Psychological care of staff following traumatic incidents at work

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This paper sets out proposals for the psychological care of staff following exposure to threatening, violent or traumatic incidents in the course of their work. Used appropriately, psychological debriefing offers staff the opportunity to discuss their feelings in a supportive setting, providing subjective benefit and mutual help. It is important that service providers have mechanisms in place which can be activated quickly when incidents occur. More research is needed to assess whether debriefing is effective in preventing negative outcome.

Exposure to traumatic incidents such as violence, threats, self-harm and suicide will always be a feature of the working lives of staff within a psychiatric setting (Wykes, 1994; Crichton, 1995). The results of such incidents may have wide-ranging effects, not only for individuals, but also for the organisations which employ them, in terms of increased sick leave, retention of staff and poor morale.

This paper focuses on the psychological care of staff following a traumatic incident in the work setting, and evolved following a fatal shooting at the Maudsley Hospital. It builds upon recommendations outlined in the Trust Working Party report (1994) and the ongoing work of the Traumatic Stress Service at the Maudsley Hospital. It is an attempt to provide a framework from which other trusts can develop a process of caring for staffs' psychological needs following a threatening or violent event.

The psychological difficulties that staff report following such incidents are characteristic of a post-traumatic stress reaction, which may progress beyond the initial feelings of numbness, anxiety, irritability and anger to more disabling symptoms such as depression and post-traumatic stress disorder (Mitchell & Dyregrov, 1993). Psychological debriefing (Dyregrov, 1989) has been put forward as a means of preventing or reducing the development of such symptoms. Detailed descriptions of the processes involved can be found elsewhere (Mitchell & Bray, 1990; Mitchell & Dyregrov, 1993). Briefly, debriefing provides an opportunity for staff to process events through ventilation of thoughts and feelings in an atmosphere of mutual support, coupled with education and normalisation. It is important to note that psychological debriefing forms only one part of critical incident stress debriefing, originally described by Mitchell (1983).

With the massive increase in the use of debriefing, both in healthcare and commercial settings (Raphael, 1986), there have been many anecdotal and uncontrolled reports of its benefits (e.g. Armstrong *et al*, 1991). However, there has been no systematic evaluation of its effectiveness (Bisson & Deahl, 1994). Research has shown that, even though it may be perceived as being beneficial (Flannery *et al*, 1991), it has not yet been shown to help prevent future psychological distress (Raphael *et al*, 1995).

Despite this, workers in the field remain committed to the principle of debriefing (Robinson & Mitchell, 1993; Deahl *et al*, 1994) and intuitively it remains appealing. Our experience in a traumatic stress clinic is that clients are grateful for the opportunity to express feelings and achieve some understanding of what has happened. We are concerned, however, that many staff do not seek help, either because there is no service available, or because of reluctance due to stigmatisation or a sense of professional inadequacy.

The following proposals provide a framework on which more detailed plans can be developed, depending on resources available. The Maudsley has the expertise of a dedicated trauma service, which helps coordinate procedures and train staff. However, the proposals have been planned in such a way that it is not necessary for such a service to be available.

Recommendations

(1) Pre-incident traumatic stress education should be available for key personnel. Each trust should endeavour to nominate a trauma advisor, possibly from the occupational health department.

