Authors' reply: Turnbull and his colleagues raise some important points, most of which are covered in our paper. Our first paragraph discusses the fact that PD was initially designed for use in groups. Turnbull *et al* will be aware that PD has been widely used as a stand-alone intervention for groups and individuals despite it being developed as part of a CISM.

The total period of the study was 28 months, 32 subjects were debriefed by a research psychiatrist and 25 by five burns unit nurses. The nurses were involved in procedures such as changing dressings but the outcome of subjects debriefed by a burns nurse was not worse than those debriefed by a research psychiatric registrar. Their knowledge of the physical aspects were reported by some individuals as having been beneficial (as stated in our paper the majority reported the PD as useful). A private side room was identified to use for the debriefings.

Most of the patients described some pain and many were taking analgesia but individuals were only debriefed at a time when they were felt able actively to participate in the process. To wait until individuals were totally pain-free and analgesia-free would have been to wait beyond the 13-month follow-up period in some instances. With regard to the slightly increased overall dimensions of trauma and levels of distress, these are discussed within our paper. We consider our discussion fair in that we included these along with a detrimental effect of PD and chance as the four possible explanations for our results.

The 'two hour' comment is somewhat bewildering given the fact that a longer PD was more likely to be associated with poor outcome (as stated in our paper). There were several individuals without significant psychological sequelae who had little to discuss and hence their PD was brief.

Turnbull *et al* state that the phenomenon of increased symptomatology after PD is well-recognised and probably part of the natural process of adjustment. What evidence do they have for this? An alternative explanation is that the PD may cause unnecessary increased distress in some individuals.

PD is a classical example of an innovation that has come into practice without an adequate research base (McKinley, 1981). It is only after its acceptance by many that its effectiveness has begun to be scrutinised in a systematic way. Negative results may therefore by extremely threatening to some individuals. We acknowledge that our research has some shortcomings which must be taken into account when interpreting the results (as they are in our paper) but to discard our results would be unscientific. It is important to note that our main conclusion (lack of positive effect of individual PD in this population) is consistent with the results of the other two published randomised controlled trials of individual PD (Hobbs *et al*, 1996; Lee *et al*, 1996).

Hobbs, M., Mayou, R., Harrison, B, et al (1996) A randomised controlled trial of psychological debriefing for victims of road traffic accidents. *British Medical Journal*, **313**, 1438–1439.

Lee, C., Slade, P. & Lygo, V. (1996) The influence of psychological debriefing on emotional adaptation in females following early miscarriage. *British Journal of Medical Psychology*, **69**, 47–58.

McKinley, J. B. (1981) From "Promising Report" to "Standard Procedure": seven stages in the career of a medical innovation. *Millbank Memorial Fund Quarterly*, **59**, 374–411.

J. I. Bisson Gabalfa Clinic, 213 North Road, Cardiff CF4 3AG

P. L. Jenkins St Cadoc's Hospital, Caerleon, Gwent

Sir: I was most interested to read the report of Bisson *et al*, as I am a psychiatrist, and a victim of a severe burn suffered near the end of my internship. I incurred third-degree burns to the upper 35% of my body. I was awake throughout the accident and subsequent fire. I received no psychological debriefing. I spent eight months in the burn unit. I entered psychiatric residency training 20 months after the burn.

As a burn patient and, later, a consultant psychiatrist, I have observed the coping of a number of burn victims. Some specific aspects of burn injuries might contribute to the negative results reported by Bisson *et al*. One difference between burns and other major trauma is that patients rarely report severe burns to be painful at the time of occurrence. Severe pain, which makes up much of the traumatic element of burn injuries, comes later, associated with dressing changes, debridement, grafting, physiotherapy, surgery, etc. Furthermore, progressive scarring after a burn often causes more ultimate problems (e.g. disfigurement, restriction of joint mobility) than the burn itself. Scarring can take 12–18 months to mature fully. Roca *et al* (1992) have shown that adult burn survivors often develop new symptoms of psychological distress after they have left hospital. Thus, early debriefing in the hospital may be timed too soon for most patients to benefit, in that their most traumatic experiences in relation to the burn may still be months down the road.

The pre-injury psychosocial status of the patient is probably the major determinant of the psychological outcome of burn trauma (Browne *et al*, 1985). Burns are often the result of human misadventure, which can be a direct result of personality. For example, many burns occur in the context of excessive alcohol use, or as a result of reckless behaviour. A number of such burn victims will already have prior histories of immature personality functioning and poor coping with adverse life events. Psychological debriefing, on its own, will not suffice to give such patients the ego strength to deal effectively with the ongoing suffering of a burn injury.

Bisson *et al* have performed a real service by performing this study of what might otherwise be considered a 'commonsense' intervention. I commend them, and the *Journal*, for providing awareness of these provocative negative results.

Bisson, J. I., Jenkins, P. L., Alexander, J., et al (1997) Randomised controlled trial of psychological debriefing for victims of acute burn trauma. *British Journal of Psychiatry*, **171**, 78–81.

Browne, G., Byrne, C., Brown, B., et al (1985) Psychosocial adjustment of burn survivors. *Burns*, **12**, 28–35.

Roca, R. P., Spence, R. J. & Munster, A. M. (1992) Posttraumatic adaptation and distress among adult burn survivors. *American Journal of Psychiatry*, **149**, 1234–1238.

R. P. Kraus London Health Sciences Centre – Victoria Campus, 375 South Street, London, Ontario, Canada N6A 4G5

Sir: We read with interest the study by Bisson *et al* (1997). The finding that the debriefed group did not benefit and may actually have had a poorer outcome is supported by the similar conclusion of Hobbs *et al* (1996), but we have concerns about aspects of the methodology which led to this result.

Bisson *et al* stated that they terminated recruitment "when preliminary analysis of the data revealed possible adverse consequences for the intervention group". We agree that it is unethical to continue a trial where there is clear evidence that one group is receiving a detrimental treatment. However, when performing significance tests in interim analysis it should be remembered that the more often one analyses accumulating data the greater the chance of

https://doi.org/10.1192/S000712500014872X Published online by Cambridge University Press