Letter

# Concerns about the effectiveness of critical incident stress debriefing in ameliorating stress reactions

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Hammond and Brooks's enthusiasm for critical incident stress debriefing (CISD) [1] causes them to ignore findings suggesting inert or iatrogenic effects of this procedure. So far the data on the effectiveness of debriefing are almost overwhelmingly negative, particularly at follow-up assessments. For example, Carlier *et al*. [2] found that among police officers who responded to a civilian plane crash, those who underwent debriefing exhibited significantly more disaster-related hyperarousal symptoms at an 18-month follow-up than those who did not receive the treatment. Mayou *et al*. [3] showed that subjects admitted to hospital after a road traffic accident who received CISD had a significantly worse outcome at 3 years in terms of general psychiatric symptoms, travel anxiety, and overall level of functioning. Bisson *et al.* [4] found that among a sample of burn trauma victims, 26% of the debriefing group had PTSD at 13-month follow-up, compared with 9% of the control group. Importantly, the Cochrane Review of 11 clinical trials found no evidence that debriefing reduced general psychological morbidity, depression, or anxiety, and recommended that compulsory debriefing of victims of trauma should cease [5].

By Hammond and Brooks's own admission, most of the evidence supporting the use of CISD is anecdotal or can be found only in unpublished dissertations. Moreover, the limited published data suggesting a positive effect have often confused respondents' reports of satisfaction over their debriefing experience with objective measures of traumatic stress [6]. Such satisfaction reports most probably reflect respondents' gratitude for the attention of a debriefer rather than a decrease in psychological symptoms [3]. In addition to other flaws in the studies cited by Hammond and Brooks (such as having the investigator conduct the debriefing sessions), between-group treatment effects remained non-significant [7], no treatment effect size was reported [7,8], or no treatment was described [8].

Although Hammond and Brooks's concern for disaster response workers is laudable, their enthusiasm for CISD as an unvalidated intervention is misplaced. Until data are produced that support the use of psychoprophylactic treatment, advocating it is inappropriate and misguided.

## References

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