Trauma Strikes When it Likes!

Prepare your organisation to manage an emergency

Carole Spiers

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TRAUMA STRIKES WHEN IT LIKES!

PREPARE YOUR ORGANISATION TO MANAGE AN EMERGENCY

Trauma Strikes When it Likes! Prepare your organisation to manage an emergency
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INTRODUCTION

'To conquer fear is the beginning of wisdom'.

– Bertrand Russell

Nothing can adequately prepare organisations or individuals for the experience of a traumatic incident, because by definition it is outside 'normal' experience. This was vividly illustrated by those affected at the London Underground bombings (2005) and the disasters of Canary Wharf (1996), the Manchester bombing (1996), the sinking of the *Marchioness* (1989), Hillsborough (1989), Kings Cross (1987), as well as numerous other tragic events which were impossible to have been predicted.

Many victims and witnesses of violence or injury sustained in accidents; criminal activity or natural disasters such as fires or floods, may well require professional, post-trauma support to help deal with the effects of their experience.

Unfortunately, more and more people are the unwitting victims of violent crime both at work and in the street. For example, a young girl who has a Saturday morning job working in a supermarket and is involved in a raid on the store. She may need as much care and support as the young man who has a serious accident in his firm's van as he carries out his delivery schedule. Yet inevitably, some traumatised individuals are unidentified as such, and can slip through the support net.

Grateful thanks is given to Gerry Jackson for his contribution to this book.

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DEFINING A TRAUMATIC INCIDENT

In 1980, the American Psychiatric Association published the third edition of its 'Diagnostic and statistical manual of mental disorders' (DSM-III) where, for the first time, post-traumatic stress disorder ('PTSD') was defined as a classifiable psychiatric syndrome.

The definition of PTSD has undergone several updates since then and there are now two working definitions available in the following documents published by the World Health Organisation (WHO):

- 'Diagnostic and statistical manual of mental disorders' (DSM-IV) (1994); and
- 'The international classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines' (ICD-10).

According to the DSM-IV (1994), the diagnostic criteria for post-traumatic stress disorder (PTSD) require the 'traumatic event' to have been an event (or events) that involved either actual or threatened death or serious injury, or a threat to the physical integrity of the person concerned or others. The ICD-10 defines it in similar terms. However, in the context of working with people who have been traumatised, such definitions are probably too narrow.

Where an incident exerts a traumatic effect on an individual, then it should be recognised as such and should trigger some form of support mechanism, whether or not the event comes within the previously mentioned definitions.

There will be instances where individuals may develop symptoms of anxiety of depression, or some of the symptoms of PTSD, but these may not always be of sufficient range or severity to attract a formal diagnosis.

AT-RISK GROUPS

Whilst all organisations should carry out risk assessments to determine whether employees could be at potential risk of psychiatric harm from events that they may have to deal with in the course of their work, there are some organisations whose staff, by virtue of their work, are always potentially at risk. These include:

- the armed forces and emergency services personnel;
- bank staff and certain others in the financial field;
- those working in retail outlets, off-licence liquor stores and petrol stations, where staff may be alone in the premises outside normal shop opening hours or even all night; and
- those who have contact with the general public in circumstances where there is a greater risk of violence.

Companies operating in the travel industry need to be aware of not only the actual incidents that do occur, but also the potential for accidents occurring – and in particular, major disasters for which effective contingency plans should always be in place. Indeed, airlines flying into the USA are required by law to have contingent and workable plans to help families and survivors deal with any airline disaster. [*Aviation Disaster Family Assistance Act 1996* and *Foreign Air Carrier Family Support Act 1997*].

There are also organisations that operate within particular industrial sectors that are inherently hazardous by virtue of the nature of their work; and although good risk management can substantially reduce the incidence of accidents, they may occur at some point in time. In such instances, contingent action plans need to be ready to be implemented, often at short notice, to support those who may be involved.

THOSE AFFECTED, DIRECTLY AND INDIRECTLY, FOLLOWING AN INCIDENT

It is not only those people who are directly involved in an incident, i.e. victims and survivors, who may suffer the effects of trauma. It can also affect those who may be indirectly involved, e.g. witnesses, neighbours, families and work colleagues, or those who may be helping with the setting up of emergency shelters or, in some cases, temporary mortuaries. For example, the people who were inadvertently caught up in an incident in Hungerford, Berkshire in 1987, where passers-by witnessed a heavily armed gunman kill 14 people, (including his mother), before taking his own life.

All of these people have the potential to be traumatised, to a greater or lesser degree, including also the emergency services (police, fire and rescue, ambulance and medical staff), clergy, counsellors, social and voluntary workers.

Although victims will inevitably be emotionally unprepared to deal with a sudden emergency or disaster, trained emergency workers will normally be less vulnerable to emotional overload as a result of extensive mental preparation and training for just such eventualities. Nevertheless, this does not preclude them from being affected and possibly traumatised by being involved.

The following are just some examples of how individuals can become directly or indirectly exposed to traumatic incident and possible post-trauma stress:

- Co-workers who may have to return to work immediately following a disaster will have to come to terms with the injuries and possible death of one or more colleagues, together with possible damage to workplace buildings caused by fire, water, etc. The workplace may have changed dramatically and the effect of this may impact on everyone within the organisation, to a greater or lesser extent.
- There may possibly be feelings of guilt associated with injury and loss of life. Management and staff may feel disorientated and emotional following the harrowing experiences of fellow workers, and will be susceptible to post-trauma stress. Employees may have to be relocated to other premises and be in a position of some turmoil for days, or possibly months, thereafter.
- The designated first-aiders within an organisation, who may have had only limited training and experience, will most certainly be called upon to deal with a major

incident before the emergency services arrive. Yet the support that they themselves will require, in the aftermath of the event, is often overlooked.

- The train driver who experiences a person committing suicide under the wheels of his train (known as 'one-under'), and the maintenance team who have to remove the human remains from the track. Some of these people will be required to re-live the situation when they give evidence to an enquiry, which can sometimes be months or even years later. This can trigger again the traumatic reaction to the original incident and the person may be unable to 'close the chapter' until all investigations are complete.
- A traumatic incident may impact on the confidence of other employees perform similar jobs within the organisation.

For example:

Anne, aged 21, works in a retail store on a Saturday morning. Her close friend Jane was sitting at the till when she was attacked by a drunken customer who pulled a knife on her. Anne was badly shaken by the incident, and now when she sits down to work, she looks at every customer very carefully in case they might pose a threat to her safety – as one customer did to Jane.

- Proper consideration also should be given to people involved in potential incidents or 'near misses'. These may include people who believe that they came close to a major accident or incident, even where they sustained no actual damage or physical injury, themselves.

For example:

Bill had booked a ticket on Pan Am flight 103 from London Heathrow to JFK New York, in December 1988, which crashed with no survivors. Bill had cancelled his ticket due to a late business meeting but was left with a feeling of guilt that someone else had taken his place and, for months, experienced nightmares of his close shave with death.

- People who are victims of a malicious hoax that gives harrowing images of danger, may also experience post-trauma stress.

For example:

Gilly, a high-profile public figure, received phone calls and letters saying that her whereabouts were known and that she was going to be murdered. She had no idea who wished to kill or frighten her and was terrified every time she left the safety of her home. Even when the hoaxer was caught she still felt insecure and needed constant reassurance to go about her daily business.

POST-TRAUMA STRESS

DEFINITION

Post-trauma stress ('PTS') can be defined as 'the development of characteristic symptoms following a psychologically distressing event outside the range of normal human experience'. Not everyone will suffer the symptoms, but it is necessary to emphasise that to be affected and to experience a reaction, are both natural and normal responses.

PTS cannot only influence an individual's feelings about themselves but can also affect their relationships with others. This can cause difficulties at work, personal relationship difficulties, ill health and sometimes the development of deeper and more disturbing symptoms.

Where the symptoms of PTS persist or intensify, for more than a month or so, the condition of PTSD can emerge. Symptoms may develop weeks, months or even years after the event, and these can vary from being mildly disturbing to, in the extreme, completely incapacitating.

The reactions of individuals to traumatic events vary, both in severity and type. Some may react very strongly to what may be regarded by others as a minor incident, whilst certain individuals seem to be able to deal with even major incidents or disasters very much in their stride. The rest of us are spread out on a continuum somewhere between these two points.

However, the majority of people will experience some form of reaction to a traumatic event, although in most cases, such reactions will subside over a short period of time. The emotional equilibrium will eventually be regained, and the incident will become just a part of life experience – not forgotten, but not intrusive.

It is difficult to predict just how any one person might react to an incident but some individuals who may be more vulnerable include:

- Those with existing life difficulties and frustrations, such as relationship problems, divorce, bereavement, chronic illness, etc.
- Those who have an inadequate social support network, such as a partner and/or family, friends and/ or colleagues with whom they can confide and discuss their feelings.
- Those who are neurotic, anxious, depressed, introverted, unwilling or unable to talk to others.

However, the minority of people who do not recover quickly is sufficiently large to make it essential that they have access to professional help and appropriate treatment – without which their condition could well deteriorate, with possible long-term consequences.

