RCN Working Well Initiative Guidance on traumatic stress management in the health care sector

Carol Bannister, RCN Professional Nursing Department, and Barry McInnes, RCN Counselling Service.

Introduction

As part of Royal College of Nursing (RCN) Congress 2000, RCN members discussed the need for a comprehensive investigation into the effects of post traumatic stress on the well-being and health of nurses. The wide-ranging discussion included: the need for standards and effectiveness in the management of post traumatic stress; issues of burn out; the inability of nurses to find space to sit and talk to each other following traumatic incidents; and the need for all nurses, including student nurses, to be supported by employers following exposure to traumatic incidents. Congress delegates also widened the debate to discuss the effects of stress generally upon the nursing workforce.

The Congress discussion called for an investigation into the effect of post traumatic stress upon nurses' well-being. As a result of the discussion, the RCN undertook a literature search to determine whether research had been undertaken to assess the scale of the problem for nurses and whether the evidence provided enough information to produce best practice guidance to RCN members and their employers. The RCN also held discussions with leading researchers and members of the UK Trauma Group to identify best practice in the management of post traumatic stress in the workplace. During the process of investigating this issue, the RCN identified a number of key researcher groups who are continuing to work on providing the best models for practice.

As an outcome of the work completed, the RCN has produced this guidance so that all employers, occupational health departments, health and safety representatives, and stewards are able to develop a system for managing post traumatic stress based upon evidence of what works in practice. It is important to note that this guidance may change as a result of new evidence in the future. By publishing this guidance on the RCN website, new evidence can be reviewed and the guidance amended in the future, ensuring that RCN members are kept up to date with the latest research findings and how new research affects best practice. In addition to this, the RCN (2005) has also published *Managing your stress – a guide for nurses.* The RCN (2002a) has also produced guidance on counselling for staff in health care settings in *Counselling for staff in health service settings: a guide for employers and managers*.

The following sections cover:

- traumatic stress and post traumatic stress disorder (PTSD)
- intervention and treatment issues
- nurses, post traumatic stress and PTSD
- the management of traumatic incidents
- RCN recommendations for employers.

Traumatic stress and post traumatic stress disorder (PTSD)

It may be helpful here to briefly distinguish between traumatic stress and PTSD. In a psychological sense a traumatic incident can be defined as an event outside the usual range of human experience, which may present a challenge to the individual's normal coping mechanisms and may result in the individual experiencing a range of potentially distressing reactions and compromised functioning.

It should not, however, be assumed that exposure to a traumatic incident will inevitably lead to psychological complications. Most people are highly resilient, and it is only when natural psychological defences are overwhelmed that significant and potentially lengthy complications may occur.

When an individual's psychological defences are overwhelmed by exposure to trauma, a range of acute reactions may then occur. These acute stress reactions (ASRs) will vary across individuals and for most people these reactions are likely to be transient. They may include: intrusive thinking; crying;

irritability; disturbed sleep and nightmares; wariness; guilt or shame; amnesia; numbing; and even at times elation or euphoria. Such reactions to a traumatic event are normal in so far as many people might experience them, although the range and severity of the reactions will vary across individuals, and with the type and intensity of the traumatic event.

It should be noted that such ASRs may be common to a range of psychological disorders including post traumatic stress, anxiety and depressive disorders. As already mentioned, many are likely to be transient and self resolving. Some, however, may progress to PTSD and depressive, anxiety or phobic disorders. In some cases they may persist for years after the original trauma and resurface in response to other stressful situations.

The presence of one or more ASRs, therefore, is not in itself indicative of the presence of PTSD. PTSD is the term used to describe a specific cluster of symptoms which continue to be experienced by individuals at least one month after the original traumatic event. For a diagnosis of PTSD the person must have:

> *"been exposed to a traumatic event in which……(i) the person experienced, witnessed, or was confronted with an event or events that involved death or threatened death or serious injury, or a threat to the physical integrity of self or others…..(and) (ii) the person's response involved intense fear, helplessness or horror."* (American Psychiatric Association, 1994)

A range of other criteria must also apply, notably the presence of a range of symptoms which fall into three main groups or clusters:

1. Intrusive – for example intrusive thinking or imagery, nightmares, re-experiencing aspects of the event, flashbacks.
2. Avoidant – for example avoiding thoughts/feelings about the event, avoiding reminders such as people and places, amnesia, withdrawal, emotional numbing, sense of foreboding.
3. Arousal – for example sleep difficulties, irritability, loss of concentration, hyper-vigilance.

