Mental Health Services For Work-Related Traumatic Stress

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The occupational experience of traumatic stress reactions in professions such as the emergency services, psychology, psychiatry, medicine and nursing is increasing. Psychological debriefing is probably the most common type of post-trauma support resource provided for those experiencing such reactions. As a recovery resource, debriefing has been readily adopted by mental health professionals. Its popularity can be attributed to the marketing of what appeared to be a readily applicable and cost-efficient solution to a growing problem 1. However, this popularity has deflected attention from evaluating the efficacy of the process and objectively ascertaining the validity of these assumptions [1,2].

Evaluation in this area is problematic for a number of reasons. Difficulty in predicting when or where a disaster will occur or who may be involved renders the task of obtaining baseline information from populations before an event occurs problematic. In the absence of this data post-event assessment (when mental health assessment and intervention typically occurs) tends to over-estimate the extent of traumatic reactivity making the situation appear worse than it is [3]. This is not the only problem. Rigorous evaluation requires that, at the very least, the outcomes of a treatment group are compared with data from a control group (both matched on salient characteristics) from whom the treatment has been withheld. This raises an ethical dilemma. On the one hand, withholding an intervention believed to be beneficial could be construed as unethical. But this may be what is required if the efficacy of an intervention is to be objectively determined. Without a rigorous evaluation the effectiveness of an intervention with respect to its role in hastening the process of recovery will remain unclear. Moreover, failure to evaluate could result in survivors being subject to 'therapeutic' regimens which are unnecessary, less effective than alternatives, or which may even make things worse. Consequently, sound ethical practice is ultimately promoted by rigorous evaluation. What has evaluation research revealed about the effectiveness of debriefing?

Cross-sectional anecdotal research, undertaken shortly after traumatic exposure, suggests that participants perceive debriefing to be beneficial [2,4]. However, several longitudinal studies comparing personnel who received a debriefing with those who did not concluded that debriefing was ineffective [5,6,7]. Indeed it may even contribute to the development or exacerbation of psychological reactions [4, 8]. Debriefing does not appear to exert a positive influence on post-trauma psychological morbidity. This conclusion calls into question the debriefing process, and raises issues about the nature of recovery and the delivery of mental health services.

With respect to the debriefing process itself, the complexity of traumatic events and differences in risk status between affected populations suggests a need to explore the relationship between alternative recovery methods, the nature of the trauma experienced, and the characteristics of those involved [2,5,6]. Debriefing is a short intervention provided at the start of a recovery period that may last for several months. Questions about the efficacy of debriefing over the longer term [4,5,6,7] suggest that intervention effectiveness should be evaluated with respect to its relationship with the demands faced by survivors over the entire course of the recovery period and not just with respect to the immediate aftermath of a specific incident. For example, exposure to the traumatic recollections of others, funerals, anniversaries, and the legal processes involved in assigning blame and addressing compensation issues are commonly occurring post-event demands which can extend human reactivity well beyond the period of tangible impact [3]. The complexity of the recovery process is further heightened by the presence of factors

which exert a persistent influence on survivors. Talking about traumatic experiences within a socially supportive context is crucial to recovery [3]. However, prevailing social, cultural and organisational norms and practices (for example, professional norms that advocate emotional denial, threats to self-esteem from receiving help, and supervisory practices) can constrain survivors' willingness to discuss their feelings and emotional reactions [3]. The timing of debriefing renders it less capable of assisting survivors to deal with these long-term environmental demands hindering the process of adaptation over the longer term [3].

The above conclusions also raise issues concerning the nature of mental health service provision. Given the under-funding of mental health services, and the fact that their provision is often hard won, the use of scarce resources to fund ineffective practices (which may even contribute to psychological reactivity) is ethically questionable. Moreover, the limited opportunities afforded by debriefing as a means of accommodating the range and complexity of recovery issues renders the process little more than an expedient 'quick fix' solution to more complex social and organisational phenomenon. Debriefing also increases the demands on participants to discuss emotionally threatening experiences and feelings. This, particularly when set against cultural and organisational norms which interpret such behaviour as indicative personal inadequacy and weakness, can impose additional distress on participants. To do so when the benefits are dubious raises a serious ethical issue.