As indicated above, not all those involved in criminal violence or other traumatic incidents will necessarily suffer psychological trauma as a result. In an overview of empirical studies into the outcomes of extreme events, Brom, Kleber and Witztum (1991) found that typically between 18 and 20% of all people who go through extremely distressing events were left with permanent coping disorders associated with PTSD. However, those who did not develop PTSD were not necessarily free of other symptoms caused by the trauma.

IMMEDIATE REACTIONS TO TRAUMA

There will inevitably be a number of differing, individual reactions immediately after the experience of a traumatic event. These may include screaming or weeping, silence or disbelief, disorientation or shock and then subsequent tiredness and fatigue, anxiety and a reduced response to stimulus and surroundings.

- Those that survive a trauma may be plagued with the recurrent question, 'Why did I survive?'…'Why me?'…'I should have done more'. These people will need help to accept that there is no rational explanation or answer to these questions.
- Some people may feel glad to be alive, while others may feel emotionally paralysed. Black humour is frequently used as a protective reaction, and this is a legitimate way of coping, but one that may sometimes be misunderstood by others who may be listening.
- In the absence of any head injury or concussion, amnesia is not uncommon. It is an emotionally protective mechanism and may appear in relation to either just part, or the whole, of the experience, e.g. 'I can't remember how I got out of the car, I just found myself on the kerb'… 'I can't remember going to hospital. I have a vague image of blue flashing lights but the first three days were just a blur'.
- The thought by the individual that they themselves could have died, is very difficult to deal with, and an indelible image of their near encounter with death, is often a recurrent thought.
- Some individuals may obtain a sense of satisfaction that they have faced a crisis and handled it well, or of having had the experience of going though a trauma, together with others, and 'coming out the other side'. This often has the effect of subsequently bonding closer together, those concerned. There may be a feeling that life now has more significance, more meaning, or that family and friends have suddenly become infinitely more important.

  Of course, there is an accepted human need, at any time, to feel part of a community, but in times of disaster, we realise how important it is to find comfort and solace in the closeness of others.

  Following the catastrophic disaster at the World Trade Centre on 11 September 2001, in New York, when the emblematic twin towers were demolished by terrorists, a spontaneous support group evolved at St Paul's chapel, which adjoins the former World Trade Centre plaza. For eight months after the terrorist attacks, until recovery work stopped at the end of the following May, hundreds of recovery workers, fireman, police, doctors, massage therapists, counsellors and countless other volunteers gave their time. They helped to heal the weary bodies and minds of those who had ceaselessly worked to recover the human remains of over 3,000 people who had been

unfortunate enough to be there that day, in the buildings that stood on the site which is now called 'ground zero'. Here, they slept, ate, cried and found essential solace in the human warmth and kindness that filled the chapel – night and day during the weeks and months that followed. Bonds were formed there that gave hope to all who entered that sanctuary – bonds that confirmed their sense of belonging to a giving, caring community.

- 'It is recognised that we all need, at times, a 'dar-es-salaam' (a haven of peace), a place where feelings of pain, anger and grief can be allowed freedom of expression. Across the front portico at St Paul's chapel, a timeline records the events of the days following 'September 11th' and offers a glimpse of the messages and cards of support that arrived daily from, not only America, but from around the world. Still today, in 2003, many of these cards have been retained to cover the walls of the small chapel, together with the scuff-marks on the pews that were created by the boots and belts of the emergency workers who gathered there. These are being left untouched as a 'sacramental reminder' of those who sought succour and support in this special sanctuary.

  'St Paul's, will always be in my mind, Heaven's outpost. By entering through the gates out front, one can leave behind the terror and destruction that leaves you feeling a severe loss and find a place where everyone has a smile'. *Robert Senatore, New York Fire Department*.

Case study

Post-trauma stress

Paddy was one of the financial traders working in the Twin Towers at the time of the attack. He managed to get to a staircase before the collapse and succeeded in walking down 34 floors. He arrived in the ground floor lobby six minutes before the entire structure failed, as floor upon floor collapsed onto the one below, killing all those still within. Paddy suffered from severe PTS and was hospitalised for three months treatment. He now is back at home outside Venice Beach on the West Coast, and spends the bulk of each day just staring out at the ocean. During his weekly sessions he repeatedly tells his therapist that 'God alone knows, it should have been me. What am I going to do and how can I rebuild my life?'

GENERAL SYMPTOMS OF POST-TRAUMA STRESS

The general symptoms of PTS may include the following:

- There can be a strong reaction of denial which may prevent people from acknowledging that they have a problem and, therefore, from seeking help. To ask an individual who has been involved how they feel after an incident will usually elicit the reply, 'I'm alright, thanks, I can cope'.
- Others will experience increased anxiety, a sense of vulnerability and isolation, and possible survivor guilt. 'Why did I survive when others didn't?' There can also be an induced sympathy for the aggressor(s), e.g. 'The Stockholm Syndrome', resulting from a hostage situation or being confined together with the hostage takers.
- There may be an inability to concentrate or to make even simple decisions; possible impulsive behaviour including excessive spending, moving home, changing job or lifestyle, or ending or creating new relationships. Some people will want to talk incessantly about the event, while others will feel the need to retreat into isolation.
- Individuals will frequently experience dreams and nightmares, and have a general feeling of either being unwell and/or of extreme fatigue.
- There are also those who will have experienced changed values or beliefs or re-adjustments in relationships. 'What's the point of marriage or work or even of living when something like this can happen?' Some discover a new faith or lose an existing one. Others may deepen already held beliefs, whether religious or secular.
- It is important to remember that any of these symptoms are very similar to those associated with loss, grief or bereavement.

SPECIFIC CHARACTERISTICS OF POST-TRAUMA STRESS

In addition to the above, some of the other specific characteristics of PTS include the following.

Arousal

This can manifest itself as an increased (over) sensitivity to particular sensory messages, e.g. sounds or smells that, in turn, may result in an inability to withstand the normal daily patterns of life and work.

An increased sense of arousal can result in sleeplessness or difficulty in concentrating and some individuals may become over-vigilant. There can be an unwarranted expectancy that something untoward is going to happen at any time and without prior warning.

Re-Experiencing (Intrusive Thoughts and Flashbacks)

The actual trauma of an event can sometimes be re-experienced days, months or even years later with 'intrusive thoughts' that comprise disturbing images of the event that involuntarily come to mind.

A 'flashback', on the other hand, is a feeling that the event, or a part of it, is actually re-occurring. For example, an individual may experience a similar smell or sound that will immediately remind them of the traumatic incident, and act as a trigger to make them feel that they are back at the original scene, experiencing the same sensory impressions that they suffered at the time.

Triggered reactions can come at any time, and may be caused by:

sights:	TV, video, photographs, media reports, people
sound:	police sirens, bangs, crashes, voices
smells:	petrol, rubber, disinfectant, dampness
tastes:	food, water, petrol, alcohol, sweat
touch:	rubber, metal, skin, dampness, water

'Out of the blue' reactions can occur randomly and without any warning or obvious 'trigger'. These may happen anywhere, and because there is no apparent cause, can be extremely frightening, both for the individual concerned and others.

Case study

David was inadvertently involved in an altercation in a pub that developed into a violent fight. A few days later, he found himself sitting on the floor in his office, completely confused, disorientated and in a state of panic. David's suppressed feelings suddenly came rushing to the surface of his consciousness with acute physical and psychological effects.

Avoidance

Those involved in a traumatic event may well seek to avoid anybody or any circumstance (e.g. flying, horse riding, cycling, going to an airport, driving a car or taking a ferry), that might remind them of the incident and if the incident took place at work, they may experience an inability, or an extreme reluctance, to return to their job. Typically they will try to avoid thoughts, feelings or situations reminiscent of the event. There may also be confusion, a loss of concentration and possibly some feelings of isolation.

Case study

Mary is a clerk who works in the upstairs office of a large supermarket, and handles large amounts of cash. The office is usually quite secure, but as she left to go the toilet one day she was suddenly grabbed from behind by a masked intruder, and bundled into a side office. Threatened with a knife and tied up, she could see that there were three men, all wearing balaclavas. The leader of the gang had deep blue penetrating eyes and threatened her into telling him the entry code for the safe. The thieves got away with £30,000 after leaving the supermarket by forcing open a rear emergency door.

Mary was off work for three days, and upon returning to work for the first time after the robbery, she suddenly visualised the robber's blue, staring eyes piercing into her, and experienced an acute panic attack. After a few minutes, the feeling passed but she left as soon as she could and returned to the safety of her own home.

Mary's doctor gave her a sick note and some medication, and told her not to return to work for at least 14 days. As Mary sat at home, she found it difficult to contemplate returning to work full-time, as any reminder of the incident caused her to feel sick as she started to relive the incident.