For a diagnosis of PTSD the disturbance should also cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

In the majority of cases the intensity of the individual's reactions begins to reduce over a period of a few days or weeks but, for some, symptoms persist. There appears to be considerable expert clinical consensus that key to the outcome is the individual's ability to adequately process the initial "flood" of sensory impressions of the event into a factual and conscious impression. The trapped sensory impressions are the basis of flashbacks and intrusive phenomena, and their processing is probably blocked by a combination of psychological defences and biochemical activity.

The likelihood of developing PTSD appears to be in part related to the type of trauma experienced. For example, one year after the Kegworth air crash, 40% of survivors were diagnosed as suffering PTSD, while a study of 188 road traffic accident victims found that 19 (10%) met the criteria for PTSD after one year.

Studies in the US have estimated current rates of PTSD in individuals exposed to traumatic events as ranging from 5-11%, and the lifetime prevalence of PTSD as 7.8% of the population. PTSD may go unrecognised for years or may never be detected. It can be devastating for the individual in a variety of ways, and a study by Tarrier et al (1999) indicated a very strong correlation between successful treatment of PTSD and the likelihood of being in employment.

Intervention and treatment issues

This section distinguishes between early interventions into the aftermath of traumatic incidents and the treatment of PTSD itself.

The area of early interventions after trauma (and particularly the use of single session interventions often referred to as debriefing) has been the subject of considerable debate in recent years. Debriefing was originally developed as a group-based intervention in response to major disasters such as the Piper Alpha disaster. Originally a highly structured, group-based early intervention designed to facilitate processing of the event by those experiencing it, its form has been adapted to various different situations including one-to-one debriefing.

Part of the assumption underlying debriefing is that it offers a structured opportunity for those involved in a traumatic incident to 'make sense' of the experience – essentially the processing of the initial sensory impressions into factual and conscious ones, thereby alleviating the likelihood of subsequent development of PTSD. Recently, however, the issue of whether debriefing is both effective and sufficient has been brought into considerable question.

A systematic review of brief early interventions by Rose and Bisson (1998) found that on balance there was no consistent evidence for the effectiveness of debriefing, and questioned its continued use. This view is supported by many leading trauma experts and is echoed in the Health and Safety Executive (HSE) (1998) study into the management of traumatic incidents in the workplace. It should be noted, however, that even if the evidence for efficacy is in doubt, recipients of debriefing often report the intervention to be helpful and supportive.

More recently National Institute for Clinical Excellence guidance (NICE, 2005) on the management of PTSD in adults and children in primary and secondary care has discouraged the systematic use of single session interventions that focus on the traumatic incident. Instead it proposes the principle of "watchful waiting" for people where symptoms are mild and have been present for less than four weeks, with follow up at one month. The guidance also emphasises the value of addressing the practical, social and emotional support needs of those affected by trauma.

The NICE guidance also proposes that trauma focused psychological treatment in the form of cognitive behavioural therapy (CBT) should be offered to people exhibiting severe post trauma symptoms or PTSD in the first month after the event.

From an organisational perspective, most trauma experts seem to agree that some kind of intervention is appropriate – the key question regards the form it should take. There is virtual consensus that organisations should provide an integrated response to traumatic incidents and that debriefing should not be provided in isolation. The elements of an integrated response might include a focus on the more immediate needs of the individual – for example offering practical help, responding to their distress and immediate physical needs, and provision of information on normal responses to trauma. The publication edited by Orner and Schnyder (2002) provides a useful recent overview of the role and nature of early interventions after trauma.

The NICE guidance (2005) proposes that following a major disaster consideration be given (by those responsible for coordinating the disaster plan) to the routine use of a brief screening instrument for PTSD for those thought to be at high risk of developing PTSD at one month after the disaster.

A model developed by the Rivers Centre in Edinburgh, a specialist treatment centre for traumatic stress, outlines a comprehensive model termed Psychological First Aid, which provides a useful template for organisations to consider (Freeman, 2001).

An intervention known as "screen and treat" has been developed which involves monitoring survivors' symptoms and referring for treatment only if symptoms do not diminish naturally. Within this model the emphasis is on demonstrating safety, acknowledging the trauma, making support available to those who want it, and providing information, above all with a focus on supporting natural recovery (Brewin, 2001).

