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Managing traumatic stress at work

An organisational approach to the management of potentially traumatic events

Trauma Risk Management (TRiM) is an evidence-based peer-support system that helps organisations deal with the psychological aftermath of traumatic events. Professor Neil Greenberg explains.

ALL organisations are required to consider the effects of 'stress at work'[1]; however, the particular nature of occupational stressors can vary considerably. For instance, the difficulties faced by British soldiers in Afghanistan are substantially dissimilar to those faced by journal editors.

In 2009, the National Institute for Health and Clinical Excellence (NICE) published public health guidance on promoting mental wellbeing through productive and healthy working conditions[2]. This clarified the numerous financial, health and legal reasons that underpin why organisations should do their utmost to enhance mental wellbeing. For instance, a 2007 report noted that impaired work efficiency, as a result of mental disorders, costs the UK £15.1 billion a year, with mental-health-related absenteeism costing an additional £8.4 billion annually[3].

Whilst, not all organisations predictably place their personnel in harm's way, in order to comply with the NICE guidance those that do so, such as the emergency services, journalistic organisations and the military, need to consider how best to mitigate and manage the psychological sequalae of exposure to potentially traumatic events. This paper explores the organisational management approaches to dealing with the psychological consequences of potentially traumatic events, taking into account the 2009 NICE guidance.

POTENTIALLY TRAUMATIC EVENTS

Potentially traumatic events (PTEs) are characterised by their potential to cause damage to an individual's health, including mental health[4]. However, whilst there is a well-demonstrated relationship between trauma exposure and the onset of mental health disorders, including, but not limited to, post-traumatic stress disorder (PTSD)[5], most people do not become ill after exposure to traumatic events[6]. For instance, a study of the London Ambulance Service personnel carried out two months after the London bombings on 7 July 2005, found 4% of respondents reported probable PTSD[7], a rate only marginally above the 3% rate found in the general UK population[8] and one comparable to the rate in UK military personnel[6].

Detailed analysis of factors associated with trauma-related psychological disorder suggest that post-event factors, including, importantly, social support and exposure to subsequent stressors, are more important predictors of psychological outcome than pre-trauma or peri-traumatic factors[5]. Put another way, whether or not someone who is exposed to a PTE will become psychological ill mostly depends on what happens to them after the event has occurred. This is important for a number of reasons.

Firstly, it explains why efforts to 'screen' out vulnerable people before a PTE happens are likely to be unhelpful, since it is impossible to 'screen' for the level of post-incident support people will be provided with or what other subsequent stressors they might be exposed to. However, organisations that are cognisant of this should be able to manage proactively the post-incident period and thereby increase their organisational resilience. Secondly, from an organisational perspective, those close to the potentially distressed individual, including, importantly, managers and colleagues, are ideally placed both to provide high levels of social support after an incident has occurred and to 'manipulate' how much pressure, at least from work, individuals will experience during the post-incident period.

There is, therefore, good scientific and economic arguments for organisations that predictably place their personnel in harm's way to provide effective and proactive post-PTE management. However, doing so can be challenging. Firstly, in order to establish such mechanisms, organisations must be cognisant of which personnel have been exposed to traumatic incidents. Whilst major events often attract managers' attention, less physically traumatic, and therefore less obvious, events may also be associated with the development of mental health problems. This may also be the case with 'near miss' events.

Secondly, the majority of people exposed to PTEs deal with them without suffering prolonged distress or developing formal psychiatric illnesses[9]. Organisations should therefore direct the majority of their efforts towards supporting the small proportion of personnel

who might benefit from them, rather than the larger number who would not. This approach allows for those who do not need intensive support to avoid undue interference, optimising the recovery environment by ensuring the provision of social support and minimising exposure to other stressors for those showing signs of distress. It also enables those who do not recover to be directed to professional sources of help in order that they can receive early and effective treatment according to nationally agreed protocols[9].