TYPICAL EFFECTS OF POST TRAUMA STRESS

Relationships

1. There can be changes in the way people see themselves, their wife, partner or children. Relationships can become very strained and difficult, with lack of ability to communicate.
2. Inability to stop talking about the event. This can become irritating and boring for others whose response might be to tell them to shut up and forget about it.
3. If one person is suffering, they might not be able to talk to their partner and retreat behind a wall of silence or suppressed anger.
4. Nightmares and dreams. Waking up in a panic or sweat. Suddenly jumping out of bed. This can be very disturbing and frightening for partners.
5. Feeling that life is a waste of time. Apathy: "There's no use bothering". Partners can become angry about this.
6. Inability to make even simple decisions. Loss of concentration. Disinterest in families, friends, hobbies. Others can wonder what this is about and become frustrated and angry.
7. Feelings of vulnerability. Anxiety about the same things happening again. Confusion and disorientation. The response can be to tell them to "pull themselves together".
8. Pent-up feelings can result in anger and violence in relationships, sometimes without any apparent cause. Shouting and remonstrating against anything or nothing.
9. Loss of self esteem or self value and worth. 'I am useless. Why bother with anything?' Partners can respond by arguing or trying to convince them that this is not true and stress the value of their relationship, the family and home.
10. Loss of interest in work or hobbies. Changing jobs. Wanting to move home. All cause upheaval in the family and seem so unnecessary to others.
11. Looking for new relationships or partners. Dissatisfaction with present partner or family.
12. Constant preoccupation with the incident. Keeping a diary of events or a scrap-book. This can be infuriating to others.
13. Avoiding anything to do with the incident. Keeping away from people, including those who are there to help.

14. A lack of understanding on the part of the person experiencing the incident of the effects of the incident or their behaviour on others in the family.
15. Shame and fear about behaviour, especially of guilt or lack of ability to cope at the time and consequently. 'I should have done this and I shouldn't be like this'.
16. Feeling a complete failure to behave like a man. 'I am even lower than an animal. I am utterly degraded.'

Try to Talk to Each Other and Share Feelings and Experiences

ORGANISATIONAL RESPONSIBILITY

A problem for an organisation that can arise is when an event in the workplace triggers a powerful adverse reaction in an individual that is compounded by the influence of an external factor or previous event.

For example, in one particular case of a workplace fire, an employee, who had recently recovered from a serious illness and was under medication, was hit by a falling beam. It may prove difficult to determine the degree of liability the organisation should accept for the treatment of such a vulnerable employee, when part of the cause is not directly connected with his or her work, but is dependent on individual circumstances.

Employers have a duty to consider the robustness of the person attending for work, irrespective of the cause of their stress.

For instance, someone who had just suffered a bereavement should probably not be driving a public transport vehicle.

Organisations have a legal duty of care both towards those who they employ and those who may be affected by their operations. There is a necessity to provide an appropriate level of support in order to discharge that duty.

A failure to do so may result in legal proceedings and an award, by a court, of substantial compensation in damages. For example, in 2001, the South Yorkshire Police force agreed to pay an out of court settlement of around £330,000 for PTSD, to a policeman to who had attended the Hillsborough football disaster in 1989 that left 96 fans dead.

However, should the failure be one of criminal negligence, then criminal proceedings against those responsible could ensue.

HEALTH AND SAFETY AT WORK LEGISLATION

The *Health and Safety at Work etc Act 1974* requires employers to do what is reasonably practicable to ensure the health, safety and welfare of employees. It does not differentiate between various forms of harm, and that includes a duty to ensure that safe systems of work are set and followed.

The provisions of the *Management of Health and Safety at Work Regulations 1999 (SI 1999/3242)* place a statutory duty on employers to conduct risk assessments both of the actual work carried out by employees in addition to that of the workplace and its environment.

These assessments are to enable employers to identify any potential hazards to health, who could be harmed, in what way and how often?

The assessment of the extent of risk allows the implementation of appropriate preventive or protective measures, or, alternatively, the complete elimination of the identified hazard.

RISK ASSESSMENT

All employers need to carry out risk assessments to identify any potential risk; whether such risk is significant and what measures should be implemented to prevent or minimise it. This applies to all employers, not just those working in hazardous fields. Risk assessment should focus on the level of risk, the expected type of traumatic incident and the staff roles most likely to be involved.

In many cases when there is a traumatic incident at work, the fact that most people recover naturally could lead the organisation to believe it is unnecessary to provide any form of additional support. However, this is not necessarily the case.

It is therefore essential that organisations design and implement effective systems that will include record keeping and monitoring, both of the causes and the effects of any incident, in addition to the contingent provision of effective support, to employees, following a major incident.

A successful trauma support programme is dependent on the positive attitude of the organisation implementing it and their genuine concern for the welfare of their employees. However, a successful outcome may also be dependent on an employee's perception of the organisation. Does it take seriously the possibility of an accident, or a violent situation occurring, and if so, has the necessary risk assessment taken place and have the appropriate actions been taken?

A post-trauma support programme should include:

- Careful selection and training of staff who are to work in potentially dangerous or aggressive environments.
- Well-designed emergency procedures and action plans.
- An education programme detailing potential hazards.
- Dedicated on-scene support.
- Professional backup following the incident – aimed at providing short and long-term psychological support, as needed.

POST-TRAUMA SUPPORT STRATEGY

It is important that senior management 'buy in' and are committed to, a post-trauma support strategy that it is translated into effective systems, procedures and good practice.

The aims and objectives of the policy should be communicated to everyone, throughout all departments. The policy should allow for ongoing support in respect of any individuals affected through the process of debriefing and any other assistance required in order for them to regain their mental and physical health. This may take days, weeks or months, depending on the severity of the effects, and will entail a qualified assessment either by an external or in-house, professional provider.

The methods of access to the organisation's support services should be conveyed to all employees both before and after any incident, and written information should be available for reference at points throughout each department of the company, firm or local authority.

Following any incident, necessary feedback should be conveyed to the line manager(s) of the affected employee(s), but should not break matters of confidentiality. However, opportunity should be given to employees, where possible, for self-referral to post-trauma support services, eg post-trauma counselling that is independent of line management.

Where an organisation decides to set up in-house trauma support teams, then sufficient time must be allocated to their training, and allowance made for 'time-off' from day-to-day activities to receive regular supervision and ongoing training.

Where the organisation is resourcing external professional support, then the nominated providers should be familiar with the company's activities, in advance, and have sufficient professional capacity and expertise to deal with most eventualities.

In some instances, repercussions of an incident may be felt for many months or even years, and any support programme will need to take this into account, in addition to allowing for the differing needs of affected individuals, both in the long and short-term.

Where legal proceedings are instituted in relation to an incident, these may well run for some years, especially after a major disaster.

THE ROLE OF LINE MANAGEMENT

In situations where affected employees are not overtly supported by their employer, (including those whose recovery may proceed naturally without any intervention), they may feel angry and disaffected towards the organisation.

They may perceive the organisation as being uncaring or even partially responsible for the incident. Such negative feelings could well hinder recovery, affect their work performance and contribute to increased absence from work, as well as adversely affecting other aspects of their lives.

Following an accident, or other event where injury is caused, managers should:

- Make direct contact with the injured or affected employee as soon as is appropriate. This should be done by the immediate line manager (not the human resources manager), but in an instance where that manager was also involved in the incident, then the next supervisor up the line should take over that role, in respect of those involved.
- Listen, express concern, empathise, acknowledge the individual's feelings and, depending on the circumstances, acknowledge the way in which they handled the situation. This contact is particularly important if the employee is off sick from work.
- Make specific offers of help, e.g. 'We would like to do the following…would that be okay with you or would you rather we left it for later?'
- Keep in touch with the employee and check what form of assistance they need. Some people prefer to be left alone while others like regular contact. In any event it is important to ensure that adequate support is given.
- Be particularly observant in day-to-day interactions with those affected members of staff and take appropriate action in the event of any individual exhibiting obvious symptoms of stress and or trauma.

'Return to Work' programmes may need to be offered and encouraged by counselling support.

BASIC LISTENING SKILLS (OR COUNSELLING SKILLS)

These skills are appropriate for use in all interactions with traumatised people and in all the support models proposed.

People involved in traumatic incidents need to feel safe to explore their concerns and be assured that they are being genuinely listened to. It is not enough to be paying attention, they need to know that the listener is paying attention and understanding what they are saying. This is achieved by 'Active Listening' and 'Empathy' and using the other skills appropriately.

Empathy

This is a way of understanding what someone tells you by entering their world and seeing things as they see them and communicating your understanding to them so they can see that you understand or that at least you are doing your best to do so. This is basic empathy. It does not include saying, "I understand exactly how you feel."

The skills of Active Listening and Paraphrasing, in particular, can help to show empathy. Also an acknowledgement of the person's present emotions, e.g. "I can see that has made you angry." or "I can see how upset you are." or "This is very difficult for you to accept."

Active listening

This consists of allowing them to see signs that the listener is with them. Good eye contact should be maintained, the listener should nod and use frequent minimal prompts (hmm, yes, I see, etc.). Body posture should be relaxed and open perhaps slightly leaning forward and looking alert. Facial expressions should be appropriate and matching the persons' mood.

Acknowledging the Pain

This is part of empathy by simply accepting how bad the person feels and that it is OK to feel that way. It may be done by repeating their actual words, "You felt really awful", by paraphrasing or by picking up their body language, "I can see you are looking upset/angry."

Paraphrasing

This is putting what someone has said briefly in your own words and saying it back to them. It enables you to check out your understanding of what they have said and for them to correct you if necessary but it also allows them to actually hear that you have understood what they are saying. A paraphrase is a very powerful tool in establishing an empathic relationship. Paraphrases can be used to respond to statements by people about facts and about feelings. Paraphrases very often begin with the word 'so…'. You do not need to paraphrase everything a person says but an occasional paraphrase, particularly of something important, is very helpful.

