

From sympathy to empathy – organisations learn to respond to trauma



Mandy Rutter reflects on the post-NICE options for critical incident management and the empathic power of peer support

We live in thought-provoking times when it comes to helping organisations recover from traumas. Debriefing was the backbone of our trauma response. There is no doubt that individuals and clinicians alike found debriefing useful for a variety of reasons, not least of which was that it appeared to be a universal and 'expert' approach. The illusion of the clinician having all the knowledge and all the answers was upheld in the debriefing approach. In addition, at some level, debriefing encouraged workplace managers and colleagues to leave trauma recovery to the professionals. The tears, the distress and the anger were all to be left for the onsite counsellor to manage. Recovery of the traumatic incident was focused on those staff affected. Recovery was not considered as involving the group, team or organisation.

The advent of the National Institute for Health and Clinical Excellence (NICE) guidelines¹ meant that as clinicians we could no longer have the one-size-fits-all approach, known as debriefing. However, without debriefing what would be in its place? This was a question asked by many clinicians, as if we had lost our knowledge of how to help distressed people. The gap left by NICE has provided us with a great opportunity to review, analyse and think about what our clients and customers do want after a trauma. This process of reviewing trauma response has led us to uncover new, creative and perhaps unexpected solutions to organisational trauma response.

Having told us what not to do, NICE did suggest that 'practical support delivered in an empathic manner is important in promoting recovery from PTSD'. But the question here is who should be providing the 'practical support'. Is it necessarily

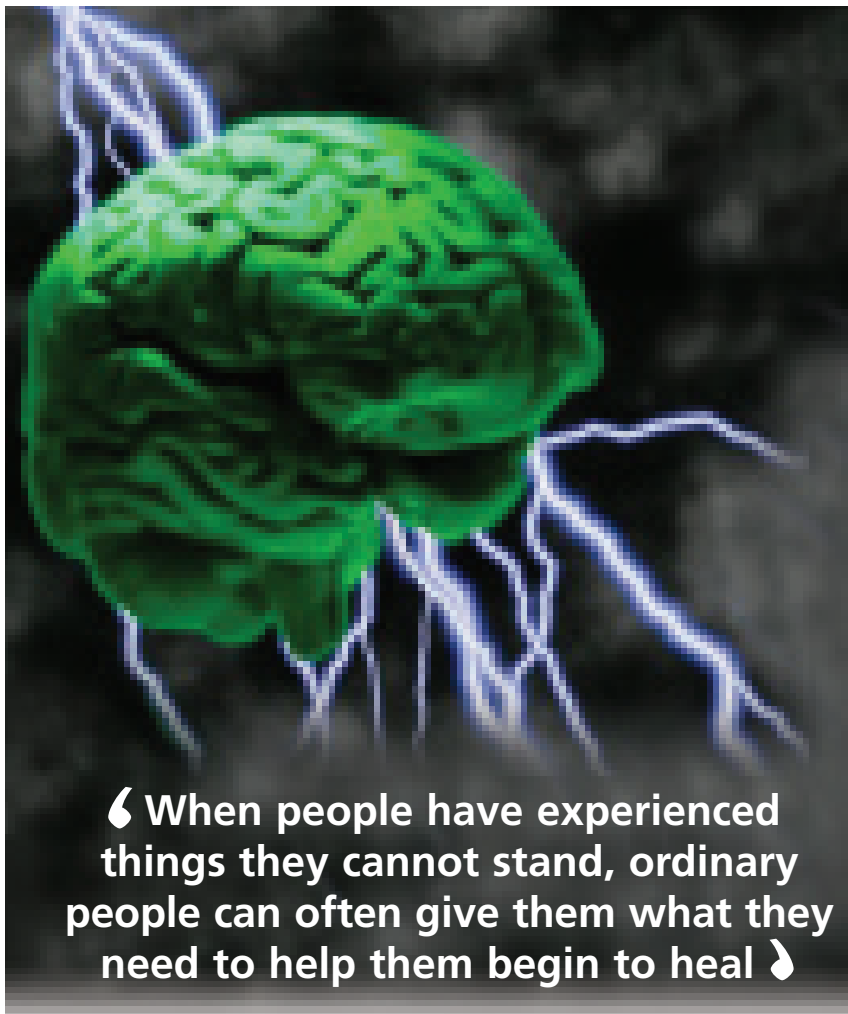
the role of counsellors to provide that immediate practical support, are counsellors the only people who can be empathic and indeed are counsellors available or able to deliver the support as and when it is required?

Over the last two years we have asked various groups of staff involved in traumatic incidents what support was, or would have been, most helpful to them at the time of a trauma. While this was purely anecdotal, the majority of staff consistently reported that they wanted to talk about the incident. However, they reported that they wanted to talk and receive help from their friends and colleagues who they knew and who they were most comfortable with. This is reinforced by Orner et al² who identified that for employees in high risk occupations 71 per cent preferred to talk to a colleague, and 85 per cent preferred to talk in a free and flexible manner about the incidents they experienced. Only nine per cent preferred to talk to an independent professional, but this is still almost one in 10 employees.

The argument for strengthening the social support network after trauma is further evidenced by work in Australia³ identifying that police officers who had good social support from peers and supervisors, a positive attitude to expressing emotion and ease in talking about trauma at work were less likely to have PTSD symptoms.

The focus on the importance of social networks within and outside work comes from research on resilience after trauma. Bonanno⁴ proposed that resilience after trauma (and grief) was characterised by a manageable distress that resolves steadily over time, generally without reaching diagnosable levels and generally without professional intervention. He

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identified that the majority of people exposed to trauma and grief showed a resilient response and that the essential factors associated with resilience were emotional ties to family, social relationships and external support systems.

