Chapter 6

Empirical Data on the Impact of a Critical Incident on the Psychosocial Functioning and the Work Performance of the Employee

6.1 INTRODUCTION

In this chapter the empirical data of the research project are presented as obtained from questionnaires and semi-structured telephonic interviews and then processed and analysed.

In the **quantitative** study, the one-group post-test design was used to quantitatively collect data to determine if employees were affected by the critical incidents they were exposed to and in what way they were affected.

In the study, 80 questionnaires were distributed to 40 pre-selected therapists. After the therapists had been identified they were requested to identify two clients within their existing caseload of The Careways Group referrals who were affected by a critical incident and who were exposed to a traumatic incident as defined in the study, namely "an event that is extraordinary and produces significant reactions in the intervening person. It may be so unusual that it overwhelms the natural abilities of people who have to cope with difficult situations. It may lead to stress, burnout or even PTSD" (Lewis, 1996:15). O'Conner and Jeavons (2002:53) define a critical incident as an extraordinary event that has the potential to cause unusually strong emotional reactions. Although these definitions may seem broad, the researcher agrees that when defining a critical incident the focus should be on the reaction of the individual. The researcher, therefore, defines a critical incident as any incident that causes emotional distress to a person and which affects his or her psychosocial functioning to some extent, whether temporarily or permanently.

The identified clients were then requested to complete a questionnaire when the therapeutic process commenced. The therapist completed a different questionnaire for each of the identified clients when the therapeutic process was completed. A total of 54 questionnaires

were completed by clients and 54 questionnaires were completed by therapists with regard to the identified clients.

In the **qualitative** study, the phenomenological design was applied as a way of data collection and analysis to establish how employees' psychosocial functioning and work performance were affected as a result of the critical incident and what impact the intervention had on their work performance.

In the **quantitative** study (clients questionnaire), the respondents were requested to indicate whether they were willing to participate in the qualitative part of the study. All respondents who indicated that they were willing to participate in the qualitative part of the study then became part of the sample for the qualitative study. With their permission, records of their assessment and intervention kept by The Careways Group were utilised for document analysis. The qualitative part of the study comprised semi-structured telephonic interviews with the respondent and the respondent's direct manager or supervisor. Each respondent was requested to give permission that he/she can be contacted and that his/her manager can be contacted. Of the 54 respondents who participated in the study, 19 indicated that they were comfortable to be included in the semi structured telephonic interview. However, only six respondents indicated that they were comfortable that their manager or supervisor could be contacted to be interviewed according to a semi-structured interview schedule and thus included in the study.

In summary, referring to the data collection process, different ways of data collection were used for different target groups. Questionnaires were distributed to therapists and employees, semi-structured interviews were conducted with employees and managers and the process notes of the therapy process were analysed in the document analysis. The different ways of data collection are illustrated in Table 4.

Table 4: Response rate

Method of data collection	Number of questionnaires distributed	Size of the Sample	Response rate
Questionnaires to clients	80	54	67,5%

Questionnaires to therapists	80	54	67,5%
	Number employees/managers requested to be part of the qualitative study	**Size of the Sample**	**Response Rate**
Semi-structured interview – clients	54	12	22,22%
Semi-structured interview – Managers/ Supervisors	54	3	5,55%
Document analysis	54	54	100%

The response rate for document analysis was the highest as all the respondents who took part in the study indicated that this documentation maybe used for the purposes of the study. The response rate for questionnaires completed by clients and therapists was 67,5% as the therapists took responsibility for the logistical efforts to ensure that clients complete and return the questionnaires. The response rate for the semi-structured interviews with clients was 22,22% and for the semi-structured interviews with managers was 5,55%.The low response rate for the semi-structured interviews might have been the result of clients' fear of being identified and/or their compromised confidentiality. The fact that only six of the 54 respondents indicated that their managers could be contacted may be a indication that they had certain reservations regarding the incident which they had been exposed to and their peculiar response thereto or that they did not share details on the incident and the outcome with their managers or was uncertain what information their manager would be providing to the researcher.

Details on data gathered from the 54 client questionnaires and 54 therapist questionnaires are provided in paragraph 6.2.1(152) and 6.2.2(207) of this chapter. The client questionnaires focused on background information, meaning of work, critical incident, trauma risk factors, situational factors, post-trauma non-risk factors, reactions to a critical incident, shattering of assumptions and interventions.

The questionnaire for the therapists focused on trauma reactions, re-experiencing the event, avoidance of the event, increased arousal, dissociative symptoms and intervention.

The semi-structured interviews with clients and managers that were conducted eight and 12 months after the termination of the counselling sessions focused on the employees' and the managers' views of the employees' reintegration in the workplace, perceptions of still being affected, work performance being affected and psychosocial functioning.

The process (sessions) notes of the therapists were used as collateral information in terms of the client's symptomatic reactions initially, progress in the counselling process and symptomatic reactions on termination.

6.2 ANALYSIS AND INTERPRETATION OF INFORMATION

6.2.1 Data on clients being exposed to a critical incident

6.2.1.1 Demographic information

According to Van der Kolk and McFarlane (1996:3), experiencing trauma is an essential part of being human. There are, however, some factors that play a part in the victim's reactions to a critical incident. Friedman (2003:21) mentions a few pre-trauma risk factors that may have an influence on the individual response to a critical incident. The pre-trauma risk factors mentioned by Freidman (2003:21–23) are gender, age, education, childhood adversity, previous exposure to critical incidents in childhood, prior psychiatric disorders and family history of psychiatric disorders, attention deficit disorder and hyperactivity disorder, previous exposure to a critical incident as an adult, adverse life events and physical health problems.

Some of the pre-trauma risk factors as identified by Friedman (2003:21–23) are reflected in the demographical information of the study and can impact on the development of reactions after a critical incident.

Demographical information was not only gathered for the purpose to determine the impact of certain pre-risk factors on the respondents' reactions but also to determine the typical profile of a respondent in the study and which part of the workforce such a respondent predominantly represents.

6.2.1.1.1 Age

Friedman (2003:21) mentions that age plays a role in the reaction to trauma and that persons under the age of 25 years are usually more vulnerable to trauma.

Question 1.1 of the client questionnaire (see Appendix 3) relates to the age of respondents. The results are given in Figure 5.

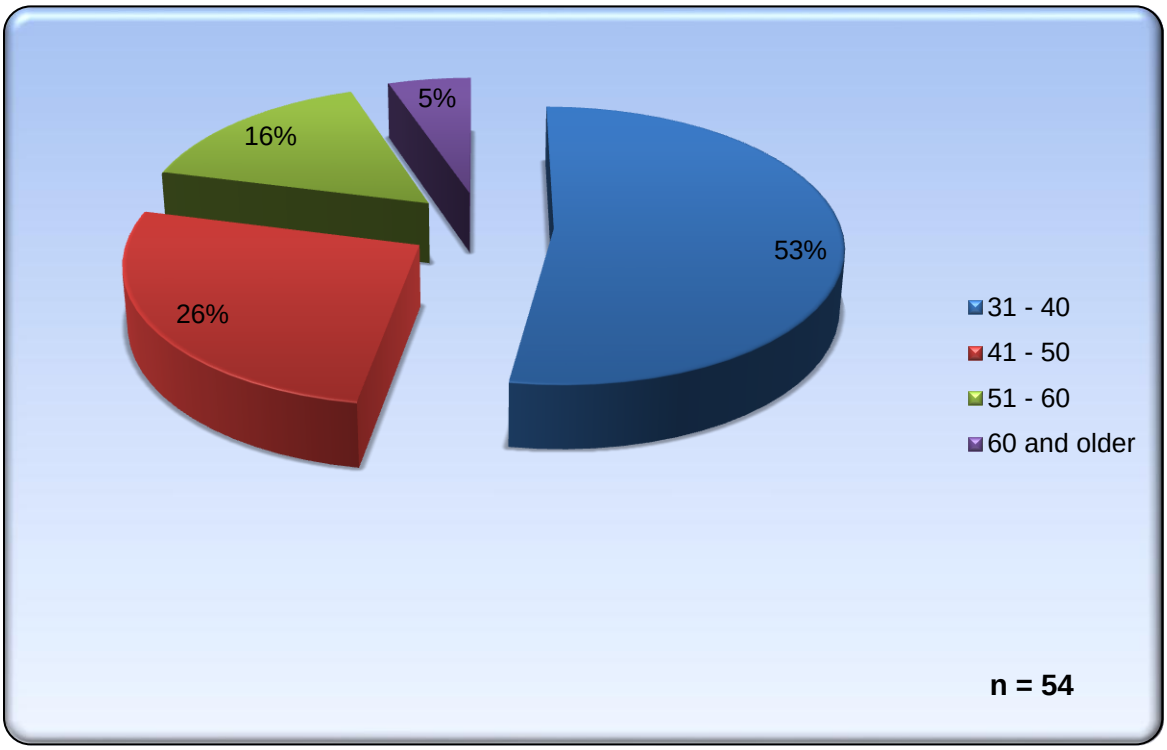


Figure 5: Age of respondents

Discussion of data

Most of the respondents (36%)fell within the age group 31 to 40. Only 4% of the respondents were over the age of 60. The mean age for the study was36 years. In relation to Friedman's view that persons under the age of 25 are more prone to being affected, it seems that age as a pre-risk factor did not have a major impact as the mean age was36 and respondents were 31 years and older.

Age also plays a factor in coping with a critical incident. The younger the person, the greater the tendency to experience a stronger reaction to the critical incident. This may relate to a

person's experience and existing coping skills. An older person usually has more experience in the coping and resolving of critical incidents in his life.

6.2.1.1.2 Gender

Friedman (2003:21) mentions that gender plays a role in the reaction to trauma. He mentions that the possibility of woman developing PTSD is twice likely as in men.
Question 1.2 of the client questionnaire relates to the gender of respondents.

Discussion of data

The majority of respondents who participated in the study were females (56%). Males that took part in the study were 44%.

According to Friedman's (2003:21) view, women are prone to develop PTSD after a critical incident. In the study, the majority of respondents were women, a fact which had an impact on the reactions to the critical incident and possibly on the overall picture presented in the study.

6.2.1.1.3 Qualifications

Friedman (2003:22) mentions that the level of education plays a role in the reaction to trauma. It is suspected that people with a higher education react less severely to trauma. He mentions that people without tertiary education are more prone to develop PTSD.

Question 1.3 of the client questionnaire relates to the qualifications of respondents. The results are given in Figure 6.