Using open Questions

YES/NO

An open question is one which cannot be answered by a "Yes" or "No". A closed question is one which can be answered with a "Yes" or "No" or another one word answer. Open questions usually begin with the words:- 'how', 'what', 'where', or 'who'.

Try to avoid 'why', as it is inclined to make people feel defensive. There are occasions when a closed question is appropriate but generally open questions have the effect of helping people continue to move on and explore their concerns in more detail.

Reality Testing

For guilty or shameful feelings about not having done well enough, first acknowledge the feelings with a paraphrase or an empathic response.

Then ask, "What did you actually do?" "What else?" Then, "What more could you have done?" If they say, "All sorts of things" – insist that they are specific. Also perhaps, "What time would you have had to do that?" "How much time did you spend doing nothing, just standing around, so you would have had time to do…?"

"If you had the same circumstances again and not knowing the outcome, what would you do?" "With hindsight, what would you do?" "What would you do differently?"

Ask the group to say how they saw the person's performance and encourage support. "Are you hearing what they are saying?" Remember it is not likely that you will change how they feel at the time but you have sowed a seed or given them a different perspective to think about.

- Realistically, what could you have done that would have saved the person's life?
- Was that actually your responsibility?
- Did you personally cause that to happen?
- Was that your fault?
- What caused that to happen?

If someone made a real mistake, first acknowledge what the feelings are and then suggest no-one is perfect, "We are all allowed to make a mistake." "Every situation is different." "Are there lessons you or others could learn?" "You will have to accept the mistake and learn to forgive yourself." Maybe a one to one afterwards and/or refer for counselling. Remember you are not likely to be able to change how they see it at that time.

The above skills are the most important ones used during Trauma Support Sessions and Defusing. Those following do not form part of the training and are included for interest, though they can be used if you feel confident and it seems appropriate. A summary at the end can be particularly useful.

Summarising

Is giving a person or group a short summary of what they have said. A summary is longer than a paraphrase and is often used at the end of a session to sum up and pick out themes or particular concerns. They can be used to check out that the listener has understood a lot of facts, especially if someone is confused or is confusing the listener. The use of a summary can help the person and the listener put facts in the right order, reduce confusion and focus on the more important parts of what has been said.

Using Silence

This is not an easy skill, many of us feel silence is awkward and have to say something to fill it. Silence can often be used to allow an individual or group to reflect for a moment on what they have just said or what they are going to say next and so move the interview on in the direction they wish. Filling the silence with a question can divert them into the

listener's direction. It is often possible to see someone with unfocused eyes looking perhaps downwards when they are marshalling their thoughts.

Focusing

Individuals may need to be helped to pick out a major concern from a number of concerns so that it can form the focus of the work. Otherwise the session can end up flitting about from subject to subject possibly avoiding the most important part of the work.

Reflecting

Is picking out a single word or phrase and using exactly the same word or words back to the person with a slight questioning inflection in the voice. The word or phrase reflected should be one with an emotional 'load' behind it and reflecting it back to them will often have the effect of causing them to explore what is behind it, thus moving the interview on.

Challenging

This is any intervention which helps someone to see a discrepancy between their perception of what is happening and reality. The aim is to help them see things from a different perspective. A challenge should not be an attack and usually will be done tentatively and gently. Often a challenge will help a person see an unused resource that they have (a challenge to strengths). You may point out a discrepancy between what they are saying and their body language (they may be telling you an awful story and smiling).

DEALING WITH ANGER

This can be very difficult and your own response to someone else's anger will be affected by how anger was dealt with in your own family of origin. For example, if you were frightened as a child by angry outbursts you are likely to feel frightened when someone is angry. If your family sometimes shouted at each other and then forgot it and moved on, you are likely to feel reasonably comfortable with anger. If anger was seldom expressed in your family you are likely to feel confused and inadequate. It may help you to remember that, although it may feel as though they are angry with you, it is not actually personal. They are angry about what has happened to them or their relatives or a perceived failure by the company.

There are some things you can do and not do when confronted by an angry person which may help to calm things down. It does not help to try to defend yourself or the company, to get into an argument or become angry yourself. It may help to break eye contact. Two people both refusing to drop their eyes is very confrontational.

Use the skills mentioned above in allowing the client to express their anger and acknowledging how they feel. Ask open questions to try to find out exactly what it is they are angry about. Tell them you are sorry that they are feeling like that and, if there is something the company may have done to contribute to how they are feeling, an expression of genuine regret will help. It also helps if you can agree with any part of what they are saying and acknowledge that that is how things seem to be at the moment. Obviously, if you can do anything to correct what it is they are angry about you should do it. So organising food or drink or getting some information for them or trying to get information and then explaining why information is not available will help.

BUSINESS MANAGEMENT ISSUES

Following a major incident an important factor for the organisation will be to contain any damage and disruption to its business activities, whilst ensuring that the working environment is made completely safe and poses no further risk to employees or members of the public. This is particularly relevant in cases of fire, explosion or natural disaster.

The organisation will need to gather detailed evidence from eye witnesses and others, about the incident and to offer support towards all those directly or indirectly involved. This can be a difficult task as it is very easy to be perceived as according first priority to the business, rather than to the employees.

Managers should be aware that a number of different agencies may be involved in any investigation, for example; the Health & Safety Executive ('HSE'), the police, the coroner, as well as the company itself. Individual employees may be interviewed on more than one occasion and it is important not to allow a situation to develop whereby individuals may be made to feel responsible prior to any official report.

CONTINGENCY PLANNING

Bearing in mind that unexpected disasters can happen at any time, organisations need to have a contingency plan in place to enable them to continue to run their business (albeit at a reduced capacity), in the event of a major disaster that may render their premises partially or totally unusable.

Within an organisation, there needs to be a team of people (from different disciplines) who have access to a critical incident management plan that clearly defines the role of each team member and ensures that the following questions can be answered effectively, in order to avoid future problems:

- Do they have a way of accessing immediately all relevant information that is integral to the working of the organisation? Are there arrangements for back-up copies of electronic and other data to be stored externally in an independent location away from the main site of operations?
- Has identification been made of possible alternative premises for emergency use, or alternatively an agency that would be able to find them suitable temporary accommodation?

- How and from where would replacement computer equipment be obtained at short notice and who would be able to re-install essential files onto any new system?
- What contingency arrangements have been made to:
  i) publicise temporary telephone numbers and replacement communications systems for customers, suppliers and business associates;
  ii) provide practical support for the workforce such as access and travelling to temporary site, replacement of personal belongings, business equipment, tools etc;
  iii) provide essential emotional and psychological support for any employee(s) affected by the incident?

The team should review the contingency planning and the control and access of data, at regular intervals and, if necessary, seek expert advice in the field of critical incident management. In specific, high risk areas, such as the City of London, formal training would be appropriate for team leaders who could potentially be caught up in a major incident similar to those that occurred at the Nat West Tower in 1993 or Canary Wharf in 1996.

PTSD DIAGNOSTIC CRITERIA

In common with other mental disorders, PTSD is very specifically defined, and a person needs to be found to be exhibiting a number of specific symptoms for a definitive diagnosis of PTSD to be made. According to the 'Diagnostic and statistical manual of mental disorders' (DSM-IV) (1994) (American Psychiatric Association), the diagnostic criteria for PTSD is as follows:

a) The person has been exposed to a traumatic event in which both of the following were present:
   i) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
   ii) The person's response involved intense fear, helplessness, or horror. (Note: in children, this may be expressed instead by disorganised or agitated behaviour.)

b) The traumatic event is persistently re-experienced in one (or more) of the following ways:
   i) Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions. (Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.)
   ii) Recurrent distressing dreams of the event. (Note: in children, there may be frightening dreams without recognisable content.)
   iii) Acting or feeling as if the traumatic event were recurring (which includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). (Note: in young children, trauma-specific re-enactment may occur.)
   iv) Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.
   v) Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

c) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   i) Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
   ii) Efforts to avoid activities, places, or people that arouse recollections of the trauma.
   iii) Inability to recall an important aspect of the trauma.
   iv) Markedly diminished interest or participation in significant activities.
   v) Feeling of detachment or estrangement from others.
   vi) Restricted range of affections (e.g. unable to have loving feelings).
   vii) Sense of foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span).

d) Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   i) Difficulty falling or staying asleep.
   ii) Irritability or outbursts of anger.
   iii) Difficulty concentrating.
   iv) Exhibiting hyper-vigilance.
   v) Exaggerated startle response.

e) Duration of the disturbance (symptoms in criteria (b), (c) and (d)) is more than one month.
e) The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

- Acute – if duration of symptoms is less than three months.
- Chronic – if duration of symptoms is three months or more.

With delayed onset – if onset of symptoms is at least six months after the stressor.

METHODOLOGIES IN THE MANAGEMENT OF TRAUMA VICTIMS

DEFUSING

Defusing (a brief informal discussion with an individual or group) should be held within hours of an incident and is most likely to be delivered by a trained manager or supervisor. It will normally last between 30–60 minutes and should be separate from any investigative process. It is often a stand-alone intervention (depending on the nature of the incident) and can also be used for assessment (and sometimes mitigation) of acute symptoms together with acting as a precursor to psychological debriefing to ascertain whether a full debrief is required.