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A further issue is raised by the fundamental manner in which reactions to traumatic events are conceptualised by those responsible for

designing and implementing recovery resources. Essentially, reactions are automatically attributed with pathological status. But pathological reactions are not inevitable. Working in highly traumatic contexts can, under certain circumstances, be a professionally rewarding experience[3]. However, the imposition of a debriefing, particularly if presented as essential for dealing with 'inevitable' negative emotions, may undermine "natural" adaptation processes and trigger a traumatic stress reaction which may otherwise not have developed [1]. This problem reflects, at least in part, the orientation of the mental health professionals who work in these contexts.

The operation of a medical/ biopsychological model generates a mental set that predisposes mental health practitioners to interpret situations in pathogenic terms. Indeed this predisposition is also evident within psychiatric diagnostic protocols. While DSM IV differentiates between an immediate ìnormalî reaction and post-traumatic pathology, the acknowledgment of this normalcy is undermined by the latter being labelled as 'acute stress disorder'. Generally the experience of a traumatic event is considered to be a sufficient condition to trigger a pathological reaction rather than basing this judgement on a rational evaluation of the needs and status of the person. This perceptual set tends to abrogate the acknowledgment that traumatic stress reactions represent normal reactions to highly abnormal events.

A professional orientation that assumes pathogenic status and which involves imposing "help" can result in debriefing generating a state of learned helplessness in survivors[1]. The transmission to survivors of an attitude that sees maladaptive reactions as being inevitable will lessen their belief in both the normalcy of their response and their ability to help themselves. The possibility that the process may engender dependence raises a further ethical question. A pathogenic orientation hinders the development of an understanding of normal recovery and adaptational processes which could be used to develop preventative programmes[3] and to design recovery programmes for those who are affected that capitalise on 'natural' recovery processes rather than superimposing therapeutic intervention models upon survivors.

As in other areas of health care, a lack of preventative effort not only indicates a misuse of limited resources, it may also result in the exposure of populations to unnecessary suffering and the prolongation of psychological reactions.

While the development of effective recovery and therapeutic resources for those affected should remain a priority, greater attention needs to be directed towards evaluation and prevention. For this to occur professional education and practice must shift from a pathogenic orientation towards the adoption of a wellness or salutogenic model[9] which focuses on mobilising community, social and individual resources and channelling them in ways that encourage self-help and adaptation. Services delivered within a medical/ biopsychological model focus primarily on identifying and treating the symptoms presented by the person and increase the likelihood that the environmental determinants of recovery will go unrecognised. Compensating for this oversight, and the development of comprehensive interventions, requires the adoption of a model that conceptualises the integrated role of biological, psychological and social-community factors in reactivity and recovery. However, the assessment and intervention needs generated by this approach will transcend contemporary professional boundaries, necessitating that planning and service delivery be multidisciplinary in nature. The lack of such a multidisciplinary framework reflects a problem common to all aspects of health care. Specialisation and the compartmentalisation of expertise renders it difficult to provide comprehensive care for complex problems whose nature transcends specialist or professional boundaries.

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In conclusion, the practical, ethical, theoretical and legal benefits accruing from sound evaluation makes this an important activity and one which should be afforded a high priority. The complexity and multi-dimensional nature of workplace mental health issues means that the expertise required for their comprehensive management is unlikely to reside within any one professional discipline. The development of effective and comprehensive procedures will require that professional training be expanded to accommodate multi-disciplinary perspectives and that integrated multi-disciplinary approaches to the management of mental health issues are implemented. Finally, it is important to shift from a predominantly pathogenic orientation to one which focuses on wellness. Such an orientation is a prerequisite to the adoption of preventative approaches to occupational mental health and mobilising the resources of survivors to encourage self-help.

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