POST-INCIDENT INTERVENTIONS

Older, single-session models of post-incident management, such as 'critical incident stress debriefing' (CISD), failed to follow the above principles. When subjected to scientific scrutiny these interventions were found not only to lack effectiveness but also to have the potential to cause harm[10]. For instance, CISD, which was developed within the US emergency services, initially aimed to prevent the onset of PTSD through the use of a single-session brief psychological intervention within the first few days after a PTE for everyone involved. However, this 'one size fits all' approach does not take into account the high degree of variability in individuals' recovery trajectories; that is to say, that those personnel who exhibit early post-incident distress frequently do not go on to develop post-incident illnesses and those who initially cope well can become ill over time. This understanding led to the suggested use of 'watchful waiting' for a month or so after an event, followed by a formal psychological health check after about a month[9]. One month was chosen as, in the main, this is sufficient time for most of those who are going to recover to have done so, and for most of those who will become unwell to have developed sufficiently clear symptoms to allow their disorder to be diagnosed by a suitably trained practitioner.

WHY EMPLOYEES DO NOT SEEK HELP

As highlighted in a recent legal case against the Ministry of Defence by ex-service personnel who claimed to be suffering with psychological injuries as a result of their military service, stigma is a very real and significant issue for the UK armed forces[11]. Stigma also acts as a significant barrier to care for non-military organisations[12].

Stigma has been defined as something that sets an affected individual apart from others[13]. It can be split into internal, or self-stigma, and external stigma. An example of the former is the belief that asking for help for mental health problems will lead to a premature end to one's career, while an example of the latter is the belief that people who suffer from mental health problems are universally weak and cannot be trusted. As a result of stigma, many employees who suffer mental health problems, linked to their work or otherwise, are often hesitant to seek help. This is problematic as untreated mental health disorders are likely to lead to lessened productivity, decreased quality of life and a greater chance that an individual will prematurely leave their employment. However, whilst many employees report being concerned about the consequences of seeking help, doing so is actually highly unlikely to limit an individual's career options, except perhaps in the short term while they undergo treatment.

The *Equality Act 2010* (and previously the *Disability Discrimination Act 1995*) requires employers to make reasonable adjustments to take account of enduring mental health disorders; simply making those with mental health problems redundant or preventing them from being promoted, without considering reasonable adjustments to accommodate them, is against the law. However, individuals who exhibit persistently poor performance, secondary to mental health problems or otherwise, may well face barriers to their career progression – not seeking help, therefore, may actually lead to the very outcomes a hesitant distressed individual was trying to avoid.

ORIGINS OF TRiM

Responding to the emerging concerns highlighted above, in 1998 the Royal Marines Commandos began to establish a PTE management process attuned to their close-knit culture and the need for personnel to remain occupationally effective in highly challenging conditions[14]. Although developed before the 2005 NICE PTSD management guidelines, the methodology of the Trauma Risk Management (TRiM) system is very much in keeping with what NICE later suggested as best practice.

TRiM is effectively a peer-delivered psychological first-aid process. It is delivered by TRiM practitioners who are non-medical personnel trained to be able to monitor those exposed to PTEs in order to assess what support, if any, they might benefit from. Importantly, the TRiM process aims to promote organisational resilience by not assuming that individuals will become ill. Instead, personnel identified as suffering with an early, post-incident, psychological reaction are provided with supported management from within their department or sub-unit in a timely fashion. Also, within a TRiM-aware organisation both managers and TRiM practitioners will reinforce the 'normality' of early psychological symptoms and engender an expectation of recovery.

Distressed but not ill personnel are not exposed to overly complex solutions or encouraged to seek immediate recourse to mental health care or evacuation. Within the military, these techniques are often referred to as 'PIES' – Proximity, Immediacy, Expectancy and Simplicity[15]. PIES refers to symptom

A typical TRiM-managed incident

The following fictional example shows how the TRiM management system might be activated and implemented.

Six personnel from a regional fire service attended a military air show one Saturday. Five were from one fire station whilst the other attendee, Bob, came from a local fire station having heard that a spare ticket was available. Although he was keen to go to the air show, Bob did not really know any of the other firefighters; all had worked for the fire service for many years. The show was going well until a mid-air crash caused a fireball of metal, from the planes, to hurl into the crowd. Although the firefighters initially might have been in some danger, once the remnants of the planes fell to earth, all six went to render what assistance they could. The work they carried out over the next hour or so until the emergency services arrived was grizzly. Because of the geographic situation, more than anything else, Bob worked by himself.

At the Monday morning planning meeting, the watch leader responsible for the five personnel collared the fire station TRiM team leader. It was decided to hold a TRiM planning meeting. The station's second-in-command, the watch leader, the station's welfare and union representative, and the TRiM team leader attended. Discussions at the meeting identified that Bob had been present at the air-show incident, as well as the five from the other station.

