Psychological debriefing in people exposed to a recent traumatic event

Q5: Is psychological debriefing better (more effective than/as safe as) than no intervention in people exposed to a recent traumatic event?

Background

Psychological debriefing is one of the most widely implemented interventions after exposure to potentially traumatic events. Informed by systematic reviews suggesting that single session debriefing may be harmful (van Emmerik et al, 2002; Rose et al,2002), WHO Department of Mental Health and Substance Abuse has previously issued a statement that it does not recommend psychological debriefing (WHO, 2003). However, the evidence informing this recommendation has never been GRADEd by WHO and the recommendation needs to be updated.

Population/Intervention(s)/Comparator/Outcome(s) (PICO)

Population: adults exposed to a traumatic event in previous 2 weeks

Interventions: single session psychological debriefing

Comparisons: no intervention

Outcomes: post-traumatic stress, anxiety and depression symptom severity (1-3 months after intervention and at follow up [+ 6 months])

Adverse effects

List of the systematic reviews identified by the search process

INCLUDED IN GRADE TABLES OR FOOTNOTES

National Institute for Clinical Evidence (NICE) (2005).Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care. National Clinical Practice Guideline Number 26. London: The British Psychological Society & The Royal College of Psychiatrists.

Adler AB et al (2008). A group randomized trial of critical incident stress debriefing provided to U.S. peacekeepers. *Journal of Traumatic Stress,* 21:253-63.

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EXCLUDED FROM GRADE TABLES AND FOOTNOTES

Bisson JI et al (2009). Psychological Debriefing for Adults. In Foa EB, Keane TM, Friedman MJ, Cohen JA (eds). Effective treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies. Second Edition. New York: Guilford Publications. (reason for exclusion: no pooled data presented).

Rose S et al (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews,* (2):CD000560. (reason for exclusion: relatively old compared to NICE Guidelines).

van Emmerik AA et al (2002). Single session debriefing after psychological trauma: a meta-analysis. *Lancet,* 360:766-71. (reason for exclusion: relatively old compared to NICE Guidelines).

WHO (2003). Single-session Psychological Debriefing: Not Recommended. Geneva, World Health Organization.

PICO Table

Serial no.	Intervention/Comparison	Outcomes	Systematic reviews used for GRADE	Explanation
1	Single session psychological debriefing/ no intervention	Post-traumatic stress, anxiety and depression symptom severity post intervention (1-3 months after intervention) and at follow-up (+ 6 months after intervention, adverse effects	NICE (2005)	The NICE Guidelines is the most recent document providing a pooled effect size for this intervention

Narrative description of the studies that went into the analysis

The NICE (2005) Guidelines describe the included 7 studies as follows. "Studies involved individuals who had experienced a range of traumatic events including road traffic incidents, assaults, miscarriages, fires and unspecified other incidents. Psychological debriefing was delivered between 10 hours and 31 days after the incident, with a duration of 30–120 min. Five studies were of individual treatment only, one study included some debriefing of groups of two to five Post-traumatic stress disorder (PTSD) sufferers and another included family members in some debriefing sessions. All debriefing interventions were single sessions and included education about traumatic stress, expression of emotions and planning for the future. Debriefing was delivered by a range of professionals,

including nurses, mental health nurses, psychiatrists and psychologists. The training and qualifications of the debriefers was not comprehensively described in any of the studies. There was no randomized study of critical incident debriefing, the group-focused approach advocated by Mitchell & Everly (1997), in contrast to the single-session, typically individually focused debriefing interventions considered in this section. " Of note, a study of group debriefing has since been conducted (Adler et al, 2008.)

GRADE Tables

Table 1
Author(s): Mark van Ommeren and Scott Baker
Date: 2009-06-18
Question: Should single session psychological debriefing vs no intervention be used for exposure to recent traumatic event?
Settings:
Bibliography: National Institute for Clinical Evidence (NICE) (2005).Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care. National Clinical Practice Guideline Number 26.

Quality assessment							Summary of findings					
							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	single session psychological debriefing	no intervention	Relative (95% CI)	Absolute		
Post-traumatic stress symptoms severity (1-4 months post intervention) (Better indicated by lower values)												
5[1]	randomized trials	serious[2]	no serious inconsistency[1,3]	no serious indirectness	serious[4]	none	175[1]	181[1]	-	SMD 0.11 higher (0.1 lower to 0.32 higher)[1,5]	⊕⊕OO LOW	CRITICAL
Post-traumatic stress symptoms severity (+ 6 months post intervention) (Better indicated by lower values)												
3[6]	randomized trials	very serious[7]	no serious inconsistency[3]	no serious indirectness	serious[4]	none	135	130	-	SMD 0.26 higher (0.01 to 0.5 higher)[5,6]	⊕OOO VERY LOW	IMPORTANT
Depression symptoms severity (1-4 months post intervention) (Better indicated by lower values)												

3[8]	randomized trials	very serious[7]	no serious inconsistency[3]	no serious indirectness	serious[4]	none	115	110	-	SMD 0.0 higher (0.27 lower to 0.26 higher)[5]	⊕OOO VERY LOW	IMPORTANT
Depression symptoms severity (+6 months post intervention) (Better indicated by lower values)												
3[9]	randomized trials	very serious[7]	serious[10]	no serious indirectness	serious[4]	none	135	130	-	SMD 0.33 higher (0.09 to 0.58 higher)[5]	⊕OOO VERY LOW	IMPORTANT
Anxiety symptoms severity, (1-4 months post intervention) (Better indicated by lower values)												
3[11]	randomized trials	very serious[7]	no serious inconsistency	no serious indirectness	serious[4]	none	115	110	-	SMD 0.03 higher (0.23 lower to 0.29 higher)	⊕OOO VERY LOW	IMPORTANT
Anxiety symptoms severity, (+6 months post intervention) (Better indicated by lower values)												
2[12]	randomized trials	very serious[7]	no serious inconsistency	no serious indirectness	serious[4]	none	88	84	-	SMD 0.25 higher (0.05 lower to 0.55 higher)	⊕OOO VERY LOW	IMPORTANT
Safety												
0	No evidence available					none	0/0 (0%)	0/0 (0%) 0%	RR 0 (0 to 0)	0 fewer per 1000 (from 0 fewer to 0 fewer) 0 fewer per 1000 (from 0 fewer to 0 fewer)		IMPORTANT