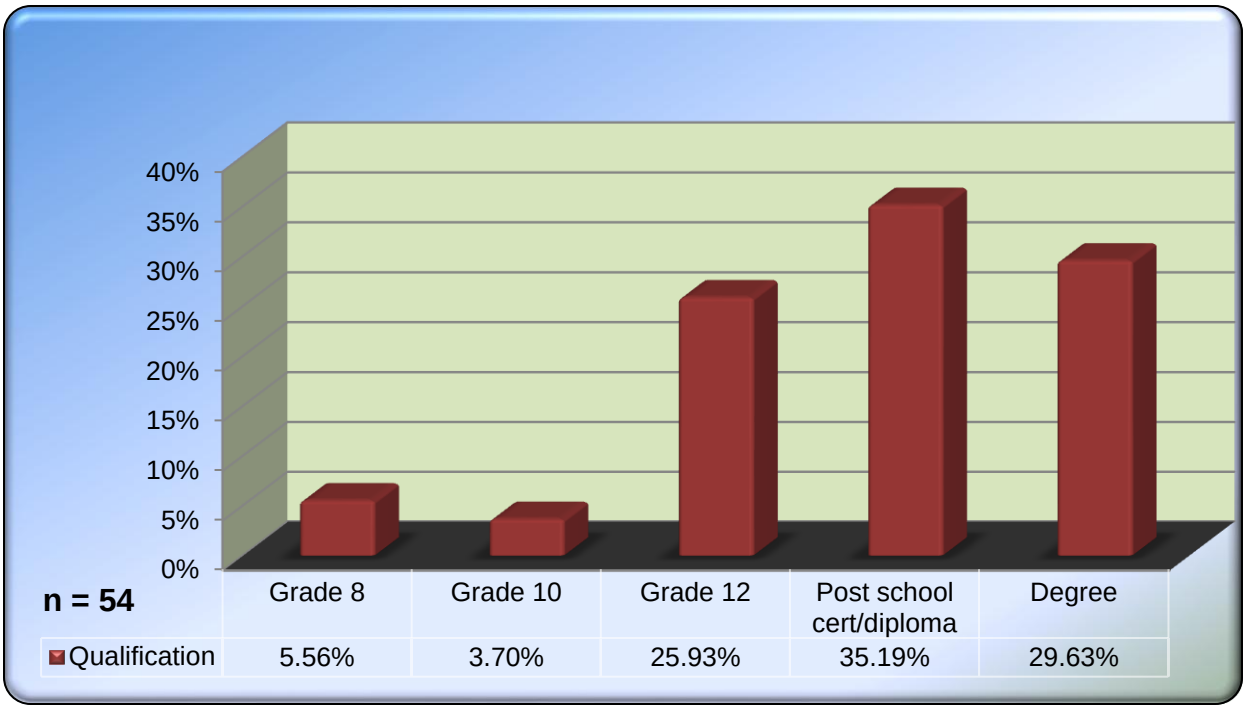


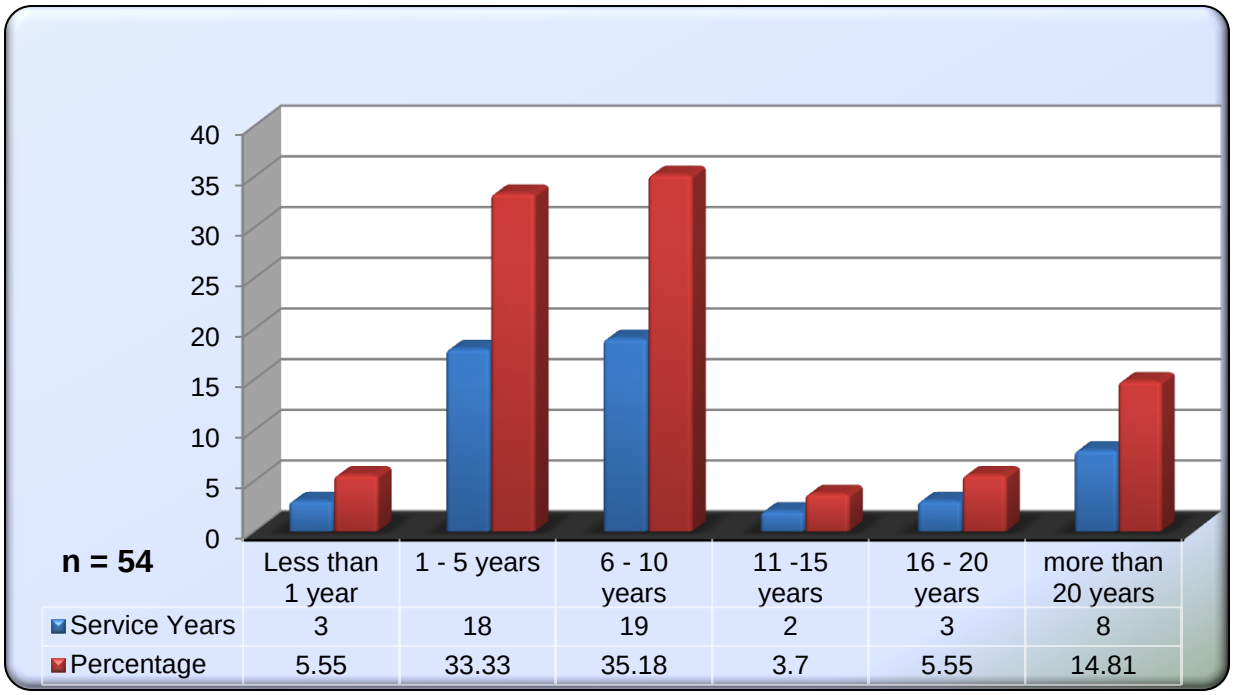
Figure 6: Highest qualifications

Discussion of data

The majority (64,82%) of respondents had a tertiary qualification and the majority were well educated. According to Friedman (2003:22), the expectation is that the higher the qualification the more the person will be equipped to deal with trauma and the reaction thereto. The majority of respondents in the study had a tertiary education, indicating that their resilience to trauma should have been better as a result of their being better equipped to deal with traumatic incidents. This should also impact on the overall trauma picture presented by the study.

6.2.1.1.4 Service years at current employer

Question 1.4 of the client questionnaire relates to the service years at the current employer. The results are given in Figure 7.



n = 54	Less than 1 year	1 - 5 years	6 - 10 years	11 -15 years	16 - 20 years	more than 20 years
Service Years	3	18	19	2	3	8
Percentage	5.55	33.33	35.18	3.7	5.55	14.81

Figure 7: Number of service years

Discussion of data

Most of the respondents (35,84%) had been employed between 6 and 10 years at their current company. The second largest group (33,96%) had been working in their companies for between 1 and 5 years. When grouped together, the majority (75,46%) of respondents worked at their current companies for less than 10 years. The mean for the service years is 9,28 years at their current companies. Although there is no specific referral to the role service years play in the reactions towards trauma it would be expected that the longer a person works for a certain company the more stability there would be and, therefore, more resilience to deal with change and trauma.

6.2.1.1.5 Level of functioning

Schulz et al. (2000:47) mention that the level of functioning also plays a factor in coping with a critical incident. The lower the person is on the ladder of career development, the greater the tendency to experience a stronger reaction to the critical incident. This may relate to a person's experience, resilience to stressors and existing coping skills. A more experienced person usually has more experience in the coping and resolving of critical incidents and can deal with more stress in his/her life.

Question 1.5 of the client questionnaire relates to the level of functioning. The results are given in Figure 8.

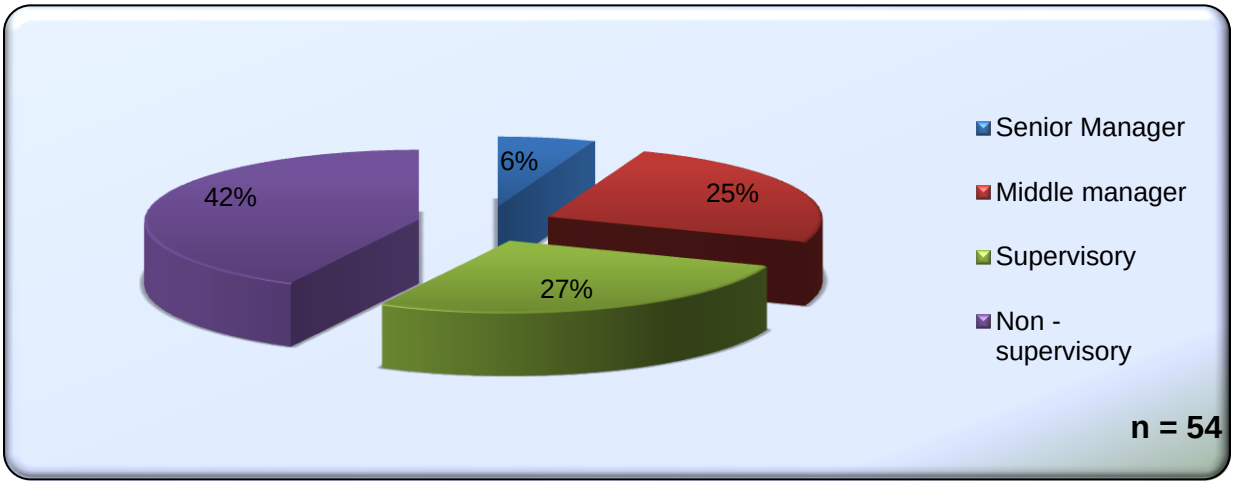


Figure 8: Level of functioning

Discussion of data

Although a large percentage (42%) of respondents occupied a non-supervisory position, the majority (58%) of the respondents had some managerial responsibilities as a result of their level of functioning. The fact that a large part of the population had some managerial responsibilities (58%) indicates that the majority of the population should have been more resilient towards a critical incident and should have had the tendency to develop less severe reactions as a result of their experience, ability to deal with stress and coping skills.

6.2.1.1.6 Marital status

There is no real evidence to support that either married or single people, due to their marital status, have the advantage when becoming the victim of a critical incident. The focus is more on support during an incident. If a person is involved in a caring relationship that is supportive, recovery is more likely. The focus, according to Schulz et al. (2000:43) is more on support on a personal level. A person in a caring relationship that feels cared for and supported, is more able to deal with the effects of a critical incident and show less severe reactions to a critical incident.

Question 1.6 of the client questionnaire relates to marital status. The results are given in Figure 9.

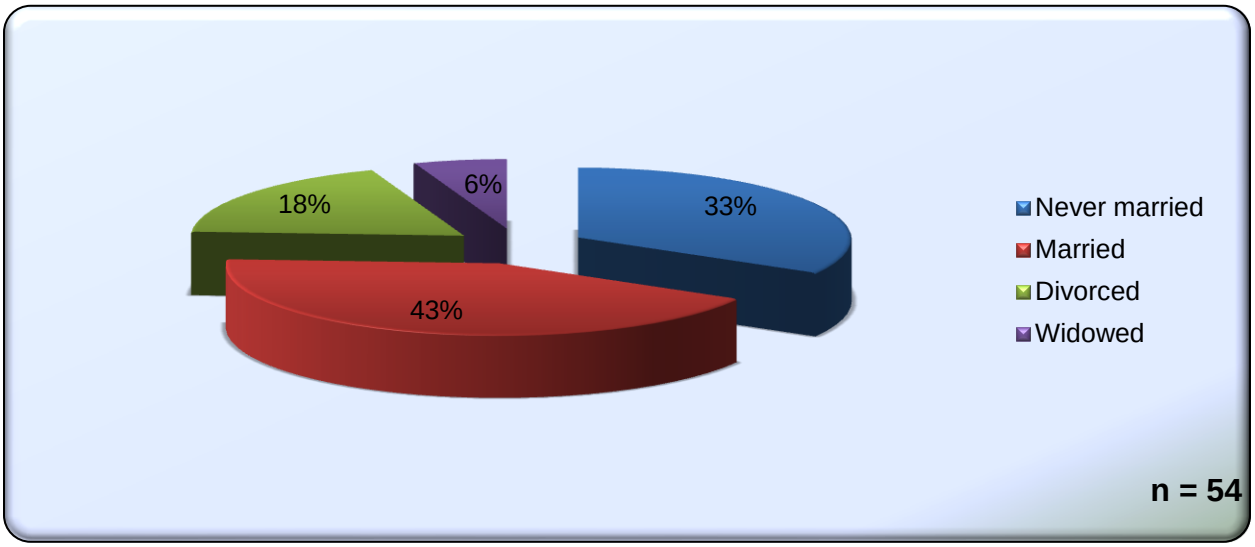


Figure 9: Marital status

Discussion of data

A large percentage (42%) of the respondents was married and a large percentage of respondents never married (33%). According to the statistics, 58% of the respondents were divorced, widowed or never married (assuming that they were single or in other relationships). If the assumption is made that the 58% of the respondents were single, without the support of a meaningful relationship, the probability is that they might have reacted more severely to a critical incident than respondents' who were in a meaningful loving relationship. Owing to the fact that the assumption, that married people are in a meaningful and loving relationship and single people not, cannot be made, it is difficult to establish if marital status had an effect on the reactions of respondents to a critical incident or the ability to be more resilient in dealing with a traumatic incident.

6.2.1.1.7 Dependants

Lewis (1996:54–57) describes physical proximity as one of the personal characteristics that may have an influence on how the individual reacts to a critical incident. If the critical incident has a personal impact on the victim, the risk of not coping with the event is greater. If a person's child is the victim of a critical incident or another child at a similar age to an own

child, there is a tendency of automatic identification with the victim, which improves the possibility of secondary traumatisation when dealing with critical incidents.

Question 1.7 of the client questionnaire relates to dependants. The results are given in Figure 10.