Those attending the TRiM meeting heard about the unpleasant nature of the tasks that the six firefighters had undertaken. It was decided that three actions should follow.

Firstly it was decided that all the station's personnel should be briefed about the incident and provided with an outline of the incident in order to dispel rapidly spreading rumours. The briefing would also serve to provide some basic information on the nature of traumatic stress reactions, how people can help themselves and where they might seek additional help or support. The thinking behind this action was that well-informed unit personnel would be suitably placed to support colleagues and it was also possible that other unit members had been at the air show, albeit perhaps further from the incident itself. It was worth noting that none of the people based at the station in question were actually involved in dealing with the incident themselves.

Secondly, it was decided to see the five people from the station together for a group risk-assessment interview. The interview would be conducted by the TRiM team leader and one of the recently trained TRiM practitioners from the unit. The aim of the risk-assessment interview was to find out how all five personnel were functioning and to identify whether any of them might benefit from extra support.

A team risk assessment was deemed appropriate as the five had previously worked well together and, from the information available at the planning meeting, they had also worked well together during the air-show incident.

Lastly, it was decided to ask the TRiM team leader at the other fire station to ensure that Bob was interviewed in order to identify how he was coping. Although the main planning meeting considered whether or not Bob should be invited to attend the group assessment with the other five firefighters, since he was previously unknown to the rest of the group and appeared to have had a different experience to them during the incident, it was felt that his own station's TRiM team would be better placed to properly assess him and to provide him with any support he might subsequently benefit from.

The outcome of these three actions ensured that the needs of all six personnel were considered. Feedback from the TRiM practitioners to the unit managers, taking into account confidentiality, allowed all six personnel to be supported effectively, so that by the time they were followed up about a month later, none required referral. Even though only two of the six had registered as being more than mildly affected at the initial risk assessment, all six were followed up because the TRiM practitioners were well aware that even those who may at first appear to be coping well can go on to suffer significant symptoms over time.

management being delivered proximal to the workplace, including combat zones, and delivered immediately to those who need it, with the expectation of occupational recovery and using simple rather than complicated solutions to emergent issues. The use of these principles has been found not only to have utility in the short term but to prevent longer-term difficulties as well. For instance, a 20-year follow-up of Israeli war veterans who suffered with acute stress reactions found that the more PIES principles applied in the immediate aftermath of an individual suffering from an acute stress reaction, the better their outcome was 20 years later on[15].

Although TRiM was pioneered within the Royal Marines, it has since been adopted by a wide variety of non-military organisations, such as the Foreign and Commonwealth Office, the British Broadcasting Corporation and a number of the emergency services, including the London Ambulance Service. TRiM aims to be NICE-compliant, in meeting the aims of both the 2009 NICE public health guidance on promoting mental wellbeing through productive and healthy working conditions, and its 2005 guidance on the management of PTSD in adults and children in primary and secondary care[2,9].

TRiM – EARLY IDENTIFICATION AND MANAGEMENT

TRiM is not a mechanism to prevent PTSD; instead TRiM aims to provide an early indication of who may go on to

develop formal illnesses and to empower managers to implement management plans which may help create the best possible conditions for psychological recovery to occur.

TRiM practitioner training aims to equip non-medical personnel to manage the psychological aftermath of a traumatic incident or series of incidents. Training covers a wide subject matter including psychological aspects of incident site management, how to plan for the psychological needs of personnel after an event, how to conduct a semi-structured risk-assessment interview and how to conduct basic psycho-educational briefings.

The TRiM course is a combination of didactic teaching and role-play. At the end of the initial two-and-a-half-day course, TRiM practitioners will have learned what leads people to developing mental health difficulties after a PTE, how to carry out a one-to-one structured risk assessment, both shortly after an event and again a month later, and how to use the information gained from the risk assessment to optimise the opportunity for personnel to recover well after being exposed to a PTE. The team leaders' course focuses more on planning how to deal with the psychological aftermath of a PTE, carrying out risk assessments in small groups and in supervising TRiM practitioners.

THE TRIM INTERVIEW PROCESS

The TRiM risk-assessment interview process aims to identify the presence of 10 evidence-based risk factors that are all known to be associated with the potential to develop longer-term psychological problems (see table 1, above right). The risk assessments avoid in-depth discussion of emotions and instead concentrate on following a semi-structured discussion about what happened before, during and after an incident.

