Managing traumatic stress in the workplace

Recent years have seen a growing number of traumatic incidents occurring across the globe, with both natural disasters and acts of terrorism occurring more and more frequently [1]. Understanding the psychological impact of experiencing such an event, and how best to support people who may be suffering with post-traumatic distress or mental ill-health, is now more important than ever. While much of the research in this area focuses on trauma at the individual level, there is a growing literature which explores the impact of trauma from a group perspective [2]. Many people predictably experience trauma in the course of their occupation; for instance, emergency services personnel, relief workers and healthcare professionals would routinely expect to be involved in major incidents. However, individuals working in commercial organizations can also find themselves embroiled in a major disaster by chance. Employers have a duty to act appropriately to protect staff mental health whether trauma exposure is predictable or occurs unexpectedly.

Employees who are exposed to trauma, at work or otherwise, may experience psychological symptoms which may negatively affect their health, productivity at work and relationships with others in the aftermath of the incident. Where trauma exposure is a predictable risk, employers are likely to have various trauma-focused psychological support systems in place; however, this may be considerably less likely in other workplaces. After a traumatic event, managers within organizations that do not routinely deal with trauma may find themselves in the difficult position of having to support their staff and ensure business continuity without any clear plan as to how to do so.

Unfortunately, evidence regarding how best to support trauma-exposed employees in this situation is limited and often conflicting. One intervention that was formerly widely used is critical incident stress debriefing. This type of psychological debriefing involves speaking with affected employees, individually or as a group, to discuss the event and their feelings towards it [3]. However, there is little evidence that debriefing is helpful—in fact, research has consistently shown it is ineffective and can even be harmful [4]. There is also no consistent evidence that any formal interventions within the first month of the incident are effective in preventing the onset of post-traumatic stress disorder (PTSD). Indeed, NICE guidelines [5] expressly recommend against the use of psychologically focused debriefing in the prevention or treatment of PTSD. Instead, they recommend ‘active monitoring’ or ‘watchful waiting’ during the first month post-incident, to help judge whether further intervention may be needed. The good news is that most people recover within this time without needing formal interventions [6].

Good practice guidelines for routinely trauma-exposed organizations [7,8] advocate ongoing monitoring of staff well-being and the use of informal peer support programmes such as Trauma Risk Management (TRiM) [9] and Psychological First Aid (PFA) [10] as first line interventions. However, organizations not routinely exposed to trauma are unlikely to have knowledge of these. While there appears to be good evidence for TRiM and PFA [7], there is mixed evidence on what other workplace interventions may be helpful. A recent review [11] found that there are few long-term follow-up studies or randomized controlled trials to evaluate the effectiveness of post-trauma interventions. Additionally, there are no evidence-based guidelines for organizations whose staff are not routinely trauma-exposed but have nonetheless been affected by a traumatic event by chance. However, it is likely that people who have experienced a trauma would prefer to talk to someone they know and trust in the immediate aftermath. There is therefore likely to be a considerable psychological benefit to being well managed and supported by colleagues. In fact, there are a number of ways managers can support their staff post-incident.

First, it is important that managers can recognize employees who are distressed and know when and how to encourage employees who need professional help to get it. Education focused on ensuring that managers have the skills to identify when an employee is struggling and when they may be ill is thus likely to be useful. Systematic review evidence [2] also suggests that employees lacking adequate disaster training; with prior psychiatric illness or traumatic experiences; with high levels of traumatic exposure during the incident; with poor social support outside of work or poor relationships with managers or colleagues; who felt at risk during the incident; who were injured or knew someone who was injured or killed; and whose personal or professional lives were impacted after the disaster are most at risk of mental health problems post-disaster. A post-incident workshop for managers educating them about symptoms and risk factors may enable them to assess which of their employees may be struggling and in need of support.

It is also important to note that employees may be reluctant to seek help or admit to struggling with symptoms of distress due to stigma [12]. For example, many may be worried about being seen as ‘weak’ or concerned about the impact it could have on their career.
A post-incident managerial workshop could also educate about the barriers to help-seeking and give practical advice for how to reduce mental health stigma (e.g. through raising awareness and advice on supportive listening without judgement).