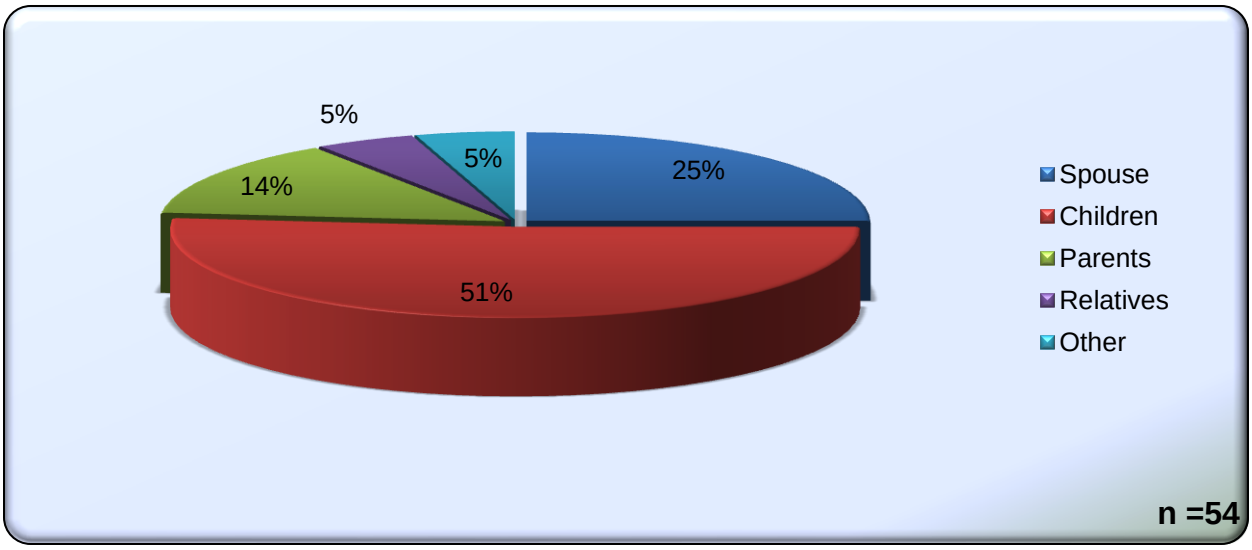


Figure 10: Dependants

Discussion of data

The majority of respondents' dependants were children (51%), followed by spouses (25%). Fourteen per cent (14%) of the respondents were also taking care of their parents. As the majority of respondents' dependants were children, where the psychological proximity was close, it might have increased the possibility of transference where their child/children or children of a similar age were the victims of a trauma. The psychological proximity in terms of a spouse was also close and secondary trauma as a result of a spouse being traumatised was likely.

6.2.1.1.8 Meaning of work

Employees are spending their working hours and thus most of their lives at work. Therefore, it is important that they should be happy and satisfied in the workplace. Chestong (in Akabas & Kurzman, 1982:8) describes the value of work as "for all persons, however, regardless of

background factors, work may provide the most realistic and available means to achieving self-esteem and the most viable course in the quest for meaning in their lives". The reason a person chooses to work has an impact on the person's motivation to work and, therefore, will play a pivotal role in the recovery process. War (in Landy, 1989:439) feels that there is more than enough evidence to conclude that work and the satisfaction of work are centrally involved in determining the adjustment of adults in virtually every culture. A happy and satisfied employee adapt better after disruption (at work or at home).

Question 2.1 of the client questionnaire relates to the meaning of work. The results are given in Figure 11.

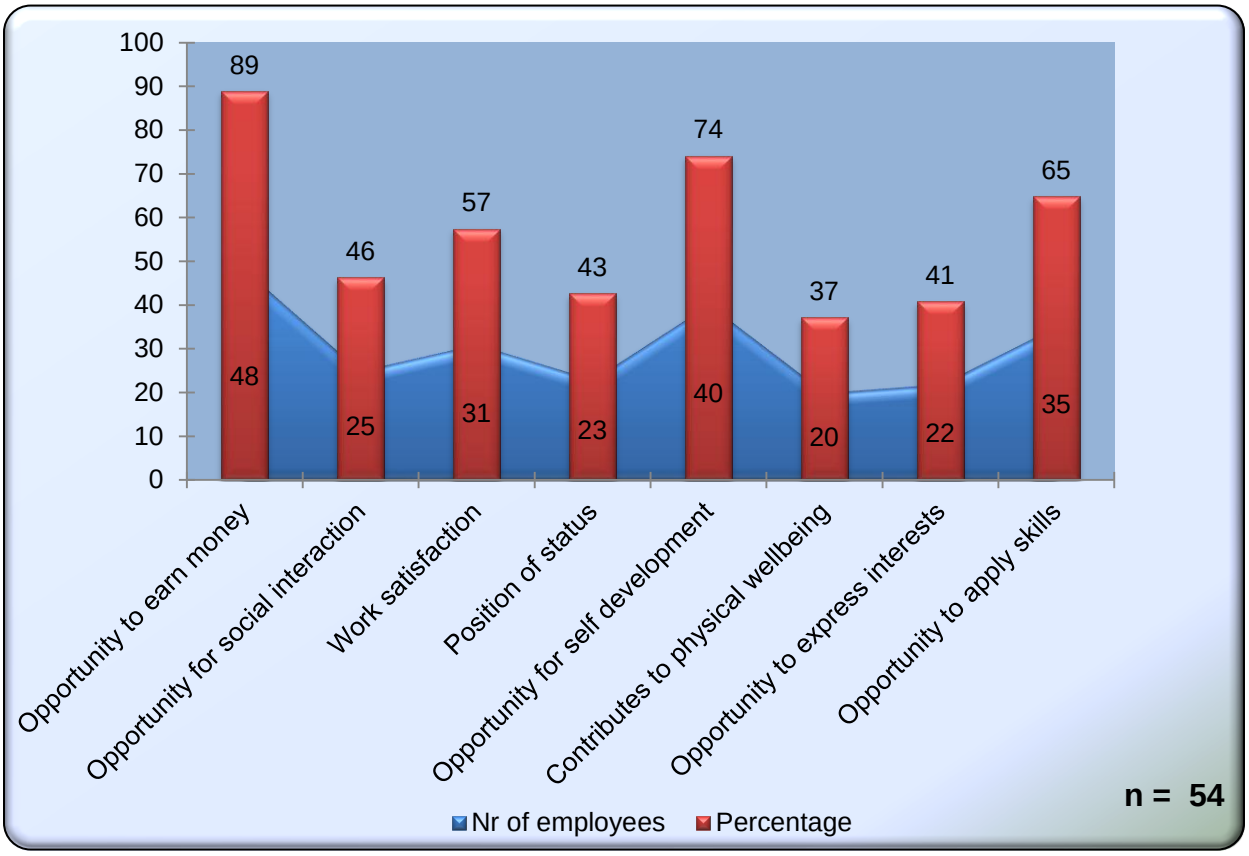


Figure11: Meaning of work

Discussion of data

The majority of the respondents indicated that work was an opportunity to earn money (89%), an opportunity for self-development (74%) and an opportunity to apply their skills. Only 37% of the respondents indicated that work contributed to their physical well-being. Of the

respondents, 57% indicated that work was satisfactory. Although most respondents indicated that work was a way of earning money, it is also evident that work was a way of self-actualisation and that growth and development were motivational factors. Respondents seemed to work by choice to develop themselves and would, therefore, focus on recovery and becoming productive as soon as they possibly can.

6.2.1.1.9 Critical incident

If the person self has not been exposed to the critical incident but it has a personal impact on him/her, the risk of not coping with the event is greater. If a person's child is the victim of a critical incident or a child at similar age to his/her own child, there is a tendency of automatic identification with the victim, which improves the possibility of secondary traumatisation when dealing with critical incidents. Where a person knows the victims of a critical incident or is closely related to them, the risk of secondary or vicarious trauma is likely. Participation in atrocities or being responsible for the harm of others, either as a perpetrator or as a witness, poses a risk for being severely affected by a critical incident (Friedman, 2003:24).

Question 3.1 of the client questionnaire relates to the critical incident. The results are given in Figure 12.

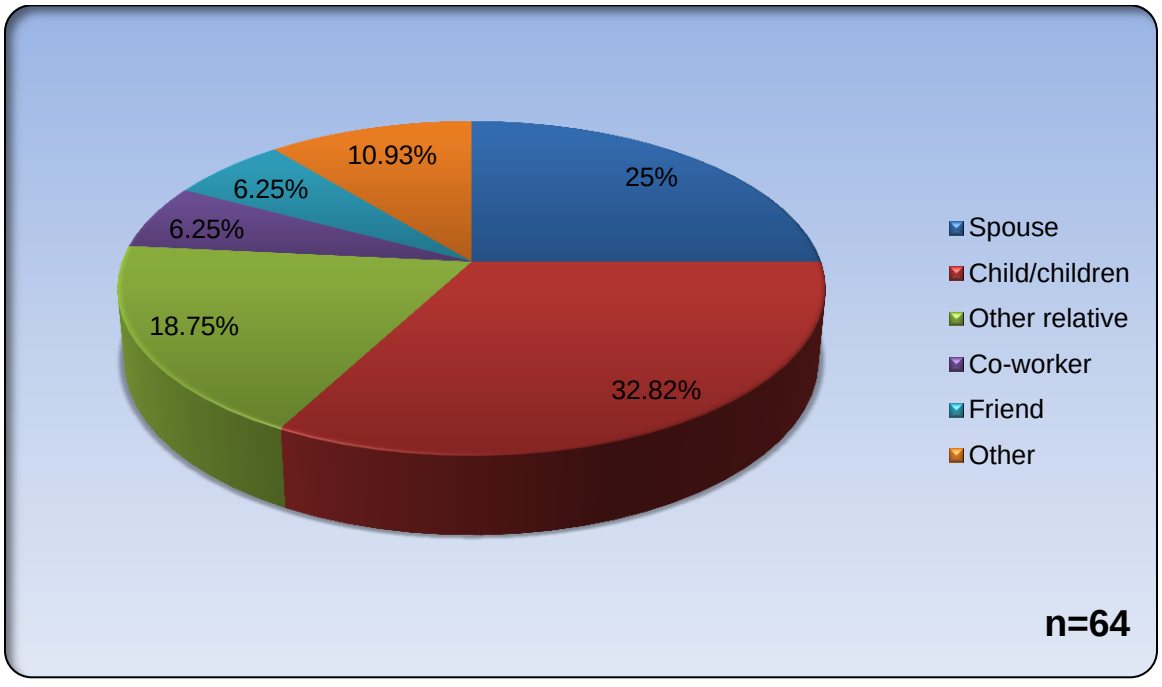


Figure 12: Relationship to person being exposed to critical incident (if not self)

Discussion of data

In Figure 12 it is indicated that out of the 54 respondents who participated in the study, 64 people other than themselves were involved in the critical incident. Of the 64 people, 32,82% were their own children and 25% were spouses. This indicates a close psychological proximity which could contribute to secondary or vicarious trauma.

The types of critical incidents that respondents or their significant others were exposed to were researched in Question 3.1.1 to 3.1.25 and the results are given in Table 5.

Table 5: Critical incidents exposed to primarily (self) or secondarily (significant other person)

		SELF				SIGNIFICANT OTHER PERSON			
		Repeatedly	Within the last six months	Prior to the last	Total	Repeatedly	Within the last six months	Prior to the last	Total
Natural trauma and trauma without intent	Civil violence/ Riots				0				0
	War situation			2	2				0
	Industrial accident and/ or fire		3		3				0
	Motor vehicle accident		4	3	7		4	2	6
	Natural disasters e.g. floods, fire, earthquakes				0				0
General crime	Crime situations and crime	5	3	1	9	3	2	2	7
Trauma as a result of sexual offences	Child molestation and/ or abuse			2	2	1		2	3
	Incest			1	1				0
	Rape and / or sexual violence		2	1	3	2		1	3
Trauma as a result of aggressive offences	Assault	2	3	3	8		2	3	5
	Torture			1	1		1	1	2
	Armed robbery	1	6	3	10			2	2
	Robbery	2	2	1	5	1	1	1	3
	Hijacking		5	1	6		3	3	6
	Smash and grab	1	3	6	10	1	2	1	4
	Physical violence either as a victim	1	1	2	4			2	2

	or as a witness								
	Responsible for a shooting accident or incident			1	1				0
	Witnessing a shooting accident or incident			2	2		1	1	2
	Domestic violence	2		2	4	1		3	4
Loss	Divorce	1	4	5	10		2	3	5
	Death of a loved one	2	10	7	19		5	6	11
Work related loss	Retrenchment		1	2	3		2	1	3
	Retirement		1	1	2		1		1
	Loss of income		5	2	7		7	2	9
Other	Other	4	3		7	1	1		2

Key to priority of exposure

Mostly exposed to

Second mostly exposed to

Third mostly exposed to

Forth mostly exposed to

Fifth mostly exposed to

Discussion of data

From Table 5, it is evident that the critical incident respondents **themselves** were exposed to most often, was the death of a loved one, followed by divorce and physical violence, either as a victim or as a witness, thirdly by crime situations and crime, fourthly by assault and lastly by a motor vehicle accident and loss of income, as illustrated in Figure 13.