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(2) Following an incident, the senior clinical staff member, such as ward manager or emergency team leader, should assume the role of coordinator.
(3) With advice from the trauma advisor, or a trauma service if available, the coordinator decides to what extent the policy is activated. We feel the threshold for activation should be low. It may not be necessary to complete all the recommendations. The trauma advisor may not need to become actively involved, but can provide advice, information and education, and be a source of future input.
(4) All members of staff involved in the incident are identified and informed before they go off shift that they will be contacted, later that day or the following day, for support. If appropriate, they will be invited to attend a debriefing. No staff member will be contacted if they do not wish it. Forcing staff to participate is counterproductive. They will, however, be told that help will be available in the future if they need it. At the end of a shift, staff may meet to reflect on what has happened ('defusing').
(5) If a debriefing session is required, then it should be organised soon after the incident, ideally within one to three days. The meeting room should be quiet and undisturbed. Only those directly involved in the trauma should be included, plus two therapists. In those trusts without a specialised trauma service, the therapists may include the trauma advisor, coordinator or clinical psychologist. Staff should be allowed to talk freely and, although there is no fixed time duration, sessions usually last about 2 hours.
(6) If staff feel that it would be of benefit to have another debriefing session then this should be arranged. Thus the debriefing is client-guided and non-prescriptive. Between sessions, staff are advised that they can contact the therapists directly if additional help is required. They are also encouraged to use their usual support mechanisms such as supervision. In many instances, staff support is the most effective. Subsequent sessions are usually made at weekly intervals and rarely extend beyond four weeks.

A group debriefing may not be appropriate following an incident involving only one or two members of staff. In addition, some staff may feel uncomfortable about participating in a group meeting. In either case, individual sessions should be offered. If it is felt that some members of staff require further help then individual sessions, by external therapists if necessary, should be arranged. A graded return to work may be necessary. Because of the possibility of a delayed reaction, staff should be informed that help will be available in the future if required.

Training in the methods of psychological debriefing is essential for the proper implementation of these proposals. It is recommended that key clinical personnel (i.e. potential coordinators) should go through a specialised course of education and training in psychological reactions to trauma and debriefing. In trusts without the provision of a trauma service, more specialist training of advisors and coodinators is necessary. It is important that therapists are not in direct supervision of group members and do not have a close friendship with them. Confidentiality and a flexibility of approach are essential.

A case vignette is presented which illustrates the process:

In the early hours of the morning, while being assessed by one of the Emergency Clinic team, a man pulled out a large pistol and started threatening staff and gesturing that he was going to kill himself. Staff retreated to the nurses station and the police were called. The man continued to threaten staff through the glass of the nurses station. About 30 minutes after pulling the gun he shot himself, resulting in severe head injuries. Staff attempted to resuscitate him, without success.

This was a particularly distressing event for the five staff members, involving threat to their own lives and witnessing the aftermath of a fatal shooting. The emergency team leader, herself involved in the incident, assumed the role of coordinator. Staff supported each other in the immediate aftermath, and were informed they would be contacted the next day. The following morning the trauma clinic was notified and staff members involved were invited to a debriefing in the afternoon to discuss what had happened and provide support. The session took place in a quiet room, and RMcI and RC acted as cotherapists. Debriefing provided an opportunity for the group to retell the trauma story in a safe and supportive environment, allowing others to experience it from different perspectives. This encouraged mutual support and understanding. Staff were allowed to express which elements of the experience caused most distress, and symptoms were explored. This permitted therapists to provide information and education on how people react to trauma, emphasising that there is no right or wrong way of feeling. Members then reflected on how they felt the session had gone, and suggested that another meeting might be helpful. This was organised for a week later, and staff were encouraged to contact the therapists in

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the meantime if they required further help. The emotional reaction to the trauma among staff members varied, and as the sessions continued, it was clear that their psychological needs became different. It was after the third session that the group decided to stop the meetings and we stressed that individual help could be provided if members felt it was necessary.

Conclusions

Psychiatric staff are being increasingly exposed to violent and traumatic incidents, resulting in psychological distress. People want and need support. Psychological debriefing provides one possible mechanism to alleviate distress and possibly prevent illness progression. Controlled evaluation, involving random allocation and the use of observer, as well as self-report ratings, is essential if its intuitive appeal is to be confirmed by sound research. Psychological debriefing should not replace the usual support mechanisms achieved through staff cohesion and line supervision, and should be adapted to suit particular situations, such as groups or individuals. Improved education, during basic and ongoing training, encourages greater awareness and acceptance. Indiscriminate use by untrained 'counsellors' is likely to lead to more harm than good.

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