Consistent evidence shows that effective social support, adequate training for how to respond to emergency situations at work and effective coping strategies (such as confrontive coping rather than denial or avoidance) are the three main ‘resilience factors’ which protect employees from adverse mental health consequences following a disaster [2]. Managers can work to ensure that their employees are well-equipped to cope with traumatic incidents. For example, pre-incident, managers can ensure that employees receive adequate training in emergency preparedness, and an understanding of the use of effective coping mechanisms (e.g. through the provision of coping workshops for their staff). Post-incident they can encourage cohesive teams (e.g. team building) and increase the likelihood that employees can access a support network at work.

A mental health training programme for managers has recently been trialled with the Australian fire and rescue service [13]. Managers completed 4-h training sessions where they covered the key features and effects of common mental health issues; the roles and responsibilities of senior officers in terms of employee mental health; and how to develop effective communication skills for discussing mental health issues with staff. Results showed a significant increase in confidence and improvements in mental health literacy, non-stigmatizing attitudes and beliefs about the manager’s role in recovery. There were also significantly reduced rates of work-related sick leave in their employees. Six months post-intervention, managers continued to report improved confidence and were more likely to have contacted an employee who was suffering from stress or mental health problems than were managers in the control group. A cost–benefit analysis suggested there was a return on investment of nearly £10 for every £1 that was spent on training. This provides promising evidence that a relatively brief psychosocial training for managers may have a positive impact on employees. Whether a similar intervention would help organizations which do not routinely expose their staff to trauma deal with the aftermath of a traumatic event is yet to be determined.

In summary, the potential psychological impact of a disaster is considerable. Whilst guidelines exist for routinely trauma-exposed organizations, as yet there are no clear guidelines for how other organizations can improve and maintain staff resilience in response to disasters which strike out of the blue. However, there are positive steps that managers can take. These include helping to overcome the barriers to help-seeking by reducing the stigma around mental health within their organizations; encouraging supportive workplace relationships; incorporating psychological elements into emergency training so that employees feel more prepared; developing their skills in identifying risk factors and symptoms of distress; and ensuring they are aware of the appropriate services they could refer employees onto. We suggest that psychosocial training for managers could help them develop the requisite skills to effectively support staff after a disaster. Whilst ideally such training should occur prior to a trauma, there may still be considerable benefit in the provision of such training to managers in the immediate post-disaster period.

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References
Policy is better by far, than precept

His suspense was understandable—his next job depended on it. Eagerly, my rope access technician glanced once more at the digital blood pressure (BP) device. For decade after decade, he had swung from one job to the next, travelling the world, negotiating customs and passport control and dodging ill-health while puffing away at a pack a day. Intermittent chest tightness from asthma hadn’t fazed him—the inhalers did their job while he continued his. ‘My BP was OK two years ago’, he contributed, in mitigation. As recently as a week ago, he had passed an exercise fitness test elsewhere. The BP was noted to be high, so he had been advised to pack it in. I didn’t need to ask if anything had changed—the smell of smoke announced the current state of affairs. Centuries after James I, King of England, published A Counterblaste to Tobacco, denouncing the ‘... custome ... harmefull to the braine, daungerous to the Lungs ... ’, the fell fumes were delaying my clinic.

When the whirring of the machine stopped, the writing was on the wall, or rather, the reading was on the screen. Emerging from the haze, the spectre of ill-health had now revealed itself: the pressures were too high for a 2-year certificate of fitness. Seeing the government health warnings had had no success, I added my specific verbal message and plea to him. As per offshore industry occupational health practice, I put my signature to a 3-week certificate and advised him to consult his general practitioner with my letter. ‘You’ve opened my eyes’, he said gratefully, ‘... I am giving up now.’ A week later, he emailed to say it was still holding.

Over the years, my worker had kept a slim figure and consumed alcohol in moderation, but went astray in the area of smoking. Reflecting on this case, I am pleased that the game of delayed-action Russian roulette had a (relatively) happy ending. In the game of cat and mouse with risky health behaviours, we realize that while the mouse has only one life, the cat can claim many. I’d like to think that my efforts will help my hardy rope access technician avert an untimely health catastrophe.

In the now iconic move, when John Snow arranged for the removal of the pump handle at Broad Street in Victorian London, the flow of contaminated water stopped, and the tide of cholera was stemmed. It would appear that the forces that govern human behaviour—including health behaviours—are also subject to the laws of motion. For our purposes, the law of inertia is of relevance—human behaviour will continue its trajectory unless compelled to change by another force. It is probably uncontroversial to state that the compulsion of policy is less disruptive than the impulsion of a stroke (or attack) of ill-health.

In occupational health, as indeed in other areas of public health practice, time and time again, policy has been borne out to be better by far, than precept.

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