

# Psychological impact of traumatic events

## Guidance for trauma-exposed organisations

**TRAUMATIC** events are often unpredictable, uncontrollable and can provoke feelings of fear and anxiety. Some employers, by the nature of the work, routinely expose their staff to traumatic events. These 'trauma-exposed' organisations, examples of which include the emergency services, military, media and charities operating in conflict zones, have both moral and legal duties to ensure that they look after the health and wellbeing of their staff.

The psychological wellbeing of employees is likely to significantly affect their functionality at work and can also have a ripple effect on their family, organisational productivity, and on wider society. Therefore, paying due care and attention to the psychological impact of traumatic events is an important consideration for all trauma-exposed organisations.

### IMPACT OF TRAUMATIC EVENTS ON ORGANISATIONS

While most individuals do not suffer longer-term psychological problems after exposure to a traumatic event<sup>1</sup>, a significant proportion are likely to experience short-term distress which generally dissipates after a few weeks. During this period, however, organisational productivity may be significantly affected and the risk of staff underperforming can be high. A small proportion of those exposed to traumatic events may also suffer from trauma-related mental health problems, including, but not restricted to, post-traumatic stress disorder (PTSD), anxiety and depression<sup>2</sup>. For example, research carried out on trauma-exposed occupations shows that up to one-third of security contractors; between 7% and 30% of combat troops<sup>3</sup>, up to 20% of ambulance workers<sup>4</sup>; and 29% of war reporters<sup>5</sup> are likely to suffer from PTSD, and many also report significant trauma-related guilt<sup>6</sup>. These prevalence rates are perhaps not surprising since working in a trauma-exposed organisation can mean the possibility of, for example, attending the aftermath of a crisis, witnessing death and severe injuries, re-living incidents when involved in similar

incidents in the future, trauma-related guilt, and heightened concern for colleagues and loved ones.

### ORGANISATIONAL TRAUMATIC STRESS MANAGEMENT

How best to support trauma-exposed staff is still unclear. Research into group experiences of traumatic events is relatively sparse and most studies are conducted opportunistically after specific events, rather than as part of a well-constructed study with a sample that is representative of a whole organisation. In 2014, the United Kingdom Psychological Trauma Society (UKPTS) published evidence-based guidance for trauma-exposed organisations to help them deal with the ethical, legal, economic and reputational impact of placing their staff into traumatic environments<sup>7</sup>. The aim is for the UKPTS guidelines to be a resource for trauma-exposed organisations to use when formulating their organisation-specific and trauma-focused health and safety policies. This paper elaborates on the UKPTS guidance and the evidence base for it.

### PROMOTING RESILIENCE – PREVENT

The aim of promoting psychological resilience within organisations is to prevent the onset of disorders following a traumatic event. The first element of this is to ensure that personnel entering into a trauma-exposed role are fully aware of the realities of the job so they can decide on their own suitability and preparedness for the higher-risk work they will need to undertake. This requires organisations to be upfront about what the likely occupational exposures might be and not to either over- or understate the traumatic nature of a particular role. There is some evidence from military studies that preparatory mental health briefings prior to deployment to high-threat environments are beneficial for later mental health after exposure to a combat zone<sup>8</sup>. These briefings may cover topics such as what to expect as part of their role, how to manage stress and how to manage challenging situations.

Where possible, organisations should also aim to

*Some employees are routinely exposed to traumatic events which can cause long-term psychological problems. Here, a team from the National Institute for Health Research Health Protection Research Unit in Emergency Preparedness and Response (King's College London) look at what guidance there is for trauma-exposed organisations to help them protect their staff's health and wellbeing.*

provide briefings or information to families, because well-informed family members might help facilitate better social interactions and support. There is considerable evidence that speaking to trusted confidants including family is associated with better mental health after potentially traumatic deployments<sup>9</sup>.

While it is important that potential staff are given an opportunity to consider their suitability to deal with traumatic exposure, it is more difficult for organisations to select staff who may be less susceptible to developing trauma-related mental ill-health. There is no reliable evidence that formal pre-recruitment screening processes have any value in predicting psychological vulnerability in trauma-prone roles. For example, pre-deployment screening of around 2,800 troops was not effective in predicting the post-deployment onset of either common mental health disorders or PTSD<sup>10</sup>. Despite knowing that some personnel will develop PTSD, because of the relatively low prevalence of the condition (in military populations PTSD prevalence is around 4–7%<sup>11</sup>), most participants who were identified as 'vulnerable' by the screening process did not go on to develop the disorder. As a result, the use of screening is likely to exclude capable and resilient potential staff members, while offering false reassurance that those deemed resilient will in fact remain resilient.