Table 5 further indicates that the critical incident **a family member or loved one** was exposed to most, was the death of a loved one, followed by the loss of income, thirdly exposure to crime or crime situations, fourthly to motor vehicle accidents and hijack incidents and lastly to assault and divorce, as illustrated in Figure 14.

The death of a loved one featured as a critical incident that both the respondent and his/her loved ones were exposed to most. Crime situations and crime were also critical incidents that impacted on both the respondent and his/her loved ones. The fact that respondents indicated that they were exposed to some incidents themselves and to some by way of their loved ones or family members being affected by the incidents implicate that they were affected primarily by some incident and secondarily by others. In some incidents, for example the death of a loved one, it seems that respondents suffered the loss themselves but were also affected as a result of their loved ones' loss or suffering.

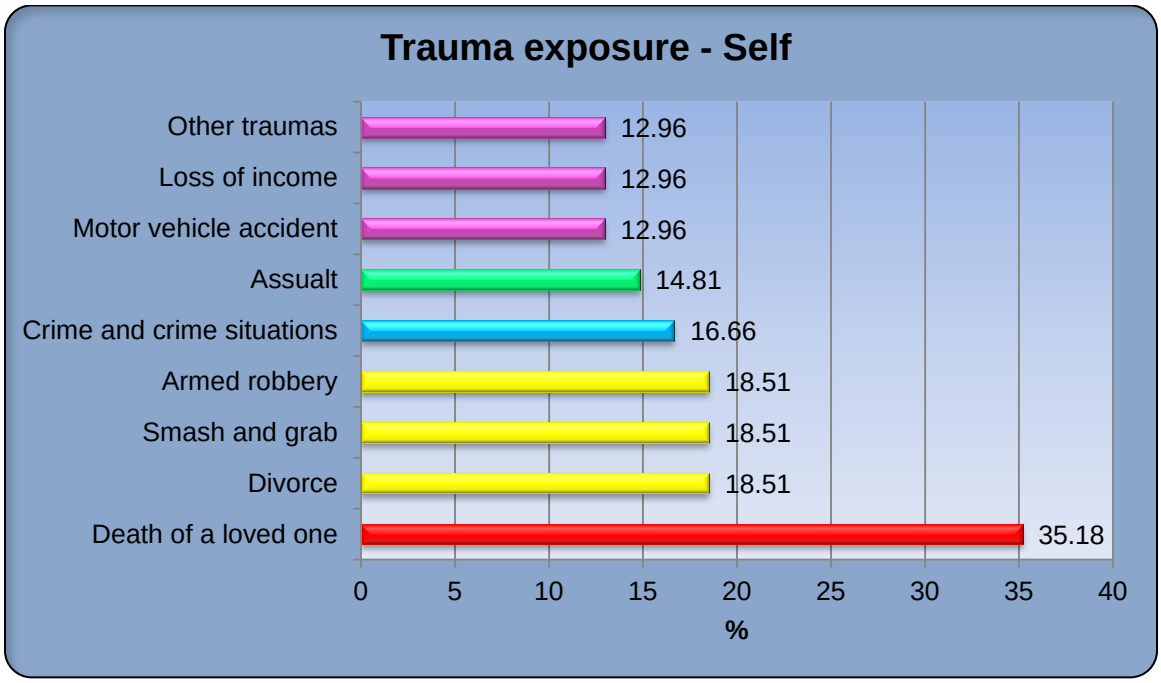


Figure 13: Trauma exposure – self

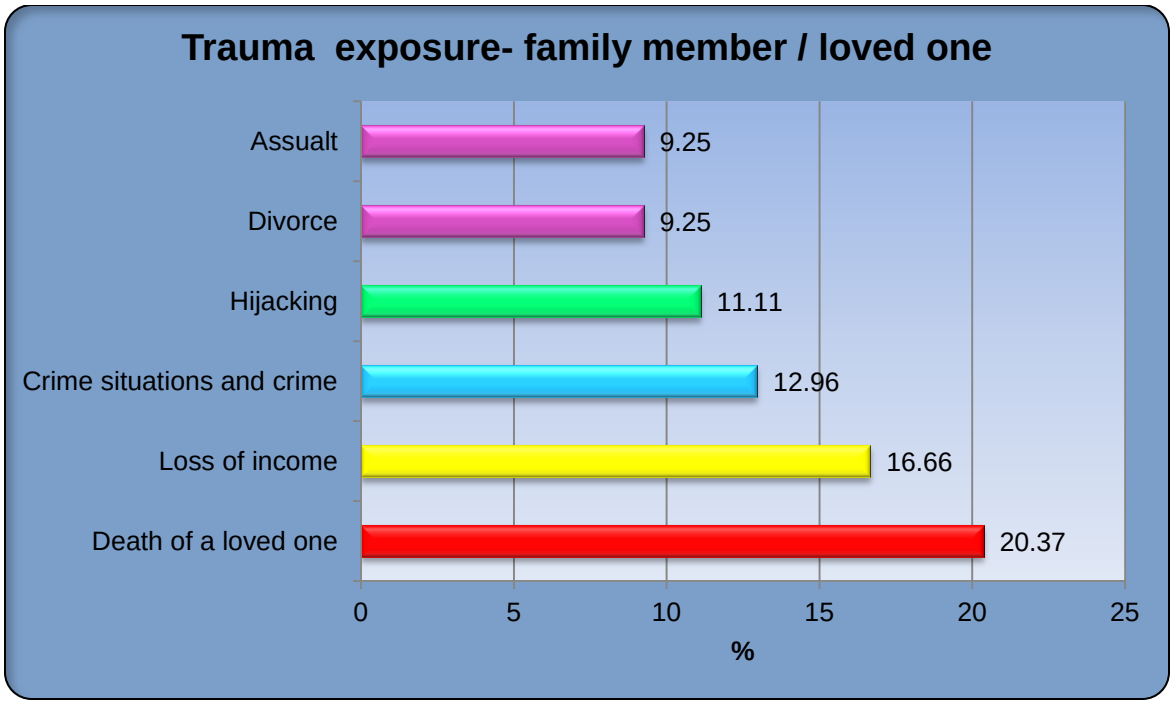


Figure 14: Trauma exposure – family member or loved one

6.2.1.2 Trauma risk factors

6.2.1.2.1 Most traumatic incident

Gilliland and James(1993:64) mention that there are certain trauma risk factors relating to the type of critical incident that seem to be influential in its impact on the victim. Tomb (in Meichenbaum, 1994:183) indicates that a critical incident is more likely to lead to the development of PTSD if the critical incident is severe, sudden, unexpected, intentional, prolonged and likely to be repetitive. Therefore, the trauma risk factors as discussed below play a pivotal role in the respondents' reactions to the incident and the development of stress related disorders such as acute stress disorder or PTSD.

This was tested in Question 3.2 of the client questionnaire and the results are given in Figure 15.

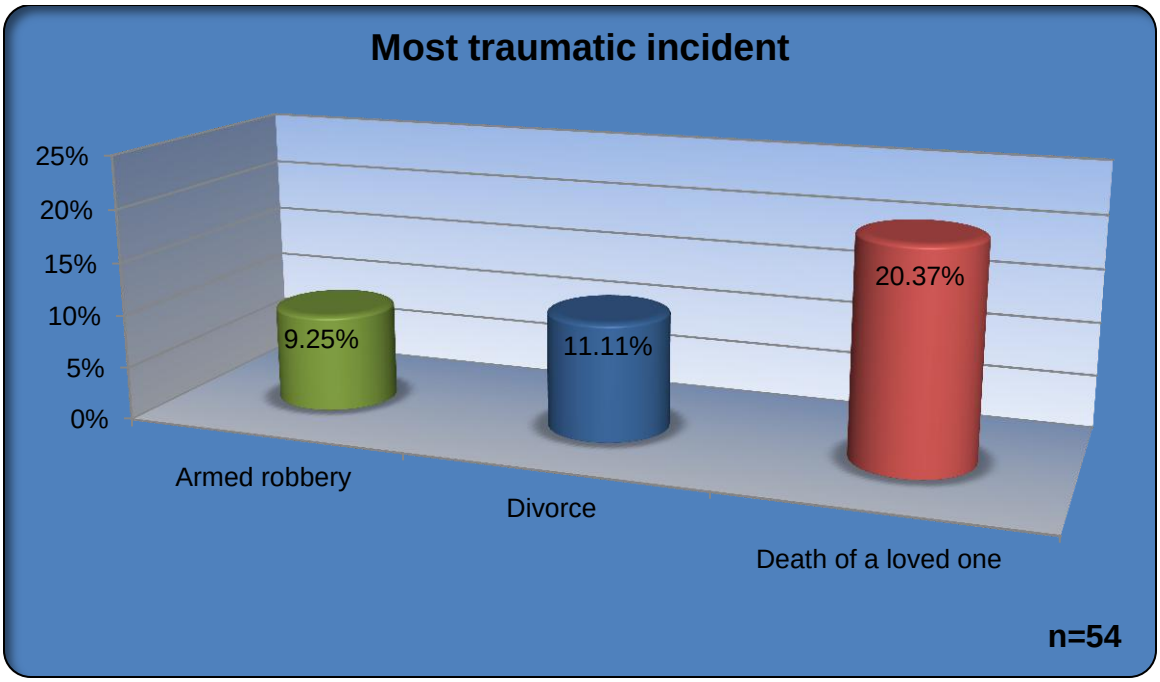


Figure 15: Top three incidents as indicated most traumatic by respondents

Discussion of data

Question 3.2 in the questionnaire provided opportunity to the respondents to indicate which critical incident was experienced as most traumatic out of all the incidents they or their loved ones were exposed to. As illustrated in Figure 15, out of the 54 respondents who completed this question, 11 (20,37%) respondents indicated that the death of a loved one was most traumatic, followed by divorce 6 (11,11%) and then armed robbery 5 (9,25%).

Responses as reflected in paragraphs 6.2.1.3.2.2 to 6.2.1.3.2.10 are based on the respondents' experience of the critical incident they have indicated as being most traumatic in question 3.2 (Figure 15).

6.2.1.2.2 Extent of life threat

Critical incidents have an inherent structure. They may comprise a single or multiple stressors, be psychologically simple or complex, and be natural or man-made.

The severity of a critical incident can be classified according to the level to which these dimensions exist in the traumatic event. The more these dimensions are present in any particular trauma, the greater the potential for a pathological outcome. However, this is not a

simple cause-effect linear relationship. Rather, personality and situational variables (such as social support and economic resources) interact with the stress or dimensions in determining the individual's post-trauma adaptation.

The extent of life threat that a critical incident poses is not necessarily determined by the nature of the incident but rather a combination of the incident, the person's resilience to trauma, his/her support network and how the critical incident is perceived and interpreted by the individual. Therefore, an incident such as a divorce can potentially pose as much life threat that an armed robbery.

Question 3.2.1 of the client questionnaire relates to the extent of life threat. The results are given in Figure 16.