Defusing is a shortened, three-phase version of critical incident stress debriefing (see **1.22** below). It recognises, but does not explore, emotional reactions to the incident (Mitchell and Everly (2001)) and gives people an informal opportunity to say what they want to about the traumatic incident.

Defusing can also be carried out alongside the operational debriefing that addresses practical issues. If so, it should take place in a quiet and comfortable setting, and the participant(s) should be provided with transport home or any other practical support as mentioned above. The environment is similar as required for debriefing and any limits on confidentiality should be enumerated at the start of the session.

CRITICAL INCIDENT STRESS DEBRIEFING (CISD)

A number of debriefing models have been developed since the 1980s, and many individuals have found that talking through traumatic events has been helpful to their recovery (although this has yet to be substantiated by systematic research). The models include those developed by Mitchell (1983), who terms the intervention 'critical incident stress debriefing' ('CISD'); Dyregrov (1989) and Raphael (1986), who both use the term 'psychological debriefing' (PD); and Armstrong, O'Callahan and Marmar (1991), who use the term 'multiple stressor debriefing model'.

The aims of the CISD model are to:

> 'Mitigate the harmful effects of traumatic stress and accelerate recovery processes in individuals who are experiencing normal reactions to abnormal events.'

Formal CISD is recommended to be implemented between 24 and 72 hours subsequent to the incident and be undertaken by trained professionals. This time delay was considered necessary as Mitchell (1983) proposed that emergency workers could suppress psychological reactions for a brief period after an incident as a result of 'training' and would otherwise be too aroused to deal with an in-depth discussion of events.

CISD is run in stages and the debriefer should keep the session open-ended as the different stages can vary in length but an average time would be in the region of 3 hours (including breaks as required). The process enables victims to talk about their experience, normalise their reactions to an event, and receive support and information to reinforce this.

Generally, psychological debriefing has been viewed positively by its participants and this had contributed to anecdotal reports of its effectiveness. However, there has been little empirical evidence to demonstrate the effectiveness of psychological debriefing in accelerating normal recovery processes following trauma (Rose (2000); Kenardy (2000); Orner et al (1999)).

However, CISD has been and is currently used by the emergency services, transport industry, banks, building societies, retail trade, and other organisations, as a standard procedure where people have been exposed to traumatic incident, violent crime or natural disaster.

A debriefing group will usually comprise up to about ten individuals, but where there are greater numbers involved, then the services of a co-debriefer, (whose role should be explained at the beginning of the session), may be required.

The venue should be on neutral ground, e.g. an office or conference room in the workplace and offer privacy and quiet in order to facilitate open discussion by the participants. Limits on confidentiality should be discussed at the start of the session, and participants in the group should be chosen with care in order to preclude anyone being reluctant to speak openly for fear of recrimination or blame.

Following the debriefing, people whose symptoms are particularly severe may warrant the provision of immediate post-trauma counselling or psychiatric help (see below).

A trauma support leaflet setting out the likely consequences of trauma and basic methods of dealing with them, should be distributed, as appropriate, to those involved together with their families. (See **appendix B** at end of the chapter.)

TRAUMA SUPPORT MODEL

This three-stage model which has been adapted in unpublished research by Suzanna Rose and Gerry Jackson in 2001, as a development of the psychological first-aid model (C Freeman et al (2001)), covers a series of interventions that may commence within the first few hours subsequent to a traumatic event and might well continue over several weeks. Some organisations are using this model as an alternative to CISD. It is less structured, more led by the participants, and is less intense.

The trauma support model has been developed by taking into account available research and the experience of professionals in the field. It is intended to be a programme of support that seeks to look after people in the short, medium and longer term; help them to be heard and feel cared for and ensure that those who are most vulnerable to developing psychiatric illness are provided with appropriate therapeutic help.

Individuals practising the trauma support model must be appropriately trained. However, the training need not be at the same level as that required for CISD – where practitioners need to be able to manage and contain intense emotional reactions, either in individuals or in groups, and conform to a prescriptive, structural procedure.

It should also be noted that those who undertake debriefing services should themselves be afforded appropriate support as it can be distressing to listen to the traumas of others. This may entail discussion with colleagues subsequent to each session, but supervision should also be available from a mental health professional such as a counsellor or psychologist. Their experience can be used to answer questions, develop the experience and skills of persons carrying out the debriefing to ensure that the work is not overwhelming.

PRACTICAL APPLICATION OF THE TRAUMA SUPPORT MODEL

Levels of support for those who have experienced or witnessed a traumatic event –

1. Initial Stage – Offer Practical Support and Brief Talk (Defusing)

Methodolody

A Defusing consists of three parts, an Introduction, the Exploration of the incident and Information giving.

Introduction

The defuser should introduce him/herself then mention the intention of the session:

- To allow people the opportunity to discuss the incident.
  To reduce the effect of the incident by providing immediate support and assistance.
- To reduce tension and regain emotional control.
- To facilitate a return to normal functioning and begin the recovery process.

Any limits on confidentiality should be mentioned, though the defusing should be separate from any investigation process. They should be told they do not have to talk about the incident unless they wish to and they can say as much or as little as they want. Set ground rules for the meeting if necessary.

Exploration

The person or group is allowed to discuss as much of the incident as they wish. They may wish to mention their feelings at this stage but they should not be unduly probed in the session. Open questions should be used together with paraphrases etc. to help the participants to feel heard and understood.

If any of the participants are very emotional or if they are being self critical of their actions the defuser should help them look realistically at the actual events and what they did so that they can move from an emotional reaction to a more factual one.

The defuser may wish to discuss with the participants whether or not they feel that a full critical incident debriefing should be offered in the next few days.

Information

The defuser should fill in any factual gaps there may be and give them credit for a good job and any helpful actions. They should be reassured that their feelings and reactions are natural and normal and that they should recover naturally over time. They should be told about other reactions they may experience. e.g. sleeplessness, intrusive thoughts etc. If their reactions and symptoms do not subside they need to consider asking for professional help.

If they wish to have a Critical Incident Debriefing they should be told that it will be arranged within the next few days.

They may be given details of sources of further support or counselling and encouraged to use support from their colleagues. They should be encouraged to talk about the event with their loved ones and given a suitable leaflet containing information about typical reactions to trauma which, again, they should show to those closest to them.

If an individual or group has been involved in or witnessed a traumatic incident, what you do, on the day it happened or occasionally the day after, should be restricted to the Initial Stage. People may wish to talk about what happened, and you may facilitate that but try to keep it brief and realistic and do not invite expression of emotions that they do not spontaneously express. You should also give them information about typical reactions and what they might expect in the next few days. This discussion and educational component is called Defusing.

Consider offering practical support as mentioned above and anything else that may seem appropriate, including suggesting that they talk about it to others who were involved or family and friends, if they feel like it.

Remember that if you, as someone trained in these skills, also attended the scene it may be inappropriate for you to carry out this stage. You may wish to ensure that your direct line manager provides the support required. Part of the defusing discussion may be to decide whether the team would wish for a full Trauma Support Session to be arranged.

In more serious incidents a Trauma Support Session will be organised in any event.

Following very serious incidents it may be that some people will be more seriously affected than usual and managers and TSTMs should be aware of this and offer Initial Stage practical support. For example: are they OK to drive home? Do they need anyone informed? Try to make sure they are not going to be alone at home and provide any other practical support that seems appropriate.

2. Middle Stage – Offer a Trauma Support Session

The history

Dr Atle Dyregrov, in a paper published in 1973, describes the concept of a Critical Incident Stress Debriefing (CISD) for people who have had a direct involvement in a disaster situation. His work has been further developed by Geoffrey Mitchell in America. CISD relies on the basic principles of crisis intervention theory as a basis for operation. In the light of recent research and considered best practice the process is now much more led by the client(s) and involves much less structure imposed by the responder. The session is now called a Trauma Support Session (TSS).

This should be run by Occupational Health staff, by professionals from outside agencies or by specially trained Trauma Support Teams members from the company's own staff. It is an informal discussion led by those involved and facilitated by the person running it. The objectives are:

- To show them the organisation cares
- To encourage talking and support
- To allow expression of impressions, reactions and feelings
- To help them make sense of it
- To reassure the participants that their reactions are natural and recovery is possible
- To give advice about coping and dealing with some reactions
- To enhance team cohesiveness and support
- To identify those who may need additional support

It is often helpful if this is done as a group session but if one or more prefers it, it can be done one to one. At this stage they may wish to express their feelings and should be allowed to do so, but emotions will not be unduly probed and any intense re-experiencing of feelings should be avoided.

The facilitator will check on the level of symptoms being experienced, will normalise them and may give advice about how to cope with some symptoms. If an individual is experiencing a very strong reaction and/or has little social support, the facilitator may recommend counselling at this stage.