Where possible, when concerns about prior history of mental health problems are identified, they should be discussed with appropriately trained and experienced healthcare professionals – consultant-grade clinicians working in trauma services or occupational health professionals who hold the ESTSS (European Society for Traumatic Stress Studies) certificate in psychotraumatology or similar<sup>12</sup>. This helps to raise awareness for possible monitoring and to ensure the staff member is equipped with the necessary knowledge and skills to manage stress, and knows how to ask for support if needed.

Another key element of organisational reliance is fostering cohesion between staff, both horizontally (camaraderie) and vertically (leadership), which has been consistently found to be associated with good mental health. For instance, one study found that leadership and group cohesion are particularly important for mental health and wellbeing<sup>13</sup>, with promotion of these factors considered the best prevention of mental health deterioration in the face of adversity. Essentially, the resilience of an organisation may lie between staff members as much as within individuals. Preparatory group staff training is one way of encouraging strong links within an organisation, as well as increasing the chances of staff feeling in control. For example, a literature

review of hospital staff responses to mass casualty incidents found that disaster drills increased knowledge of procedures and confidence in taking action in such an event<sup>14</sup>. Not only do scenario rehearsals and preparation seem to lead to reduced stress and increased perceived control, they also appear to increase group cohesion, and trust in leaders<sup>15</sup>.

### MONITORING AND INFORMAL SUPPORT – DETECT

Even with the above processes in place, some people are likely to experience potentially severe distress after a traumatic event. The National Institute for Health and Care Excellence's (NICE) guidance on the management of PTSD recommends a period of 'watchful waiting' for the first month after a traumatic experience, rather than enforcing formal professional healthcare services<sup>16</sup>. Individuals' recovery trajectory should be thus monitored; acknowledging that most people, even those who experience severe distress after an event, recover naturally. In fact, immediate counselling and psychological debriefing has been found to be more detrimental to the psychological wellbeing of traumatised individuals than the absence of treatment<sup>17</sup>. Recovery is likely to be linked to accessing informal social support<sup>18</sup>, the use of effective coping techniques (eg exercise<sup>19</sup>) and the passage of time.

Being able to implement watchful waiting within an organisation is thus a key element of secondary prevention and there are a number of initiatives that organisations can adopt to help achieve this. For instance, training peers to be able to actively monitor for traumatic stress signs and symptoms without the need for professional healthcare involvement is a feature of the Trauma Risk Management (TRiM<sup>20</sup>) programme. TRiM was initially set up within the armed forces, but has since been used in media, emergency response and diplomatic organisations<sup>21</sup>. It has been found that TRiM may indeed be associated with reduced sickness absence lengths after a traumatic event and may lessen some of the negative effects of high-trauma exposure<sup>22</sup>.

Other models of peer or organisational support include psychological first aid (PFA)<sup>23</sup>, which may also help staff to be better able to support colleagues showing early signs of distress. PFA is designed to provide a compassionate and supportive response to people who appear to be suffering and may be in need of help<sup>24</sup>. It can involve practical support, including: addressing basic needs; providing comfort; assessing concerns; assisting people in obtaining information and helping them get in contact with social or welfare support; and protecting them from

further harm. Like TRiM, PFA is not an approach that aims to be intrusive or relies on the provision of counselling. Unfortunately, although based on seemingly sensible strategies, research into the efficacy of PFA is currently very limited<sup>25</sup>.

There is considerable evidence that mental health stigma and perceived fears about reputation and career impact can act as barriers to care, which can escalate a normal response to trauma into a negative psychological response<sup>26</sup>. This may be particularly evident in staff who work in routinely high-risk roles, where they may believe there is a need to be mentally and emotionally strong in order to maintain employment<sup>27</sup>.

Additionally, the more time that passes after the incident, the more difficult it becomes to ask for help, particularly when comparing themselves to colleagues who appear to be coping well. This may mean that individuals either fail to recognise, or fail to disclose, that they are having difficulties coping after a traumatic event. Although not specific to occupational trauma, the Adult Psychiatric Morbidity Study found that approximately 70% of people in England with PTSD were not receiving professional healthcare<sup>28</sup>.

While not an easy task, organisations should promote the value of seeking help, reassure their staff of easily accessible and confidential support, and increase information provision and trauma-awareness/anti-stigma campaigns company-wide. A study after the London bombings in 2005 found that increased psychological health in ambulance workers was not correlated with knowing about the support available and how to access it, highlighting a possible stigma issue<sup>29</sup>.