The recently published work⁵ focusing on trauma management at the Royal Mail Group provides much-needed evidence that the way employees perceive the support offered by their organisation after a trauma plays an important part in their recovery.

Pressure to encourage employers to think about their responsibility to the psychological needs of their staff after a trauma has come from another interesting area, that of Her Majesty's Government. In a recent report⁶ addressing lessons to be learnt from the 7 July London bombings, two relevant comments need to be underlined. On what could have been done better: 'More could be done to spread best practise among employers about how to treat staff after a disaster, particularly those suffering from post-traumatic stress disorder.' And what could be done in the future: 'Examine how we might build volunteers into the official emergency planning/training process given that the most immediate response to any disaster often comes from those people and businesses that happen to be in the immediate area.'

Putting ideas into practice

Moving the evidence and ideas to operational reality

within organisations is another challenge, and again one where we asked questions. If staff want to be supported by their colleagues, how equipped are employees and managers in the workplace to provide the basic practical and emotional support in an empathic manner, during times of a crisis?

The answers we got to these questions were interestingly mixed. Some managers and employees were very definite that while this was clearly an important area to work on, it was not their particular strength and they would always get someone else in to do it. However, this was the minority. In a large number of organisations, there were individuals who either identified themselves, or were identified by their managers and human resources team, as being enthusiastic about providing immediate support to their colleagues in the event of a traumatic incident. Many of these individuals had previous experience as volunteers in Samaritans, Red Cross or St John's Ambulance. Others had studied basic counselling skills or taken Open University courses. And for some, their experience in supporting friends and families through difficult times had led them to want to understand and use that experience to help others in the workplace.

In order to assist human resources staff with the framework for developing a team of 'First response' volunteers, we created a job description, person specification and interview guidelines for recruiting such a team within the workforce. We devised a training course for those volunteers selected utilising the principles of psychological first aid. The training course provided knowledge about typical trauma reactions and offered participants the chance to practise listening and responding skills. There was also an emphasis on the importance of self-care.

The training course itself was a revelation for some participants: 'I now know why I was so spaced out on July 7th, and then felt upset and frightened when I was on my own two days later.' 'I once sat with my injured friend for an hour waiting for the ambulance, I have always felt bad because I thought I didn't do anything to help him, but now I realise that by staying with him, talking to him, and listening to him, I was probably helping him a lot.'

The most difficult task for many volunteer staff on the training course was to demonstrate empathy. The motivation and desire to be empathic was obvious, but this empathic response seemed to require much and varied skill practice. The ability to hear, notice and respond to the distressed person from their point of view was far more difficult for staff than we had imagined. There was a great intensity in many volunteers to find a quick solution that matched the circumstances rather than the person they had in front of them. There was also

a tendency to focus on the details of the trauma rather than how the distressed person was managing themselves during and after the trauma.

However, after 18 months of attempting to bring empathy into the workforce, the training course evaluations consistently commented that the practice element of the course had been the most useful. Participants had gone away from the training reporting to us that because they knew how to listen, they also knew what to say when offering appropriate support matching the needs of their distressed colleagues.

While this training does not claim to reduce long-term post-trauma symptoms, it does extend and complement an organisation's immediate crisis management response by focusing on the human aspects of business continuity. It also strengthens the resilience of the workforce by enabling staff to reach out to each other and feel confident in their own ability to respond. The responsibility for recovery after a trauma becomes a jointly owned task between those affected, those caring for them and the professional clinicians.

'When people have experienced things they cannot stand, ordinary people can often give them what they need to help them begin to heal.' ■

References

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- 5 Rick et al. Early intervention following trauma: a controlled longitudinal study at Royal Mail Group. Institute of Employment Studies, University of Sussex; 2006.
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BACP 13th annual research conference York, 11-12 May 2007

A CW members may well be aware of the 'Improving Access to Psychological Therapies' (IAPT) initiative and all it entails, promises and challenges. While the focus is on counselling in primary care, therapists in all sectors will be interested in and possibly affected by new directives about stepped care and the commissioning of a mixed economy of psychological therapies: NHS initiatives frequently impact on service delivery in other sectors. No matter what the outcome of the Government spending review, the psychological therapy pilots in Doncaster and Newham engage academics, practitioners and social commentators in debate about the delivery of psychological therapies, a debate we will capture at our annual research conference in York, next May.

We're delighted that Dr Tony Roth (University College London) will give a keynote on 'Can research help improve access to psychological therapy?' He is joined by Professor Dave Richards (University of York) who will present on 'Stepped Care; the challenges for the psychological therapy professions'. Dave has strong views about the role of professions in public life and is developing an evidence base around stepped care. Both speakers will update us on current developments in this politically live arena - the debate promises to be challenging and stimulating.

On the first day of the conference, Friday 11 May, we're delighted to welcome Professor Robert Elliott, who has joined Professor Mick Cooper at Strathclyde University. Robert will present on 'Practice-based research on the effectiveness of psychotherapy and psychotherapy training'. His keynote will be followed by a range of research presentations, the opportunity for networking and the conference dinner.

Research papers, posters and workshops will run throughout the conference. Many of the presentations will be of direct relevance to therapists in the workplace, including a paper on the forthcoming systematic review of workplace counselling by John McLeod, University of Abertay, which looks at the implications of the research to policy and practice. There has also been some interesting work submitted on the effectiveness of brief therapy in an employee assistance programme (EAP) and research on whether counselling positively impacts absenteeism in the workplace.

Do join us for a lively conference at the cutting edge of research in a fast developing arena. If you would like further information, please check details in the website at http://www.bacp.co.uk/research/conference2007/brochure_web.pdf or email events@bacp.co.uk

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