- An offer of any appropriate practical help
- Comforting and consoling distress
- A brief discussion and education on normal responses to trauma, recognising and respecting the normality of the post trauma reaction, called 'Defusing'.
- Protection from further threat and distress
- Providing immediate care for physical needs
- Providing support for necessary practical tasks
- Facilitating reunion with loved ones

It consists of:

- Facilitating some telling of the trauma story
- Allowing some ventilation of feelings as appropriate
- Linking people to systems of support
- Monitoring avoidance type symptoms
- Encouraging them to take some control of their lives again
- This may be achieved by offering a Trauma Support Session

Structure

It is considered that these sessions should be managed in a way that is as close to how people naturally deal with traumatic events as possible. In other words they should be encouraged to talk about whatever they want to talk about, whilst being facilitated in doing so by the person running the session. So there is no formal structure as such, but it should be ensured that all the following components are included somewhere during the session. The session will be quite informal with the participants deciding whether they want to be seen as a group or as individuals (generally, they prefer to be seen together). In fact including each part in the order shown seems reasonably logical and will ensure important parts are not omitted.

It is important that they are not encouraged to intensely re-experience their original feelings during the session as research shows that this may be harmful. So if people start to become very emotional and upset the feelings should be acknowledged with a paraphrase and they should be moved on. Taking them back to the story about what actually happened can be an effective way of doing this with a question like, "What happened next?"

The section below consists of the methodology for running a Trauma Support Session.

METHODOLOGY OF A TRAUMA SUPPORT SESSION

Introduction

You should introduce yourself and invite them to consider whether they would prefer to be seen as a group or individually. Tell them the idea of the session is to give them a chance to say what they want in order to start to process the event and for you as TSTM to assess how they are and, with them, to decide if any immediate counselling is needed. It is emphasised that it is they who are leading the session. The issue of confidentiality is an important one and the need to respect any disclosures made during the session is heavily emphasised. In addition they are told that no record or report to senior managers will be made. The TSTM will be available to individuals if necessary immediately after the session.

Telling the Story

You may find that no-one will say anything at first but if you sit and look encouragingly at them, some-one will probably start the ball rolling and start to speak. So long as they are sticking to the subject allow them to speak as they wish. In the majority of cases they will usefully discuss what happened to them, including the feelings that have been generated because of it.

If they want to talk about it is important that they keep the whole event in context, rather than talking about a particular part of it about which they feel especially negative. So if an individual or part of a group starts to concentrate on one part where they see themselves as having failed in some way, you will need to ask them about the rest of the incident and their performance so they can see the whole of it and how they did in a realistic way.

If an individual or group are very confused it may help to take them back to a time when nothing unusual was happening and they were safe and allow them to start the story from there. They should be allowed to express their feelings and emotions but you should not encourage them to dwell on them unduly. A simple paraphrase or empathic response will suffice.

Once they have started with the story it may be helpful to ask open questions to get them to tell it all and to tell it in the right order, as it happened. Paraphrasing during this process will help the participants to feel genuinely heard. This process is not about changing anything and any attempt at problem solving should be avoided.

If a group or an individual really does not wish to talk about it you should respect that but ask if it is OK if you check how they are and give them some information and a leaflet. You can then continue with the remainder of the process below. But remember that they are entitled to their defences and do not try to break them down.

Reactions and Symptoms

They will probably naturally refer to how they have reacted since the event and what symptoms they have been experiencing. These might include sleep disturbance, disturbing intrusive thoughts or dreams, tears, irritability etc. etc. By comparing their reactions the group is helped to realise that they and their reactions are normal. This phase is important as a means by which the TSTM may be able to determine the need for follow up services.

If they do not discuss this aspect naturally you will need to enquire about it. A simple question like, "How have you been since the incident?" may be enough to get them started. Asking about some of the specific typical difficulties people experience may also help. If they are experiencing several symptoms you may find it useful to administer the Post Trauma Questionnaire to check on their level of symptoms at that time. If anyone has six or more symptoms you should consider arranging an assessment by a counsellor.

Normalising, Education and Support

Following the telling of the story you should verbally tell them what reactions and symptoms they might typically experience, at the time or later, and to link your comments with any reactions they have mentioned, emphasising that they are a natural and normal response to disasters and traumatic incidents. So long as their symptoms continue to subside they should not worry, but if they stay the same or get worse, they should either contact you or ask for counselling help direct.

As part of this section of the process you should enquire about their support networks. Those who do not have good social support around them or who have many other problems in their lives are much more vulnerable to developing PTSD or other psychiatric illness. You need to know that they have someone to whom they can talk about the event and feel understood and supported. The person doesn't need to do anything to make it better, just listen and offer support, perhaps a hug or cuddle might help. Those who live alone may be vulnerable to lack of support and, sometimes, those living with a partner can find that their partner doesn't understand and/or isn't prepared to offer support. Talking about it with others who were involved often feels particularly therapeutic.

You could give advice about maintaining a healthy diet, exercising, not drinking alcohol excessively, keeping up normal interests and not withdrawing in their close relationships or socially.

If a person is finding it hard to return to where it happened, particularly if it is a workplace incident, they should be encouraged to do so when they feel ready. People will often try to avoid going to the scene and eventually they need to do so. It may be helpful for them to be accompanied for the first time or two or some other way of gradually allowing them to get used to the idea at their own pace.

They should also be offered any practical help they need, such as time off work, help with information to relatives, transport, perhaps child care or collecting children, arranging for them to be accompanied on the first journey or two into work. An offer of regular contact

or visits by colleagues can be a great help for someone who is off sick and feeling isolated. You are unlikely to find out if they need anything by asking, "Is there anything we can do?" They will just say "no." Try making specific offers of whatever seems appropriate. If you notice any of the Typical Reactions to Trauma listed above try to build into the session somewhere the responses suggested.

Ending

They should be asked if there is anything else they want to say and, if it is true, be told that they did a good job or as well as anyone could have been expected to do. Thank them for talking to you and make sure they know that you are available for advice if they need it and/or how they can obtain counselling if they feel they need it.

The Trauma Leaflets should be given out at this stage and they should be encouraged to read them and show them to their partners, families or support networks. Do not forget to remind them that you will be contacting them, either by a further visit or by telephone in about 4 or 5 weeks.

In a group situation it is sometimes appropriate to see each individual after the joint session and go through the Post Trauma Questionnaire with them, particularly if there are a lot of symptoms around.

After the session it may be helpful to provide light refreshments, which helps to facilitate interaction between the members. Some of the members may like to shake hands with the Trauma Support team.

3. Final Stage – Monitoring Of People Over A Period Of Time

This may be done by a manager or other trained person or professional. This is to assess how individuals are recovering (are the symptoms the same, getting better or getting worse?). Three to five weeks after an incident is an important time as individuals still experiencing 6 or more symptoms then are much more vulnerable to developing PTSD. The level of symptoms can be checked using a Post Trauma Screening questionnaire, which may be self administered or administered by another person.

If there is no improvement or things are getting worse over time, further intervention should be arranged, such as counselling.

Remember that social support is an important component of recovery and those who do not have that in their lives are much more vulnerable to developing PTSD. If there is a lack of support for an individual some provision should be made to supply it, either through regular contact with work colleagues or from counselling.

Anyone who is off sick must not be forgotten and regular contact should be maintained, both by managers and colleagues. Return to work sometimes needs to be facilitated and encouraged by specialist counselling.

Many organisations have a leaflet that sets out the likely consequences of trauma and elementary ways of dealing with it. These should be distributed to those involved and their families.

PEER SUPPORT GROUPS

Peer support is used by some organisations as a means of utilising work-team members rather than staff having a specialist support function.

Supervision is required for any peer support team, to ensure that they can themselves cope with the emotional demands placed upon them.

Points to note:

- It is essential that peer support team members acknowledge their own boundaries and limitations and know when and where to refer on, when necessary.
- They should always appreciate that although they are fulfilling a professional role, they are, nevertheless, not formally trained, trauma professionals.

A 'buddy system' is another model of peer support that is increasingly being used. This would usually comprise individuals who have experienced a particular trauma in the past and are called upon to give support to others. With the empathy they have gained from their own experience, they often have skills and expertise to support others. However, it is essential that they have worked satisfactorily through their own responses and reactions and are not jeopardising their own mental health by helping others. As with any peer support option, supervision, training and support are vital components to ensure that this is a viable alternative.

POST-TRAUMA COUNSELLING

There is a need for organisations to be aware of the type of post-trauma reactions that employees may be experiencing and the symptoms that may be exhibited. It is important to be able to identify changes in behaviour, for example: avoidance or being over-anxious about returning to the place where the incident happened; being unable to talk about the incident or becoming emotionally very detached are often warning signs that after-effects of trauma are being experienced and the individual(s) may need post-trauma counselling support.

It may be that the employee has contacted the personnel or occupational health departments to complain of nightmares or flashbacks and that these symptoms are adversely affecting their relationships.

An effective model when working with traumatised individuals is cognitive behavioural therapy (CBT) (SD Solomon, ET Gerrity and AM Muff (1992)). This is a structured form of therapy that encourages clients to recognise that their thinking processes may be irrational and may be contributing to negative emotional reactions, such as extreme anxiety, that are effecting their lives.

Counsellors or clinical psychologists who are experienced in working with traumatised clients, should always be used wherever possible. Details of specialist consultants may be obtained from the British Association for Counselling and Psychotherapy, the UK Trauma Group or other organisations who specialise in the treatment of trauma.