The treatment of PTSD, once diagnosed, has been the subject of numerous studies and recent guidance. The Department of Health (2001) guidance on treatment choice in psychological therapies reported best evidence of efficacy for exposure-based and other cognitive-behavioural methods, including eye movement desensitisation and reprocessing (EMDR), as well as evidence for hypnotherapy and psychodynamic psychotherapy.

Most recently the NICE guidance (2005) has built upon the DH guidance by recommending a range of interventions based upon the best available evidence. The guidance underlines the use of psychological interventions as a primary treatment and specifically states that drugs should not be used as a first-line treatment. Where symptoms are present within three months of a trauma it proposes that people are offered trauma focused CBT and discourages use of non-trauma focused interventions such as relaxation or non-directive therapy. Where symptoms have been present for more than three months after a trauma the use trauma focused CBT or eye movement desensitisation and reprocessing (EMDR) is advocated. The guidance finds no compelling evidence for the efficacy of non-trauma focused interventions such as supportive/non-directive therapy, hypnotherapy, psychodynamic therapy or systemic psychotherapy.

Nurses, post traumatic stress and PTSD

What are the issues for nurses and nursing in relation to post traumatic stress and PTSD? In attempting to answer this question, it may be helpful to touch on stress generally, post traumatic stress and PTSD.

Nurses by virtue of their work may be occasionally or routinely exposed to stressful and sometimes traumatic situations in their work. In common with other health service staff, nurses are known to experience higher levels of stress than the general working population (Borrill et al, 1998). Within a nursing or health care context, traumatic incidents may include situations such as being threatened or assaulted, witnessing an assault, being held hostage or providing care in the wake of a disaster.

Exposure to stressful situations – for example stresses inherent in the work, bullying and harassment – may not necessarily come in the form of a single traumatic incident, but depending on the degree and frequency of exposure, individual nurses may exhibit symptoms similar in both nature and severity to PTSD. For example, a study by the RCN Counselling Service's counsellor in Belfast of nurses reporting bullying and harassment has shown many to exhibit most or all of the symptoms of PTSD.

The RCN Working well survey (2002b) included a psycholigical health measure – the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM), developed by the Psychological Therapies Research Centre at the University of Leeds. The report shows poorer levels of mental health correlated with bullying, harassment and assaults on staff per se, but with bullying and harassment from colleagues having a more damaging affect on psychological health than harassment from patients. In relation to post traumatic stress and PTSD specifically, little is known about their real prevalence in the nursing population.

The management of traumatic incidents

As far as is known, there has been no systematic attempt to audit the management of traumatic incidents by health service employers. Anecdotally, the proactive management of such incidents would appear to be very variable, ranging from extremely comprehensive to virtually non-existent. This situation is likely to be exacerbated by what appears to be a lack of clear guidance for employers.

The vast majority of RCN members describing traumatic incidents in the course of their contact with the RCN counselling service feel that their employer has failed to respond adequately to their situation. Many members will have either been or will currently be on sick leave. They often report a lack of any initial practical or psychological support and a lack of ongoing contact or expressions of concern from their employer, and often also their colleagues and managers. It seems very much a case of "out of sight, out of mind", with many individuals languishing on extended sick leave in the absence of any real recognition of their needs and potential treatment options.

An interpretation of this situation is not that employers are routinely exercising wilful disregard, but that many seem not to recognise their obligations towards employees nor have any awareness of how to effectively manage such situations. This applies to human resources and occupational health staff as well as managers.

In practice, nurses and other health service staff often do not come forward readily for help. Many may display an attitude that 'I am ok because I am not a victim or casualty', or 'none of my family have been hurt so I have nothing to complain about'. They may have an expectation that since human suffering

and sometimes death is part of their role, they are meant to be stronger and more in control than anyone else. It may also be that the more time passes since a critical incident, the harder it may become for any request for help to feel legitimate, especially if others involved appear to be coping.

This means that employers should not assume that because staff are not showing overt signs of distress that they are not suffering. A key part of the response needs to be to create a climate where incidents can be discussed openly, both formally and informally, and where staff can voice their normal human reactions and be supported in seeking help if required. Such a climate can be fostered by all staff, but this is an area where managers, occupational health and staff counsellors particularly have a critical role to play.

The role of the employer should not necessarily be to provide treatment, but to routinely facilitate an early intervention after an incident which will provide immediate practical and emotional support, normalise often highly distressing reactions, and as far as possible ensure continued contact with the individual, where necessary referring on to professional trauma support.