Risk assessors are taught to avoid emotional catharsis during the risk assessment and to gently 'shut down' the interview should an interviewee become increasingly distressed. There is evidence that one of the reasons that some of the earlier trials of single-session debriefing had such poor outcomes was that those who were already highly distressed did especially poorly when forced to re-tell the story of their traumatic experience (a process which is termed 're-traumatisation')[16].

Whatever the outcome of the risk assessments, TRiM practitioners would try to ensure that effective support is put in place by managers and colleagues of personnel who have experienced a PTE. Should anyone be identified as being at substantially higher risk of developing longer-term problems, the TRiM practitioners would have the option, and indeed would be encouraged, to discuss their concerns with the team manager or more experienced TRiM practitioner, medical officer or mental health professional. Where necessary TRiM practitioners could assist highly distressed personnel to take up an early referral for a professional psychological health assessment, for example, through an occupational health department.

Table 1: TRiM practitioners' list of risk factors for assessing the risk of developing later psychological disorders

1	The person perceives that they were out of control during the event
2	The person perceives that their life was threatened during the event
3	The person blames others for what happened
4	The person reports shame/guilt about their behaviour during the event
5	The person experienced acute stress following the event
6	The person has been exposed to substantial stress since the event
7	The person has had problems with day-to-day activities since the event
8	The person has been involved in previous traumatic events
9	The person has poor social support (family, friends, unit support)
10	The person has been drinking alcohol excessively to cope with distress

Finally, about a month after the initial assessment, a second set of interviews would be undertaken in order to ascertain whether the exposed individuals had adjusted to, or coped with the psychological aspects of the incident. Satisfactory adjustment would be taken as a substantial lowering of the TRiM risk-assessment score at the second risk-assessment interview and also agreement between the TRiM practitioner and the interviewee that any temporary problems were resolving. The follow-up interviews are done on a one-to-one basis. Those who had not adjusted to the event would either be referred on for help or monitored again if the adjustment had been slow. TRiM practitioners will have easy access to supervision and co-support at all times.

THE EVIDENCE THAT TRIM HELPS

The TRiM process has been subjected to a considerable amount of research including a large randomised controlled trial carried out in the UK armed forces[17]. Studies have also been done looking at whether TRiM can measure changes in psychological health after traumatic events[14] and whether TRiM training can alter perceptions towards mental health problems[18]. The summation of this and other research has shown TRiM to be highly acceptable to those whom it aims to help,

CONCLUSIONS

- **Organisations** that predictably place employees in harm's way are both morally and legally bound to put measures in place to ensure they cater for possible adverse psychological consequences resulting from exposure to potentially traumatic events
- **There** is scant, if any, evidence to support pre-event, or indeed pre-employment, screening for putative psychological vulnerability
- **The majority** of people exposed to potentially traumatic events recover without the need for complex interventions. The National Institute for Health and Clinical Excellence (NICE) advises a period of 'watchful waiting' followed by a formal assessment of psychological health after a month
- **Trauma Risk Management** (TRiM) is a NICE-compliant peer-support system designed to empower organisations to deal with the psychological aftermath of traumatic events
- **TRiM** aims to deter managers from outsourcing post-incident psychological first aid, which has the potential to be harmful, and instead builds upon organisational cohesion, which has been shown to be beneficial to mental health
- **Successful** application of TRiM allows organisations to both facilitate social support and, temporarily, to decrease employees' exposure to further high-intensity stressors
- **After** a month, those who are found not to have recovered are encouraged to seek professional support; in this sense, TRiM aims to help overcome the stigma associated with mental health problems
- **Although** developed by the UK armed forces, TRiM has been successfully used by a variety of non-military organisations, including the emergency services, media organisations and the Foreign and Commonwealth Office

not to cause harm, to improve organisational functioning, to be able to measure changes in psychological health over time after a PTE and to be able to change trainee TRiM practitioners' attitudes towards dealing with stress in others.

The data is highly supportive of TRiM although it is fair to say that TRiM is not 'penicillin' for PTSD. Preventing PTSD is not currently possible, but through the use of psychological first-aid processes, such as TRiM, organisations can maximise the opportunity for personnel to remain resilient when exposed to traumatic events, and thereby stay productive. TRiM also ensures that the minority of people who need mental health support after experiencing a traumatic event are encouraged to seek it. ■

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Notes

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