Case study

John and Marcus were part of a 20-strong team of engineering fitters who were welding tank plates on a reserve-feed cooling water tank at a nuclear power station in the north of England. It was late in the afternoon and both men were working from a scaffolding platform about half way up the tank, vertically welding the joints of the steel plates to ensure water-tightness.

Suddenly, a scaffold pipe worked loose from its fixing and the entire scaffold on which the men were working collapsed. John fell over 15 metres and was killed instantly as his head struck an angle iron support at the base of the tank. Marcus fell on top of him, sustaining a fractured pelvis.

The foreman hit the alarm siren, which automatically closed down the electricity supply, and other workmen rushed across the site. Someone had already called an ambulance and Marcus, who was unconscious, was left untouched to await the emergency crew. In the minutes that followed, the entire gang of fitters watched as the paramedics arrived, injected Marcus with morphine, and put him gently onto a stretcher then into the ambulance. With blue lights flashing and siren blaring, they sped off to the local hospital, whilst a second ambulance crew gently wrapped up and took away John's body. Official photographs of the accident scene were taken, for record.

Apart from John and Marcus, there were 18 other welders on site that day, in addition to a gang of painters who were working on the adjoining tank. One or two of the men were physically sick, before they and the others gathered up their tools and overalls then slowly made their way off the site, too shocked to talk. The administrative staff's offices also overlooked the scene, and they too saw the incident.

Billy, who had completed the Red Cross training, was the appointed first-aider for the company. He had put his certificate up on the wall, but never expected to have to use his training. It was considered quite lightly by him at the time, e.g. 'I will be here to look after you all, don't worry', he would say. As soon as this terrible accident happened, suddenly people were looking to Billy to give support and advice.

The following day, three of the men who at worked at the site, failed to report for work. A management enquiry was set up to find the cause for the disaster and to allocate responsibility. The scaffolding itself had been supplied and erected by a sub-contractor, and the health and safety inspector was making his own official enquiry and report. In all, over 25 men had either witnessed the accident directly or had arrived in the first few minutes immediately afterwards in response to the alarm. Most of them had seen John's body. However, nobody was prepared for what they had seen, and virtually all were affected to some degree.

Their families were also indirectly affected, as their men-folk tried to come to terms with the image that was now embedded in their minds. In the first few days after the harrowing event, many had difficulty in sleeping and some went to their GP for a sedative. Unfortunately, for many the image was there, immediately upon waking. The engineering employer was a large company, and fortunately had an occupational health department staffed by three qualified nurses, all of whom had received defusing training. In the days following the accident, they ensured that they spoke to all those employees who had been on the site that day. A team of debriefers was called in to give a group debriefing to those who wished to receive it. Following this, one-to-one post-trauma counselling was also given.

In the event, two of the men suffered more serious effects and were off work for two months. They have now returned. Marcus recovered quickly and was probably fortunate that he was spared the sight of what had happened to John, as he had been knocked unconscious by the fall.

The scaffolding firm was prosecuted by the HSE for breach of safety regulations, and subsequently fined £25,000 for negligence. John's widow is now taking proceedings to sue his employer in the civil courts for compensation. As John was only 27 years old at the time of the accident, the claim is likely to run well into six figures.

Postscript: It can take a long time to re-establish that feeling of being part of the company again. Mary was on holiday when the above incident occurred. On returning to work, following the incident, she felt a sense of guilt for not having been there, and of isolation because all she could do was 'listen to what people are saying', with the result that she no longer felt included as a member of the group.

CRITICAL INCIDENT MANAGEMENT

Police in the UK have an overall responsibility for coordinating the work of the other emergency services (but not to control or direct), whilst ensuring that the work is facilitated without impediment or undue restriction.

The various facilities mentioned below may or may not be required in the context of major disasters. (This will depend on the particular circumstances of each disaster.)

Cordons

Standard police procedure is to set up two cordons: an inner cordon to provide security at the scene itself, and prevent unauthorised access; and an outer cordon to provide a controlled area external to the inner cordon, access for emergency services and a secure area for them to position mobile control vehicles. Depending on the circumstances, a representative from the organisation that is involved in the incident may be needed at the police mobile control centre to give essential information about the company, buildings and/or staff.

It is usual that between the inner and outer cordons, the police will set up a rendezvous point (RVP) to control access to the scene. Incoming personnel and vehicles will be kept at the RVP until they are required at the scene and then escorted forward.

Survivor reception centre (SRC)

A survivor reception centre (SRC) should be set up where there are a number of uninjured (or walking wounded) persons involved. For instance, at the Ladbroke Grove train crash disaster in 1999, the nearby Sainsbury's store was used as the SRC. Typically, this will facilitate care for people, provide hot drinks and/ or food, ensure security and safety from further harm, to have personal details taken down for the record, to ensure nobody has sustained any serious injury to themselves, to establish contact with families, and finally to arrange transport home or to another destination.

These facilities will usually be organised by the police and assisted by the local authority. There should also be a presence of employees of the organisation who were not involved in the incident but who can provide support and assistance with the services mentioned above. These individuals should be identifiable by an identification tag showing their name and position.

Friends and relatives reception centre (FRRC)

This facility would normally be set up where there is an accident involving passengers travelling by road, rail, airline or ferry – in order to accommodate and answer questions from anxious relatives or friends who are waiting for incoming passengers, or where numbers of friends and relatives are likely to arrive at the scene, looking for those involved.

The rationale is to control the influx of unauthorised persons and to prevent interference or hindrance with the work of the emergency services. Details of people arriving at the centre will be taken and attempts made to reunite them with their relatives or friends. As before, this would normally be a combined effort by the police and the local authority, and a presence by the organisation involved is desirable to assist with the work. The physical act of reuniting people should be carried out somewhere other than at the SRC or FRRC.

Relative liaison officers (RLOs)

In cases where there are a number of fatalities, the police will appoint relative liaison officers to look after the needs of each bereaved family and assist in the identification processes. In some circumstances the organisation may wish to appoint a 'buddy' (or preferably two) in order to provide care and support and to act as a single link with the employing company.

Casualty bureau

A casualty bureau is a communications centre set up by the police. (Similar centres are also used by airlines.) Its brief is to collect and collate information from all points and from the scene itself to ensure that those involved receive all the information they require regarding the condition and whereabouts of their colleagues, friends or relatives. Such centres are also responsible for collating information about the identification of any deceased victims and the informing of next of kin.

A liaison representative from the organisation will be required at this centre, to assist with whatever information they have from their internal records regarding the injured and, possibly, also details of close relatives.

Mortuary

This is the location where the technicalities of the process of identification of the deceased will be carried out. In some circumstances, an existing local mortuary will be used, though often, if there are large numbers of deaths, a temporary mortuary facility may be established near to the point of the disaster. Normally no one from the organisation will be required to work in this facility, though mortuary workers will often require information, most usually from the casualty bureau liaison representative.

Evacuation

Where it becomes necessary to evacuate buildings, the instructions of the police and/or the emergency service must be complied with immediately and without query. Modern office buildings often have a small footprint and a high-rise profile, and it is important that an emergency evacuation plan should be developed and regularly rehearsed to ensure that it is practical and effective, prior to it ever being needed. A disorganised evacuation will cause panic, wasted time and further endanger life.

Crowd management

Where large numbers of people are involved, crowd safety; planning; assessing risks; putting precautions in place; emergency planning and procedures; communication; monitoring crowds and review needs to be taken into consideration (HSE (2000)).

Media

In any major incident, the media will usually be present in large numbers and will seek to interview anyone who apparently has any knowledge that may be of interest. It is therefore useful to appoint a media liaison person who should be a senior manager, with some appropriate training. Any other person approached by the media for comment about issues relating to either the company or the disaster, should always refer such enquiry to the designated media liaison official.

KEY LEARNING POINTS

The treatment and management of trauma is a difficult and complex subject, and more random controlled studies are needed to establish the outcomes that are being produced by current interventions and which components (of particular interventions) are of most value.

Until further research and substantiated reports are available, professionals involved in post-trauma support will tend to use existing methods. Notwithstanding the fact that we are moving towards more evidence-based practice, it is important that whatever methodology is used, it must identify those who are particularly at risk, so that psychotherapeutic resources can be concentrated on those particular individuals or groups, with the maximum beneficial effect and without undue delay.

CISD is used in many organisations and appears to be beneficial in many cases of trauma support. Nevertheless, many practitioners are reconsidering the efficacy of their approach, and may well adopt something similar to the trauma support system described above.

The most important objective is to provide an ongoing system of support that combines pre-emptive action management and essential reactive treatment, as necessary. The system

should include risk assessment, suitable support training prior to any potentially damaging incident, provision of effective management during the event and immediate support after the event.

In light of these considerations, it is also important to bear in mind the following.

