overload. It is suggested that there is a need for an approach that involves an intervention based on the expectation that the potential for growth and recovery is possible for everyone exposed to traumatic events. The alternative approach would be aimed at enhancing personally directed efforts to see the traumatic experience as an opportunity for self-efficacy rather than reinforcing the belief that the outcome will be illness and the need for treatment (23). The approach suggested is one that shifts the focus of debriefing from reducing harm and symptoms to one that places increased emphasis on health and salutogenics. The central concern of the debriefing then becomes not what is causing individuals to suffer but rather what helps people to remain healthy.

## Discussion

A review of psychological debriefing brings into focus the fact that humankind has had to deal with death, injury and disasters throughout history. There appears to be an inherent wish for those that have suffered to be able to tell others of their experiences. Why do diverse people and cultures engage in describing disasters and other traumatic events? It would appear that there are a number of different purposes including the need to:

- be recognized for doing a good job;
- make the event more understandable;
- gain sympathy and support;
- identify ways to cope better;
- be informed about the event and potential reactions;
- meet and learn from others who have suffered similar situations;
- handle their guilt and shame;
- be understood and be forgiven;
- help others by sharing skills.

It is clear that with an intervention as popular and widely used as debriefing the outcomes must be carefully evaluated before beneficial claims are made. It is also important that those who use debriefing are aware of potential hazards of failing to recognize and provide treatment for those individuals that are at risk of developing long-term mental health problems.

## Conclusion

Following a personal, community or national crisis or disaster there is a need to provide some form of early intervention and crisis support. The essential components of successful early interventions include planning, education, training and support for those affected. Whilst in any group of people exposed to a traumatic event some may go on to develop clinically significant disorders, this should never be regarded as the normal outcome. The goal of all early interventions should be to maximize the likelihood of a positive mental health outcome using the person's own adaptive coping mechanisms and support structures.

Psychological debriefing is one of early interventions available to support people who have experienced an event which caused fear, helplessness or horror. As one of the earliest reported types of interventions in this area, it has received more research interest than other early interventions.

The process of telling one's story as a way of dealing with disasters is a process that the human race has employed since the beginning of time. Therefore, it is not surprising that for many people the opportunity to talk about their traumatic experiences is welcomed and valued. In the past this telling and retelling of stories was undertaken within a community or family. Today, with the breakdown of these group counselors, debriefers and mental health professionals are taking the roles of the family, friends or community leaders. The 'professionalization' of these roles has resulted in the process being formalized and standardized, making the training and delivery easier to evaluate and monitor.

There are a number of different models and approaches to psychological debriefing. Even when a practitioner has been trained to use a particular model, there has been a strong tendency to adapt the model to meet personal and situational needs. This has meant difficulty in assessing the effectiveness of psychological debriefing with so many differences in delivery methods. Indeed, some of the originators of psychological debriefing are horrified by the way that some researchers and practitioners have misused their models and practice guidelines.

When early intervention services are offered to traumatized people, it is important to ensure that those involved are capable and competent in a range of inter-related skills. There is no common understanding of what is required in terms of training, supervision and support for those people who offer early interventions including psychological debriefing. It is therefore difficult for anyone wishing to use these services to know where to go for advice.

Good practice in psychological debriefing needs to take account of the special needs of those who require this kind of support and the importance of tailoring the intervention to meet individual, community and cultural needs.

Psychological debriefing is a brief intervention and, though some have claimed that it can prevent the onset of PTSD, this is not a claim that the majority of practitioners would support. Indeed, there is a high level of consensus that psychological debriefing will only be effective as part of a larger program of crisis management and post-trauma care. The aim of psychological debriefing is two fold. Firstly, for the individual it is to promote normal recovery, resilience and personal growth. Secondly, within the organization or community to provide a means of enhancing social

cohesion and group understanding. There is a need to evaluate all early interventions including psychological debriefing. However, the more traditional experimental approaches to research are difficult to achieve ethically in the real world of crises and disasters. The use of a blend of qualitative and quantitative experimental designs provide an opportunity to establish protocols and approaches which, though unable to reach the 'gold standard' of the laboratory, do enable judgments to be made on the efficacy of interventions.

There is still work to be done before it is possible to prove that psychological debriefing is effective as an early intervention following traumatic exposure. However, the picture on what needs to be done is becoming clearer. The members of the working party hope that their research and efforts to clarify the issues will be a helpful way forward and offer the following recommendations.

***Recommendations***

1. Establish the most appropriate timing and duration of early interventions including psychological debriefing.
2. Develop and refine screening tools to be used with individuals and groups to identify those who would benefit from this form of intervention.
3. Design guidelines on the follow up that should be offered following an individual or group debriefing.
4. Establish minimum standards of training, supervision and support to be provided for practitioners of psychological debriefing.

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