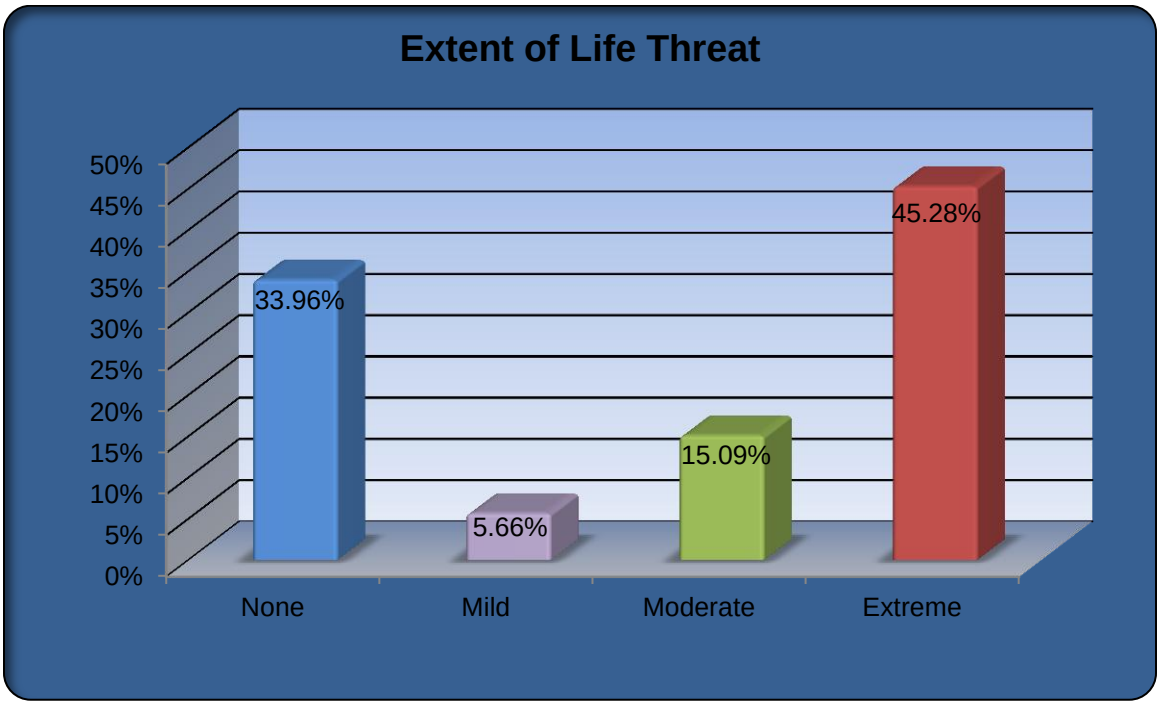


Figure 16: Extent of life threat

Discussion of data

Most of the respondents experienced the critical incident they specified as most traumatic as extremely life threatening (45,28%). A significant portion (33,96%) of the respondents felt that the incident had no life threat. In total, 66,03% of the respondents' life was threatened to some agree.

6.2.1.2.3 Onset of the critical incident

Tomb (in Meichenbaum, 1994:183) concludes that a critical incident is more likely to lead to the development of PTSD if the critical incident is severe, sudden, unexpected, intentional, prolonged and likely to be repetitive.

The less the warning, the more profound the emotional impact of a critical incident. If a critical incident is sudden and unexpected, for example an earthquake, it leaves people with no time to prepare emotionally for the possible outcome.

Question 3.2.2 of the client questionnaire relates to the onset of the critical incident.

Discussion of data

In 79,25% of the cases the onset of the incident was unexpected. In only 20,75% of the cases the respondents expected the critical incident to occur and could prepare themselves emotionally to some agree. As indicated the majority of respondents experienced the critical incident as unexpected, leaving them no or little time to prepare emotionally. It could be expected that the incident would have a profound emotional impact.

6.2.1.2.4 Degree of disturbance in home routine

The degree of disturbance in the home routine was determined through Question 3.2.3. The results are given in Figure 17.

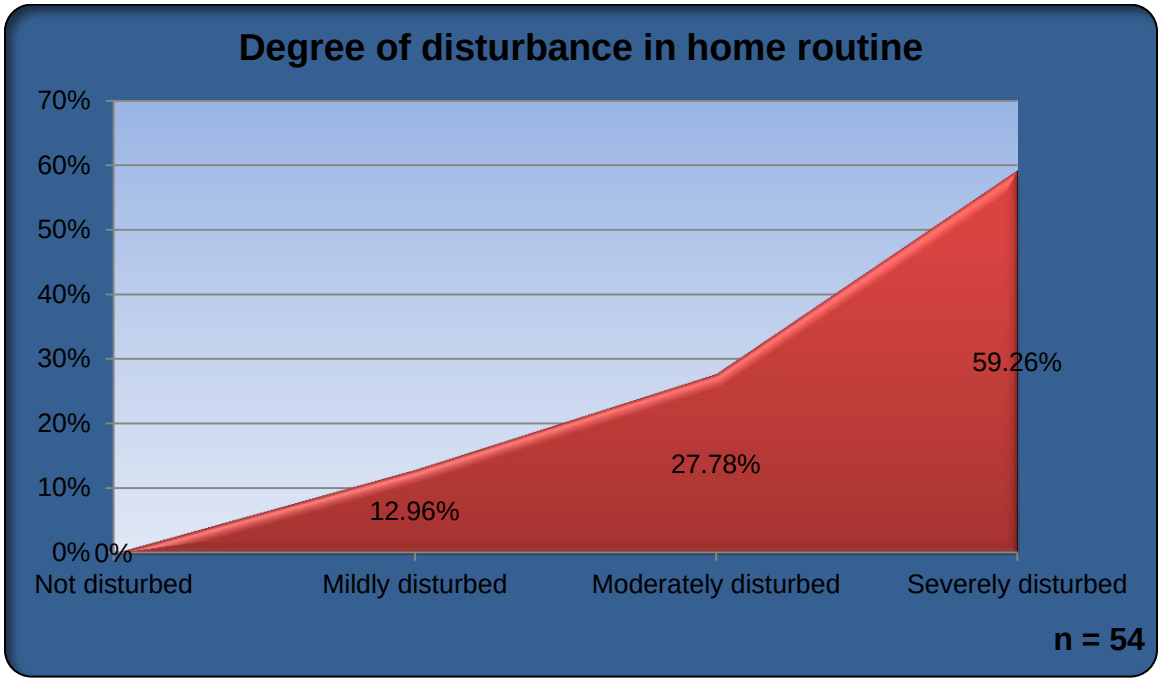


Figure 17: Degree of disturbance in home routine

Discussion of data

From the respondents' reaction to the degree of home disturbance it is evident that the majority of respondent's households were disturbed to some degree. A total of 100% indicated that they were affected in some way. The majority (59,26%) indicated that their home routine was disturbed severely by the incident. This indicates that the impact of the incident rippled out to persons close to the person being affected and affected people who were not directly involved in the incident.

6.2.1.2.5 Degree of exposure to death, dying and destruction

Friedman (2003:22) mentions that the higher the severity ("dose") of the critical incident, the greater the magnitude of trauma exposure, the greater the likelihood of being traumatised. The most severe trauma often includes perceived life threat or serious injury.

Question 3.2.4of the client questionnaire relates to the degree of exposure to death, dying and destruction. The results are given in Figure 18.

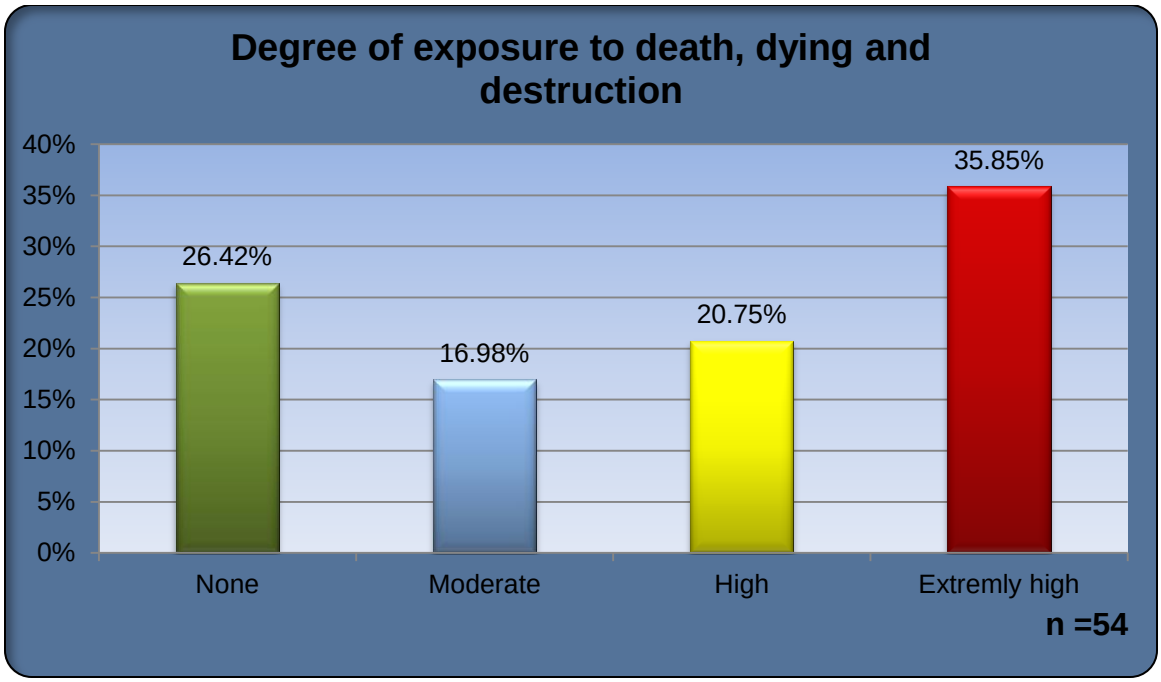


Figure 18: Degree of exposure to death, dying and destruction

Discussion of data

Most of the respondents (19) experienced the critical incident exposure to death, dying and destruction as extremely high (35,85%). Fourteen respondents (26,42%) felt that the incident they experienced as most traumatic had no degree of exposure to death, dying and destruction. In total 73,58% of the respondents felt there was a degree of exposure to death, dying and destruction.

As the majority of respondents perceived the incident as high and extremely high in terms of degree of exposure to death, dying and destruction, it can be concluded that they experienced it as "severe", increasing the likelihood of being traumatised.

6.2.1.2.6 Degree of moral conflict inherent to situation

Moral conflict refers to the respondent's reaction to the incident in retrospect. It is typical for victims of trauma to experience guilt relating to their role in the trauma. Victims of trauma usually ask themselves questions such as "did I act in the right way during the incident?" or "did I not perhaps provoke the perpetrator?" (in the case of rape) or "I only thought of myself, I did not help anyone else".

Question 3.2.5 of the client questionnaire relates to this issue. The results are given in Figure 19.