[1] NICE (2005) Forest Plot on page 3 of Appendix 15c analysis 01.
[2] Drop outs is more than 30% in 1 of the studies NICE (2005) Forest Plot on page 3 of Appendix 15c analysis 13.
[3] I-squared is less than 50%.
[4] The sample sizes are extremely small given that this is selective preventive intervention. (see article by Cuijpers 2003)
[5] This summary estimate does not include the data of a very large RCT on group critical incidence stress debriefing among 952 peacekeepers. This study found no substantial differences on the main outcomes measures (Adler et al ,2008).
[6] NICE (2005) Forest Plot on page 3 of Appendix 15c analysis 02.
[7] Drop-outs greater than 30% in more than 30% of trials NICE (2005) Forest Plot on page 3 of Appendix 15c analysis 13.
[8] NICE (2005) Forest Plot on page 3 of Appendix 15c analysis 04.
[9] NICE (2005) Forest Plot on page 3 of Appendix 15c analysis 05.
[10] I-squared is 53%.
[11] NICE (2005) Forest Plot on page 3 of Appendix 15c analysis 06.
[12] NICE (2005) Forest Plot on page 3 of Appendix 15c analysis 07.

Reference List

Adler AB et al (2008). A group randomized trial of critical incident stress debriefing provided to U.S. peacekeepers. *Journal of Traumatic Stress,* 21:253-63.

Bisson JI et al (2009). Psychological Debriefing for Adults. In Foa EB, Keane TM, Friedman MJ, Cohen JA (eds). Effective treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies. Second Edition. New York: Guilford Publications.

Cuijpers P (2003). Examining the effects of prevention programs on the incidence of new cases of mental disorders: the lack of statistical power. *American Journal of Psychiatry,* 160:1385-91.

Mitchell J, Everly GJ (1997). The scientific evidence for critical incident stress management. *Journal of Emmergency Medical Services*, 22:86-93.

National Institute for Clinical Evidence (NICE) (2005).Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care. National Clinical Practice Guideline Number 26.

Rose S et al (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews,* (2):CD000560.

van Emmerik AA et al (2002). Single session debriefing after psychological trauma: a meta-analysis. *Lancet,* 360:766-71.

From evidence to recommendations

Factor	Explanation
Narrative summary of the evidence base on the scoped question	There is low quality evidence suggesting there is unlikely to be a clinically important difference between psychological debriefing and no intervention on preventing PTSD symptoms 1-4 months post intervention (N=5; n=356, SMD 0.11 (95% CI -0.1 to 0.32). Similarly, there is very low quality evidence suggesting there is unlikely to be a clinically important difference between psychological debriefing and no intervention on preventing depression symptoms 1-4 months post intervention (N=3; n=225, SMD 0.0 (95% CI -0.27 to 0.26). There is very low quality evidence for a small effect favouring control over psychological debriefing on preventing PTSD symptoms and depression symptoms at follow-up (+ 6 months) (N = 3; n = 265; SMD =

	0.26; 95% CI, 0.01 to 0.50; N = 3, n =265, SMS = 0.33 95%CI, 0.09 to 0.58, respectively). There is very low quality evidence suggesting there is unlikely to be a clinically important difference between psychological debriefing and control on preventing anxiety symptoms at 1-4 months post intervention and at +6 months post intervention (N = 3; n = 225; SMD = 0.03; 95% CI, -0.23 to 0.29; N = 2; n = 172; SMD = 0.25; 95% CI, -0.05 to 0.55, respectively).
Summary of the quality of evidence on the scoped question	LOW for the PTSD symptoms outcome (1-4 months post intervention) VERY LOW for all other outcomes (see GRADE table)
Additional evidence (eg related evidence that was not scoped	This summary estimate does not include the data of a very large RCT on group critical incidence stress debriefing among 952 peacekeepers. This study found no substantial differences on the main outcomes measures.
Balance of benefits versus harms	Of 6 critical or important outcomes, none showed a benefit in the meta-analysis. Moreover, 2 of 6 outcomes showed evidence of harm. The balance of benefits versus harms is not favourable.
Define the values and preferences including any variability and human rights issues	Despite the lack of effects in preventing mental health problems there is some evidence that recipients of psychological debriefing value the intervention (eg Adler et al, 2008). Despite the case for not using it, it likely has to be substituted for another intervention (such as psychological first aid) since survivors seek help and services are motivated to grant it .
Define the costs and resource use and any other relevant feasibility issues	
Final recommendation(s) Psychological debriefing should not be used for people exposed recently to a traumatic event as an intervention to reduce the risk of post-	

traumatic stress, anxiety or depressive symptoms.
Strength of recommendation: STRONG

Update of the literature search – June 2012

In June 2012 the literature search for this scoping question was updated. The following systematic review was found to be relevant without changing the recommendation:

NICE National Clinical Guideline Number 123. Common Mental Health Disorders. National Institute for Health and Clinical Excellence, 2011