Recent mental health awareness initiatives such as those in the armed forces – ‘Don’t bottle it up’<sup>30, 31</sup> – highlight the benefit of anti-stigma campaigns, with documented increased help-seeking over subsequent years<sup>32</sup>. It is possible that the reduced median help-seeking time for UK military veterans from 14 years post-symptom onset, to approximately two years post-symptom onset, may be a result of increased mental health awareness campaigns, both within the military and within wider society<sup>33</sup>.

It is advisable for trauma-exposed organisations to ensure the availability of appropriately trained and experienced psychological health professionals to provide advice after an unusually traumatic event<sup>34</sup>, or where the whole organisation has been involved and/or affected by the incident. Organisations that have access to mental health professionals who are aware of the organisational culture and processes are likely to benefit more from their advice, rather than from less organisationally aware professionals.

## TREATMENT

A small proportion of people who are exposed to traumatic events will suffer a mental health disorder that requires effective and timely treatment. Each trauma-exposed organisation should decide upon an approach that is right for them, which takes account of the types of work their staff carry out. For instance, trauma-exposed organisations might decide to fast-track to treatment services those personnel with skillsets which are in short supply, or even to provide such services in-house. For example, many armed forces operate their own mental health services that are both cognisant of the needs of the organisation and can provide rapid evidence-based treatment where required<sup>35</sup>. Where the link between the psychological problem and occupational role is less clear, organisations are more likely to deliberate about the degree of involvement they play in the recovery of their staff, although regaining occupational fitness is beneficial for both the individual who has been traumatised and the organisation they work for.

There is plenty of strong research on the best evidence-based care for trauma-related mental health problems, including PTSD, anxiety, depression and other psychological disorders. If after a period of ‘watchful waiting’<sup>16</sup> staff appear not to be spontaneously recovering, then formal, evidence-based interventions are recommended by NICE. The best evidence is for the use of psychotherapy (as described below), with weaker evidence for the use of antidepressant medications, unless primarily used for treating co-morbidity such as depression, or used alongside psychological treatment to maximise the opportunity for a positive treatment outcome<sup>16</sup>.

Trauma-focused cognitive behavioural therapy (CBT)<sup>36</sup> is one of the most effective treatments for trauma-related mental health problems, particularly PTSD, and draws upon the relationships between thoughts, emotions and behaviour. Variations include cognitive processing therapy, cognitive restructuring, cognitive therapy, prolonged exposure and stress inoculation training. In military populations, group cognitive processing therapy has been found to be effective for PTSD<sup>37</sup>. Eye-movement desensitisation and reprocessing (EMDR)<sup>38</sup> is the other main evidence-based psychotherapy for PTSD. EMDR is based on the idea that traumatic memories are inappropriately stored, and through stimulating the brain’s information processing system, through EMDR, the memories can be integrated into a non-traumatic recollection of the event which when thought about does not cause anxiety, fear or other distressing emotions<sup>38</sup>.

In the event that the recommended treatments are ineffective, other less well-researched therapies

## CONCLUSIONS

- **Following** a traumatic event, a minority of people will suffer mental health problems, most of whom will not seek professional help unless they reach a personal crisis point
- **Organisations** that routinely expose their staff to traumatic events should pay specific attention to ensuring the health and wellbeing of their employees
- **Organisational** responses and healthcare intervention efforts should be evidence-based where possible, and there is ample research on this to guide actions
- **Guidance** from the United Kingdom Psychological Trauma Society provides an outline of what works and what does not work
- **Management** of traumatic events should exist within a clear policy framework to protect staff

may be tried<sup>16</sup>, but these are only recommended to be used under the guidance of a trauma-specialised healthcare professional who is satisfied with the reasons for straying from the NICE recommendations.

## SUMMING UP

Numerous organisations, including many that are vital to maintaining society's infrastructure, routinely expose their staff to traumatic events. It is important for these organisations to formulate appropriate health and safety policies to protect their staff to keep them functional, as well as to protect their health. After traumatic events, most people will exhibit resilience, although many will experience short-term distress, which needs careful management and is likely to respond well to effective social support and temporary modifications to workload or type of work. A minority will, however, suffer mental health problems and will benefit from timely access to evidence-based care.

Unless encouraged to do so, most individuals suffering with a trauma-related mental health disorder will not seek professional help unless they reach a personal crisis point. There is ample research on the appropriate actions for trauma-exposed organisations to take to prevent, detect and treat the effects of traumatic stress, and the UKPTS guidance published in 2014 provides an outline of what works and what does not work. We suggest that such organisations would benefit from following the guidance, and should review their management strategies regularly to remain abreast of new recommendations from research.

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## Conflict of interest

The fourth author is the president of the UK Psychological Trauma Society and also consults commercially with organisations about their management of traumatic exposure in the workplace.

## Notes

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