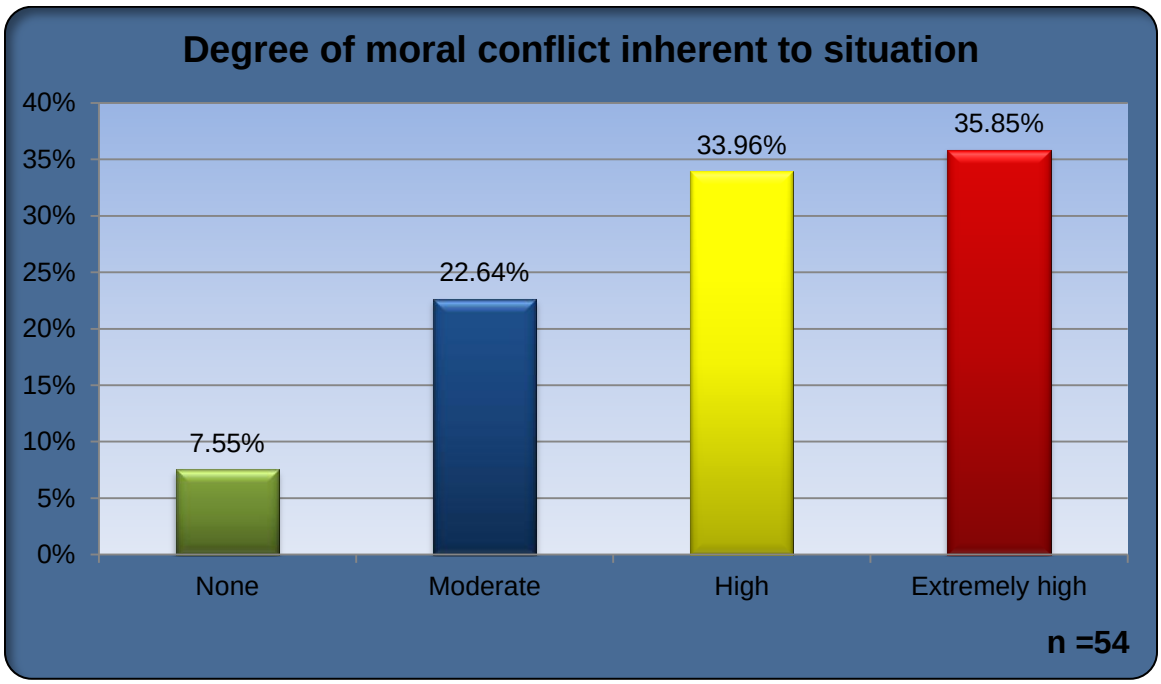


Figure 19: Moral conflict inherent to situation

Discussion of data

The majority of respondents (92,45%) indicated that there was a degree of moral conflict perpetuated by the critical incident they experienced as most traumatic. Nineteen respondents (35,85%) perceived the degree of moral conflict inherent to the situation as "extremely high" and 18 (33,96%) as "high". Only 7,55% of the respondents felt that there was no degree of moral conflict inherent to the situation.

Taking in consideration that the majority of respondents experienced some degree of moral conflict, it indicates that they had some feelings of guilt relating to the trauma and questioned their role and conduct in the incident.

6.2.1.2.7 Respondents' role in trauma

The closer a person lives to an incident and the victims, the stronger the reaction (Lewis, 1996:53). If a person is directly affected by a critical incident, the trauma reaction has the

potential to be more severe. Where a person knows the victims of a critical incident or is closely related to them, the risk of secondary or vicarious trauma is likely.

Question 3.2.6 of the client questionnaire relates to the respondent's role in trauma. The results are given in Figure 20.

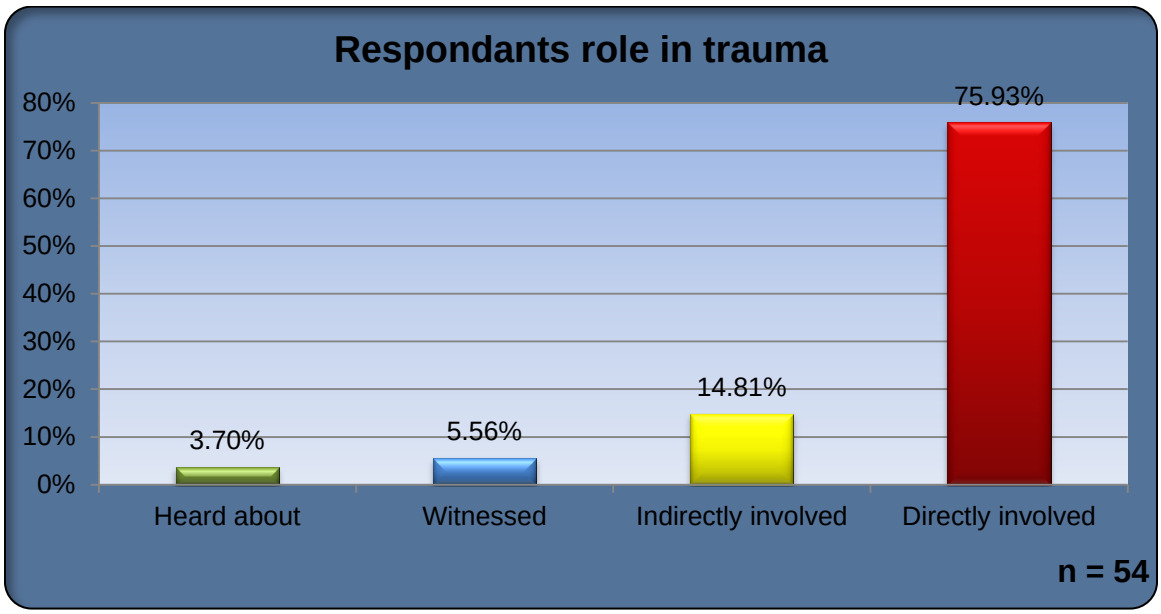


Figure 20: Respondents role in trauma

Discussion of data

Most (90,74%) of the respondents indicated that they were involved in the trauma. The majority (75,93%) indicated that they were directly involved and 14,81% were indirectly involved. A minor proportion (5,56%) witnessed the incident and 3,70% of the respondents heard about the incident. As the majority of respondents indicated that they were directly involved in the incident, indicating a close physical proximity to the incident, it can be assumed that their trauma reaction was exacerbate by their direct involvement.

6.2.1.2.8 Proportion of the community affected

The portion of the community affected by a critical incident also affects the trauma response of the individual. The larger the community that is affected, the more transference of reactions takes place between individuals. Natural disasters such as earthquakes are associated with an impact on a larger part of the community. The effect of a large number of people being affected has a greater risk of creating hysteria.

Question 3.2.7 of the client questionnaire relates to the proportion of the community affected. The results are given in Figure 21.

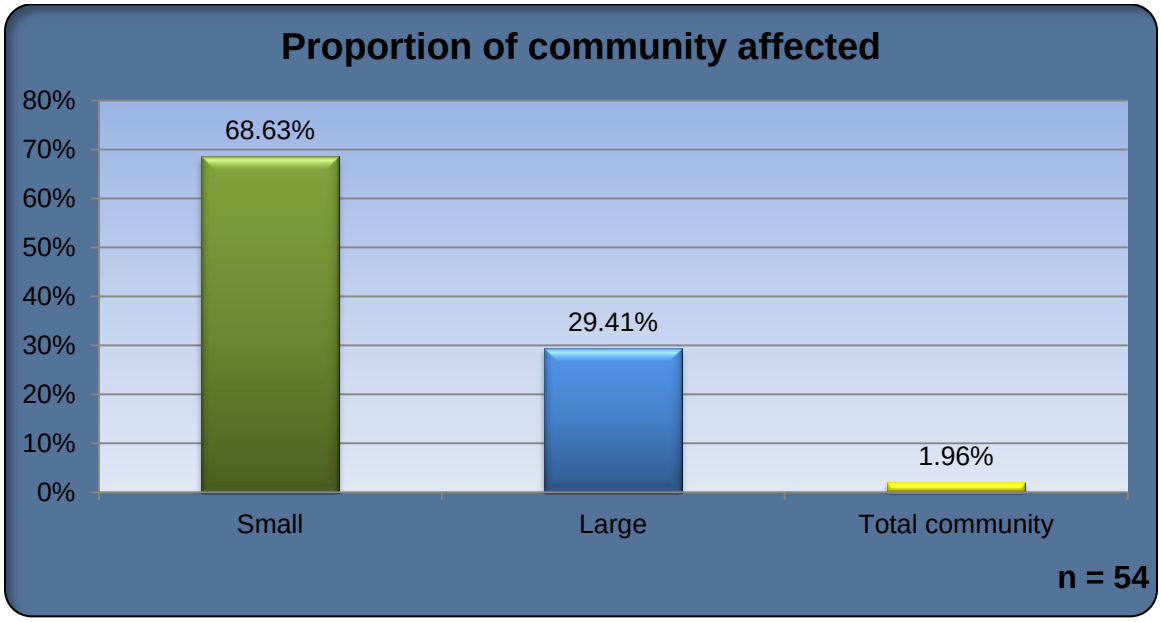


Figure 21: Proportion of the community affected

Discussion of data

Respondents indicated that, in most cases (68,63%), only a small part of the community was affected by the critical incident they experienced as most traumatic. In 29,41% of the cases the respondents' perceptions were that a large part of the community was affected. In only 1,96% of the cases the total community was affected. The majority was of the opinion that only a small part of the community was affected. It can, therefore, be assumed that "proportion of community affected" did not exacerbate the trauma experience of the individual.

6.2.1.2.9 Degree of bereavement

Degree of bereavement refers to the loss the individual associates with the critical incident. This can be the physical loss of a loved one as a result of the incident, the loss of a relationship (e.g. divorce) or the loss of innocence in the case where a person's privacy was violated. The more loss a person experiences as a result of the critical incident, the more the likelihood of being traumatised. After a critical incident, part of the recovery process is to work through these losses and to reach acceptance.

Question 3.2.8 of the client questionnaire relates to the degree of bereavement. The results are given in Figure 22.

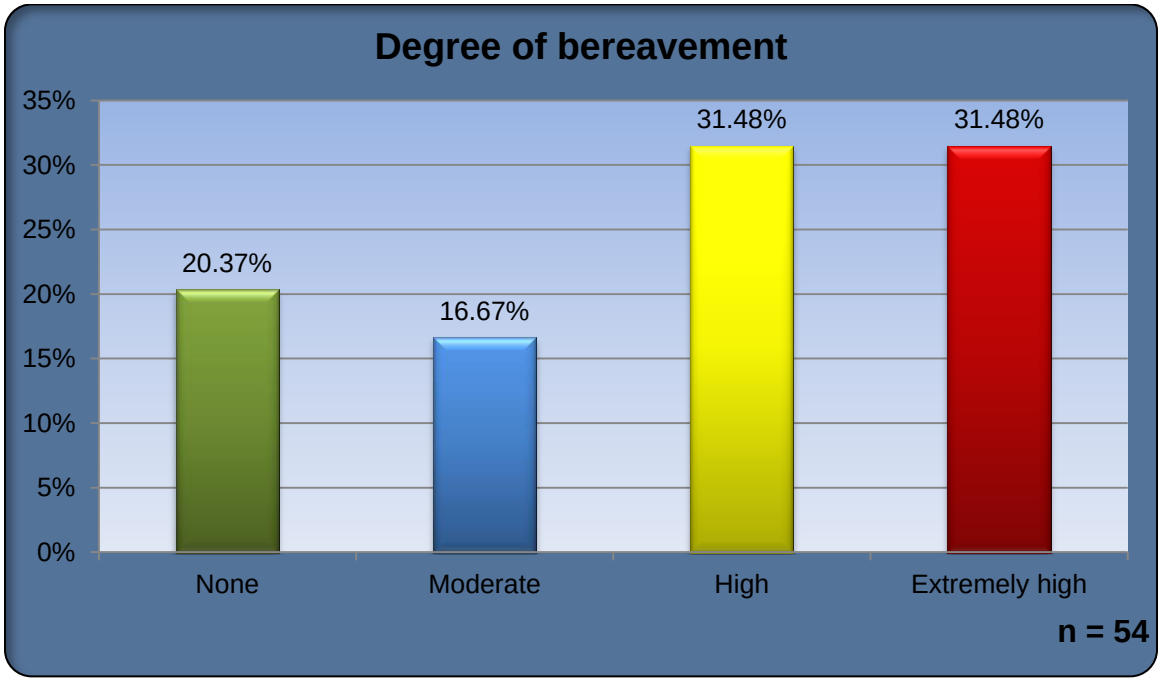


Figure 22: Degree of bereavement

Discussion of data

In the majority (79,63%) of cases, there was some degree of bereavement, with the "extreme high" and the "high" level of bereavement both at 31,48%. Only 20,37% of respondents did not experience any degree of bereavement. As the majority of respondents experienced a high level of bereavement, the assumption can be made that they suffered a significant amount of loss as a result of the critical incident impacting on their trauma reaction.

6.2.1.2.10 Duration of trauma

Lewis (1996:3) mentions that long-term distress is damaging to a person's emotional and physical wellbeing. The longer the distress continues, the greater the impact on the physical and emotional well-being of the person.

Question 3.2.9 of the client questionnaire relates to the duration of trauma. The results are given in Figure 23.