- The differing reactions of individuals to traumatic events will vary in both severity and type.
- PTSD is the term commonly used to identify the reactions that some people experience in the aftermath of an extreme incident.
- A diagnosis of PTSD is often difficult – only a small proportion of people will be positively diagnosed. However, many more are likely to experience some traumatic symptoms after the event.
- The provisions of the Health and Safety at Work etc Act 1974 covers the statutory duty of care that applies to the health and safety of all employees and others within the workplace.
- Exposure to traumatic events will vary and employees may suffer from post-trauma symptoms without experiencing PTSD.
- A lack of support and care by the organisation following an incident may cause feelings of anger or frustration in the workforce.
- Managers should be particularly observant of those who have experienced trauma so that any symptoms and reactions are noticed and treated without delay.
- Stress can follow anything from a minor incident to a major disaster and can affect any of those directly or indirectly involved.
- An organisation's crisis management procedure(s) should include all the necessary assistance and support in dealing with an unexpected traumatic incident, including training, identifying those involved, providing all required support and, where applicable, access to professional counselling.
- Where any member of staff is on sick leave absence subsequent to an accident or other distressing event, then managers should keep in regular contact until there has been a return to work.
- Specialist counselling should be provided for those identified as experiencing post-trauma symptoms and they should be given time off work to attend appointments.

APPENDIX A

COPING STRATEGIES DURING AND AFTER TRAUMATIC EVENTS

How do helpers, rescuers, observers and others cope with their involvement in traumatic incidents? The process used is known as **distancing**. This is achieved through the following strategies:

Being Active

People keep themselves busy and concentrate on the task in hand. They may ignore what happens around them.

Giving Mutual Support

There is usually much talking, touching and physical contact between teams and groups of helpers and rescuers.

Suppressing Emotions

Many people make a conscious effort to control and suppress any emotional reactions and prevent them from emerging.

A Sense Of Unreality

There is the experience of shock which can numb reactions and make the incident seem unreal. Some say 'I feel like an actor in a film or play'.

Avoidance

Some people feel emotionally detached. The bodies of the dead or injured seem like dolls or dummies in an exercise. Some consciously think of the people as not being real human

beings. This does not work for very long, for feelings seem to emerge eventually. Some think of their homes or gardens, what meals they would be preparing or having and even the washing-up, ironing or house-work.

Preparation

There can be a feeling that mental and emotional preparation before the incident can help – e.g. when hearing the news or on the way there to the site of the incident.

Professionalism And Training

Being professionally trained for the task will help. There may be a sense of 'knowing what to do' and of team solidarity. Previous experience of similar incidents gives confidence to some. Confidence in self and colleagues is important.

Regulating Exposure

Limiting the amount of time involved. Avoiding information about the incident or what was happening elsewhere.

Being given periods for rest. However, these should not be too long so that a conflict arises between using the strategies and not having to use them.

Having A Sense Of Purpose

There can be a feeling that 'I have to do it and I am the right person to do it'. Knowing that one is helping is important. 'You are doing it for this person or for their relatives'.

Humour

Humour is a positive way of coping with trauma and is used much by Police, Fire and Rescue workers, medical staff and others. However, it is not generally used when 'outsiders' such as survivors, relatives or onlookers are present. When children are involved, few use humour, often very 'black humour', is directed at the abuser and not the victim. Humour is a way of releasing emotions, but also of avoiding them.

And Afterwards…

Talking To Self, A Colleague, Friend Or Partner

Some people find they talk to themselves on the way home from an incident, or share feelings and experiences with their colleagues, friends, wife, husband or partner. Some even talk to the dog or other pet.

Listening To Music

Listening to the radio or to music helps some people to relax and take their minds off what they have been doing.

Being Grateful

Some people say it helps them to think that they are grateful to be alive or to have families, children.

Hobbies, Exercise, Sport

Some people take exercise or involve themselves in a sport or a hobby.

Expressing Emotions And Feelings

Some people are able to express feelings and emotions afterwards, but some can't. Swearing is common, clenching of fists, shouting, stamping feet, banging or throwing things around can be a ways of expressing emotion.

Source: Post Traumatic Stress Reactions Among Police Officers after the Piper Alpha Disaster: Alexander Wells (1990) Post Traumatic Stress in British Police: Hetherington & Guppy (1990).

APPENDIX B

EXAMPLE OF THE CONTENT FOR A LEAFLET FOR USE WITH CLIENTS AND THEIR FAMILIES

The reactions and effects of involvement in a traumatic incident

You have been involved in a very traumatic incident, and you are likely to have some form of reaction to it. These reactions may happen immediately, or may not occur for weeks, months or occasionally even years after the incident. Not everyone suffers reactions but the majority of us do. These reactions are likely to be worse if:

- Many people died or were injured during the incident, or death or injury was sudden, violent or happened in horrifying circumstances.
- You have a feeling of helplessness or wanting to have done more.
- You do not have good support from family, friends or colleagues.
- The stress resulting from the incident comes on top of other stresses in your life.

What follows has been compiled from the experiences of others who have been involved in similar incidents.

Emotional reactions

Your emotions or feelings are likely to be in chaos after the event, or alternatively you may feel nothing. Some of the more common emotional reactions are listed below.

Guilt:

- For not having done more.
- For having survived when others did not.

Anger at:

- What has happened.
- Whoever caused it or allowed it to happen.
- The injustice or senselessness of it.
- Not being understood by others.
- Those in charge.

Fear:

- Of breaking down or losing control.
- Of a similar event happening again and not being able to cope.

Shame:

- For not having reacted as you might have wanted to.
- For feeling helpless, emotional and wanting others to be with you.

Sadness:

- About the deaths, injuries and the whole circumstances of the incident. You may feel depressed without knowing why.

Mental reactions

You may very likely find that you cannot stop thinking about the incident, dream about it or suffer loss of memory, concentration or motivation. You may experience flashbacks (feeling that part of it is happening again). You may hate to be reminded of it. You could feel always on your guard or easily startled.

Physical reactions

People often experience tiredness, sleeplessness, nightmares, dizziness, palpitations, shakes, difficulty in breathing, tightness in the throat and chest, sickness, diarrhoea, menstrual problems, changes in sexual interest or eating habits, and many other symptoms – frequently without making a connection with the incident.

Other difficulties

You may feel hurt, and your relationships with others, particularly your partner, may feel under additional strain. You may find yourself taking your anger out on your partner or family. You may not be aware that you are doing this, and your partner will probably not understand that it is part of your reaction to the incident. You may find yourself emotionally withdrawing from your close relationships. Just when you need it the most, you may reject the support of those closest to you. Try not to do this.

You may find that the incident has reminded you of some past trauma, at work or in your personal life, and the feelings about that could come back with all their original force. That may also need to be dealt with.

What can be done to help?

Nature often heals by allowing feelings to come out and by making you want to talk about these. Talking about the incident and your feelings about it with your partner, others who were involved, or any sympathetic listener, is very helpful. Take the opportunity if it arises. It will probably help those closest to you to understand and support you more effectively if you show them this leaflet.

Talking to a trained counsellor is often a great relief and can reduce much of the tension and anxiety. Trying to avoid your feelings, or trying to avoid thinking or talking about the incident in the belief that you can cope may be unhelpful and possibly harmful in the long term. This can lead to storing up problems that will come out sooner or later, and possibly in the form of worse physical or nervous difficulties, sometimes a long time afterwards.

When to look for professional help

- If you feel that you cannot handle intense feelings or body sensations, or if you feel that your emotions are not falling into place over a period of time, and you feel chronic tension, emptiness or exhaustion.
- If, after a short time, you continue to feel numb and empty and do not have any feelings.
- If you have to keep active in an attempt to suppress your feelings.
- If you continue to have nightmares or are sleeping badly.
- If you have no one to share your emotions with and you feel the need to do so.
- If your relationships seem to be suffering, or sexual problems develop.

- If you start to have accidents or your work performance suffers.
- If you start to smoke, drink or take drugs to excess.
- If you are suffering from exhaustion or depression.
- If you cannot control your memories of the experience and they are affecting your personal well-being.

DO REMEMBER:

- THAT YOU ARE BASICALLY THE SAME PERSON YOU WERE BEFORE THE INCIDENT.
- THAT TALKING ABOUT YOUR EXPERIENCE AND THE FEELINGS CAN HELP.
- THAT SUPPRESSING YOUR FEELINGS CAN LEAD TO FURTHER PROBLEMS.

APPENDIX C

BRIEF SCREENING QUESTIONNAIRE FOR POST-TRAUMATIC STRESS DISORDER

Your own reactions now to the traumatic event

Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened a few weeks ago. Please indicate whether or not you have experienced any of the following *at least twice in the same week*:

		Yes, at least twice in the past week	**No**
1.	Upsetting thoughts or memories about the event that have come into your mind against your will		
2.	Upsetting dreams about the event		
3.	Acting or feeling as though the event were happening again		
4.	Feeling upset by reminders of the event		
5.	Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, sweating, dizziness or feeling dizzy) when reminded of the event		
6.	Difficulty falling or staying asleep		
7.	Irritability or outbursts of anger		
8.	Difficulty concentrating		
9.	Heightened awareness of potential dangers to yourself and others		
10.	Being jumpy or being startled at something unexpected		

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BOOK LIST

- **Tolley's Managing Stress in the Workplace** By Carole Spiers (published by LexisNexis). An essential manager's guide to work-related stress – http://www.carolespiers.com/productdetail.cfm?ProductID=4 or www.amazon.co.uk ISBN 075451269X
- **When Disaster Strikes**, Beverley Raphael, ISBN 0-04-445784-7
- **Post Trauma Stress**, Frank Parkinson, ISBN 0-85969-662-6
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- **Counselling for Post Traumatic Stress Disorder**, Michael J. Scott and Stephen G. Stradling, ISBN 0-8039-8409-X

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