The guidance on the development of counselling for NHS staff in England requires that NHS employers provide, as part of their counselling provision, responses to traumatic incidents in the workplace (NHSE, 2000). While this requirement is welcome, only further study will show to what extent employers are acting upon this guidance.

In response to the bombings on the London transport system on 7 July 2005, the Department of Health issued a brief guidance note to the Directors of Public Health of PCTs and Medical Directors of NHS Trusts on the management of acute stress and PTSD as a result of the bombings (DH, 2005). This provides guidance on the short term management and longer term treatment of people in the main groups likely to have been affected by these events, and outlines further sources of help and further reading. While in response to the specific events of 7 July, the guidance provides a useful overview - which has wider applicability - to some of the key issues involved in trauma management.

RCN recommendations for employers

The management of critical incidents should take place within a clear policy framework, and should provide an integrated response to those affected, as outlined earlier. Interventions should be evidence based wherever possible. The following RCN guidance takes into account key research evidence available to date. We recommend that employers review their arrangements every six months to take account of new recommendations from researchers.

Risk assessment

There is a legal requirement under the Health and Safety at Work Act (1974) and the Management of Health and Safety at Work Regulations (1999), that employers undertake an assessment of risk to health arising out of the work that staff do. Rick, Young and Guppy (HSE, 1998) produced a review of literature and current practice for the HSE in order to identify the way forward in the management of critical incidents. They recommended that employers assess the risk of psychosocial hazards in the workplace to build up a picture of the problem. They concluded that the risk assessment must include an identification of the hazards that lead to PTSD, evidence that these hazards cause harm and an assessment of the effectiveness of the management procedures already in place. The following RCN recommendations about risk assessment and management are drawn from the HSE report and other research evidence.

1. Employers must investigate and analyse critical/traumatic incidents in order to confirm that their systems are effective

- organisations must have robust investigation and reporting systems, which reflect the real incidence of critical incidents within their organisation
- employers must audit their reporting systems to ensure that they reflect the true situation within their organisations
- investigation and reporting systems must establish a causal link between hazards and harm to staff

- it is essential that employers have clear and measurable aims for any post-incident intervention against which the performance of the intervention can be judged
- all key stakeholders such as health and safety representatives, occupational health staff, counselling services, employee and employer representatives must work together as a multidisciplinary team to ensure that the systems in place to manage critical incidents are effective and that co-working between these groups occurs.

2. Employers must analyse factors which influence the degree of risk including:
- the geographical location of staff
- the physical location of staff
- the physical layout of the building/s
- the security arrangements or devices used
- seasonal variations in risk
- the timing of incidents
- the nature of incidents.

3. The risk assessment must also include analysis of:
- the provision of training for critical incidents
- the provision and availability of occupational health and counselling services to all staff
- recording and reporting procedures
- pre-incident activities which should identify good practice which can then be promoted throughout the organisation.

4. Employers must have a policy for the management of critical incidents
The policy will include:
- a definition of incidents which will trigger action following exposure to a traumatic event.
- the processes for referral to occupational health, counselling or specialist services
- the identification of key services and functions which need to be involved in the delivery of services and their main responsibilities
- clear standards for the delivery of best practice in the management of critical incidents
- procedures for monitoring and evaluation which judge the effectiveness of the management systems in place
- a review date to evaluate the effectiveness of the policy and to ensure that the operational policy is based upon current best practice evidence – this should be done at a minimum of six monthly intervals.

5. Training in the operation of the policy:
- the psychological impact of exposure to traumatic incidents on staff, and the range of reactions which could be anticipated
- the signs and symptoms of PTSD and associated psychological disorders
- the definition of critical incidents which should trigger action
- the roles and responsibilities of staff, managers, occupational health and other functions such as counselling and specialist services
- each person's responsibilities within the policy and what they must do.

6. Referral for treatment where symptoms of distress have not diminished or are increasing
- clear referral pathways and criteria
- ensure involvement of occupational health and counselling services

7. Review and audit
- a multidisciplinary/multi-agency team or group which takes responsibility for the review of policy and procedures
- the employer must ensure that there are monitoring processes for the management of critical incidents in place
- the occupational health department and counselling services must ensure interventions for post traumatic stress and PTSD are included within their clinical audit systems
- the employer must check that the critical incident management process meets the needs of the employees

- there must be a documented review of the management of each incident which must feed into the multidisciplinary group and the wider development of the policy whilst preserving client confidentiality.

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