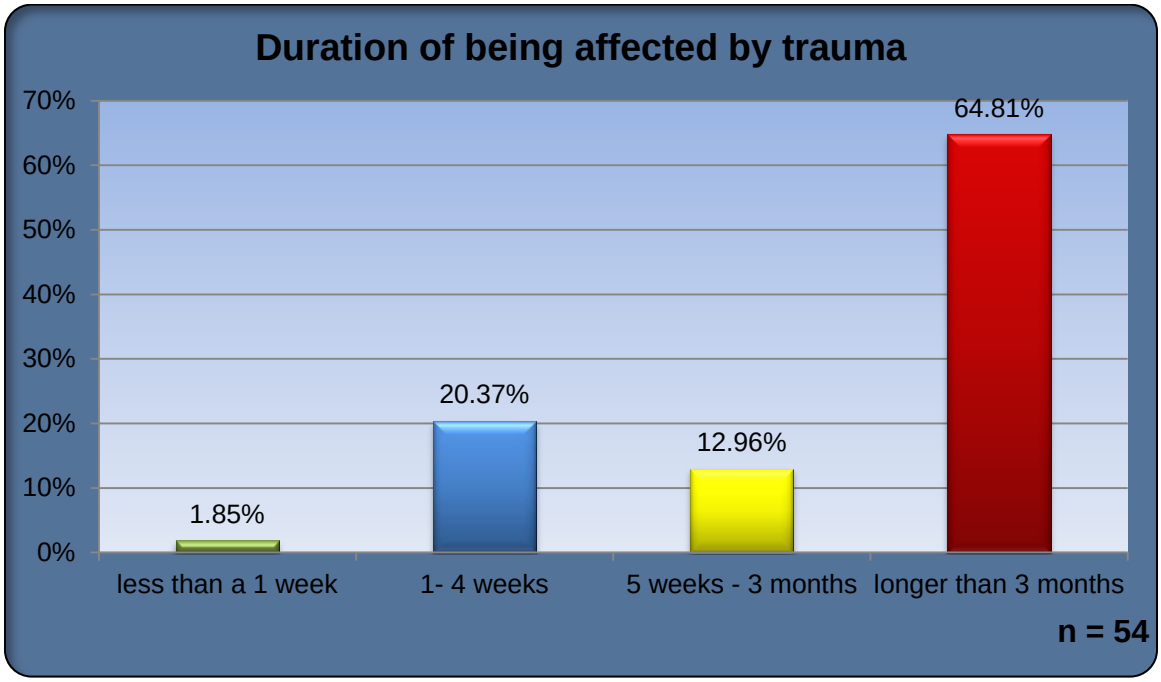


Figure 23: Duration of being affected by trauma

Discussion of data

The majority (64,81%) of respondents were affected for three months and longer by the incident they experienced as most traumatic. Being affected for the duration of one to four weeks was perceived by 20,37% of the respondents as the actual duration of being affected. Only 1,85% of respondents felt affected for less than a week.

As the majority of respondents experienced the effect of the trauma for longer than three months, it can be assumed that the long-term distress associated with the trauma affected the physical and emotional well-being of those individuals more than the respondents who experienced the effects of the trauma for less than a week.

6.2.1.2.11 Potential for recurrence of the incident

Expecting a trauma to recur and the anticipation of the impact thereof are traumatising in itself. If a person feels the likelihood that it may happen again, the trauma impact increases in comparison to the understanding that it has passed and will not happen again, a situation where less impact can be expected.

Question 3.2.10 of the client questionnaire relates to the recurrence of the incident. The results are given in Figure 24.

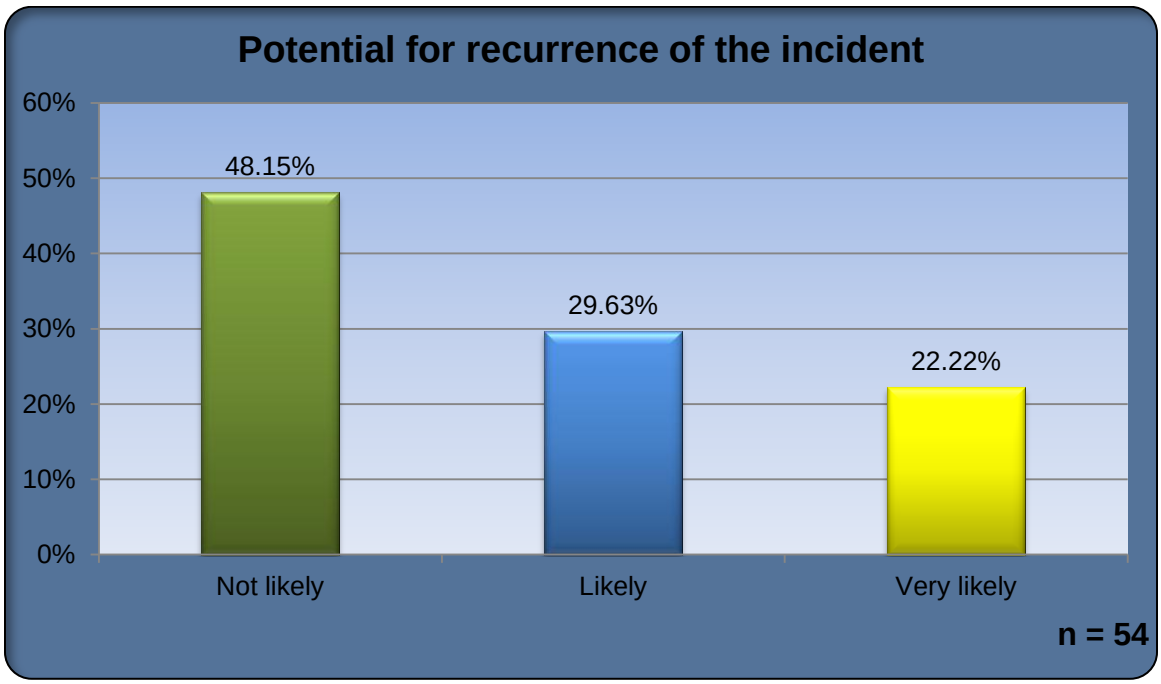


Figure 24: Potential for the recurrence of the incident

Discussion of data

Most (51,85%) of the respondents felt there was potential for the critical incident they experienced as most traumatic to recur, with 22,22% of the respondents indicating that the potential was very likely. A large percentage (48,15%) indicated that the potential for recurrence was not likely. In the case of the respondents who felt that the likelihood for reoccurrence was high, the possibility existed that their trauma reactions would be more severe as opposed to the respondents who were convinced that it will not happen again.

In summary, the trauma risk factors point out that in the critical incident that was experienced as most traumatic (as indicated by each respondent), the degree of threat was extreme.

The onset of the incident was predominantly unexpected and the degree of disturbance to the home routine was severe. The degree of exposure to death, dying and destruction was mostly experienced as extremely high. The degree of moral conflicted inherent to the critical incident was mostly extremely high. Nearly 80% of the respondents were directly involved in

the trauma. The majority of the respondents were of the opinion that only a small proportion of the community was affected by the critical incident. The degree of bereavement experienced by respondents was mostly high and extremely high. Most respondents were affected by the critical incident for longer than three months. Just more than half of the respondents were of the opinion that the potential for recurrence of the incident was likely. Considering that mostly all the trauma risk factors as experienced by the respondents seemed to be extreme or severe, it seemed likely that these factors could influence the impact of the trauma, contribute to a more severe level of being affected by the incident and prolong adjustment after the incident.

6.2.1.3 Situational factors

There are certain situational and personal predisposing factors (Lewis, 1996:52–57) that may affect the victim's reaction to a critical incident and have an influence on the development of PTSD.

Responses as reflected in paragraphs 6.2.1.3.3.1 to 6.2.1.3.3.11 are based on the respondents' experience of the critical incident they have indicated as being most traumatic in Question 3.2 (Figure 15).

6.2.1.3.1 Anticipation of incident

The less the warning, the more profound the emotional impact of a critical incident. If a critical incident is sudden and unexpected, it leaves people with no time to prepare physically and emotionally for the possible outcome (Lewis, 1996:52).

Question 3.3.1 of the client questionnaire relates to the anticipation of the incident. The results are given in Figure 25.

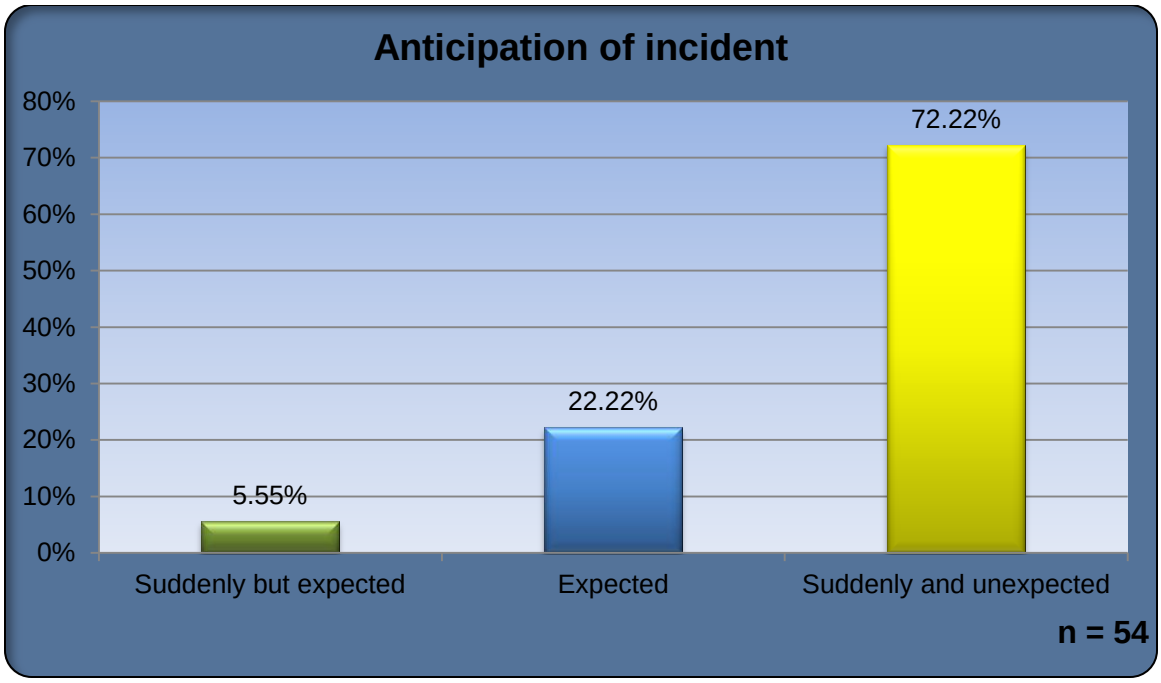


Figure 25: Anticipation of incident

Discussion of data

In 72,22% of the cases the incident occurred suddenly and unexpectedly. In 22,22% the critical incident was expected. In the majority of cases respondents had no warning and could not prepare in any way for the impact of the incident.

The fact that respondents were unprepared for the critical incident leaves room to assume that the impact of the critical incident on an emotional level was exacerbated by the fact that there was no time to emotionally prepare for the incident.

6.2.1.3.2 Nature of the crisis

Lewis (1996:52) and Friedman (2003:24) are of the opinion that the victim's emotional response is different to a man-made situation than to a natural disaster. In the case of a man-made critical incident where there is interpersonal violence, for example rape, physical attack or torture, it is more likely to cause traumatisation than in the case of an impersonal event such as a natural disaster. Man-made situations refer to critical incidents where the trauma is caused as a result of the intended actions of another person.

Question 3.3.2 of the client questionnaire relates to the nature of the crisis.

Discussion of data

Respondents indicated that the critical incident they experienced as most traumatic were predominantly (86,45%) man-made situations. Only 13,46% of the respondents were exposed to natural disasters.

As the majority of respondents experienced the critical incident as a man-made situation, it can be assumed that the majority reactions were more severe as a result thereof.

6.2.1.3.3 Severity of the crisis

Friedman (2003:22) mentions that the higher the severity ("dose") of the critical incident, the greater the magnitude of trauma exposure and the greater the likelihood of being traumatised. The most severe trauma often includes a perceived life threat or serious injury. Every person perceives a critical incident differently and what may be a severe incident to one person may be a minor incident to another. It is, however, essential to remember that the critical incident and the nature thereof is not the most important, but rather the different perceptions and/or association people have with the critical incident.

Question 3.3.3 of the client questionnaire relates to the severity of the crisis. The results are given in Figure 26.

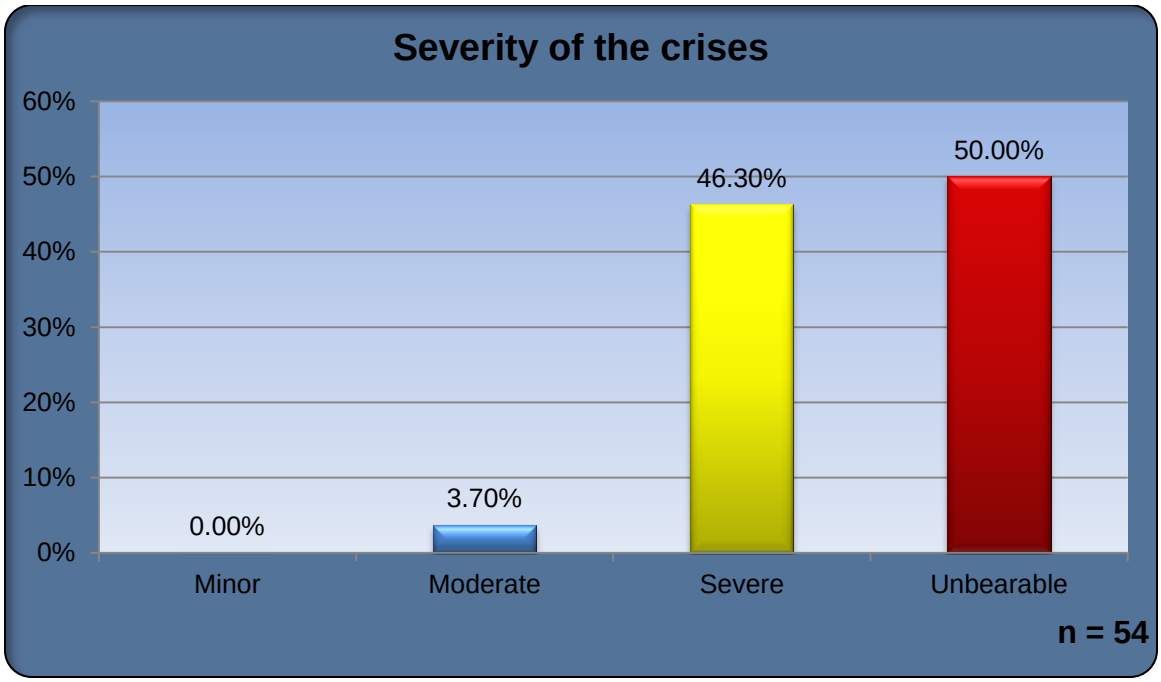


Figure 26: Severity of the crises

Discussion of data

Respondents indicated that 50% experienced the critical incident as unbearable and 46,30% experienced it as severe. This indicates that respondents perceived and experienced the incident as severe, increasing the magnitude of trauma exposure and the possibility of being traumatised.

6.2.1.3.4 Physical proximity of the incident

The closer one lives to an incident and the victims, the stronger the reaction (Lewis, 1996:53). If a person is directly affected by a critical incident, the trauma reaction has the potential to be more severe. Where a person knows the victims of a critical incident or is closely related to them, the risk of secondary or vicarious trauma are likely.

Question 3.3.4 of the client questionnaire relates to the physical proximity of the incident. The results are given in Figure 27.

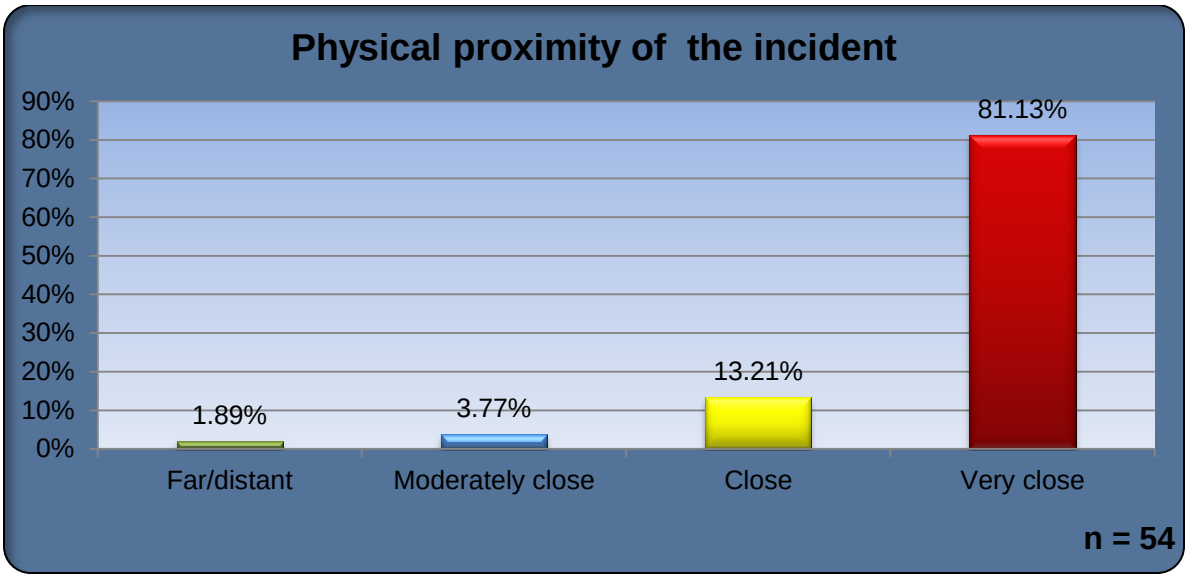


Figure 27: Physical proximity of the incident

Discussion of data

In this study, 81,13% of the respondents indicated that the physical proximity was "very close" and 13,21% indicated that it was "close". It is evident that the respondents' experience was that the incident was very close and directly impacting on them, increasing the potential for more severe trauma reactions. As the incident was perceived as being very close to them, it can be assumed that they experienced stronger trauma reactions.

6.2.1.3.5 Feelings of guilt

Participation in atrocities or being responsible for the harm of others, either as a perpetrator or as a witness, poses a risk for being severely affected by a critical incident (Friedman, 2003:24). People typically experience feelings of guilt associated with the incident. These feelings of guilt stem from feelings like "I could have prevented the incident or have minimised the impact in some way" or "I should have been braver". The presence of guilt contributes to the severity of the trauma and the trauma reactions of the person.

Question 3.3.5 of the client questionnaire relates to the feelings of guilt. The results are given in Figure 28.

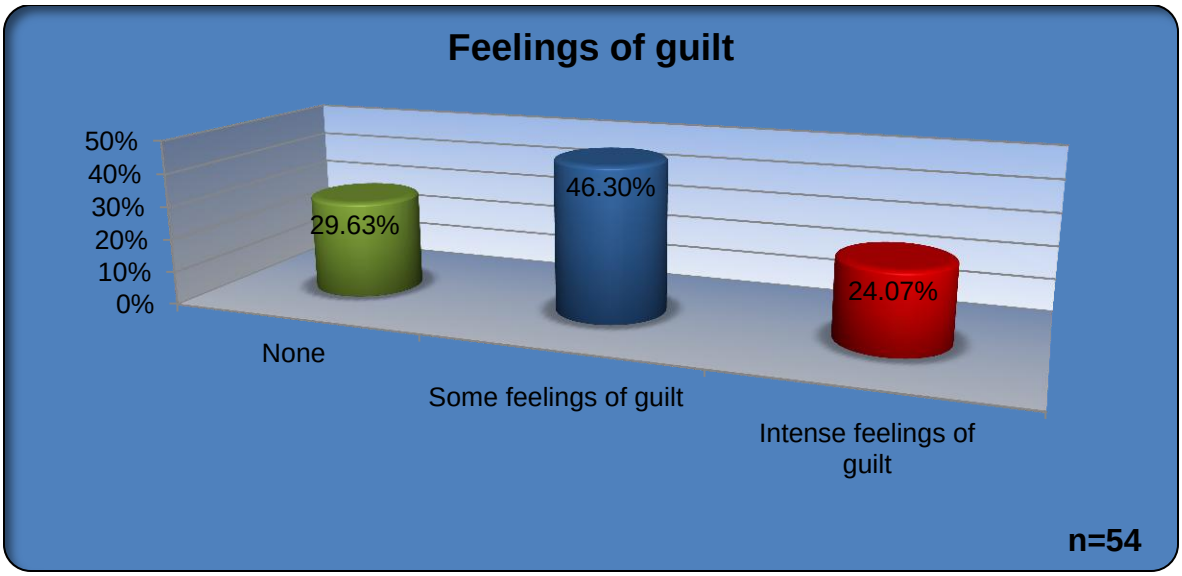


Figure 28: Feelings of guilt

Discussion of data

In the study, respondents indicated that there were some feelings of guilt (46,30%) and 24,07% of the respondents indicated that they had intense feelings of guilt. These feelings of guilt are expected to have some impact on their reactions, possibly increasing the severity of the trauma reactions.

6.2.1.3.6 Duration of incident

The longer the critical incident continues, the greater the risk of being traumatised (Friedman, 2003:25).

Question 3.3.6 of the client questionnaire relates to the duration of the incident. The results are given in Figure 29.

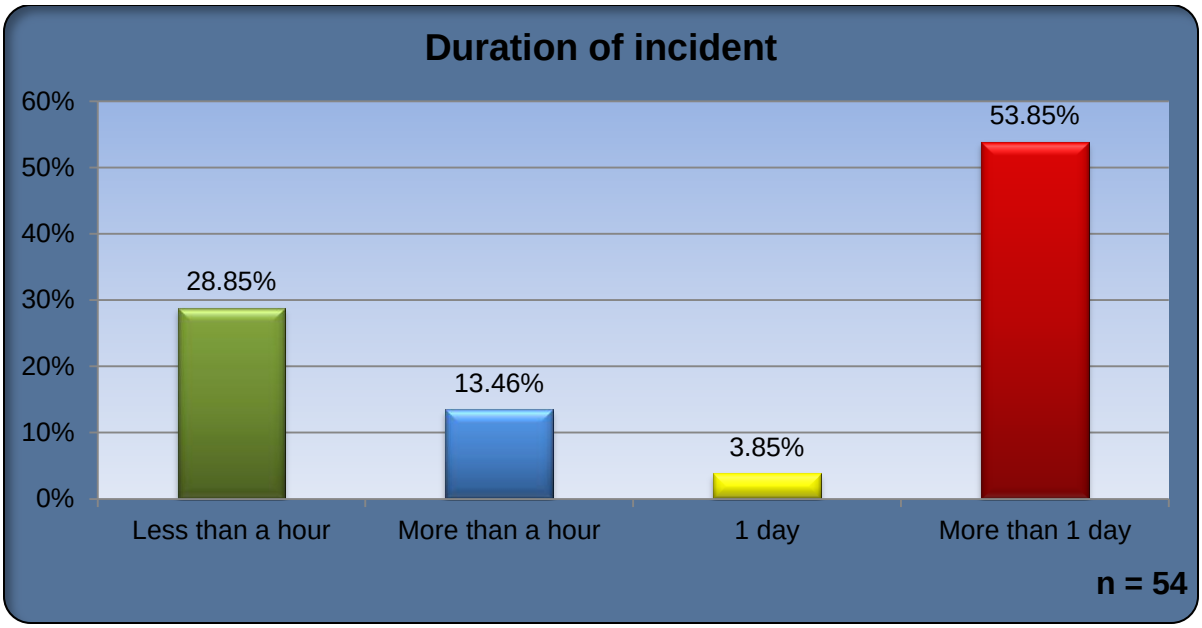


Figure 29: Duration of incident

Discussion of data

Most of the respondents (53,85%) in the study indicated that the critical incident continued for longer than one day. This indicates that the time they were exposed to the incident, was prolonged and could possibly impact more strongly on the traumatic experience or reaction.

6.2.1.3.7 Psychological proximity

Psychological proximity is an indication of the closeness of the relationship with the person being affected. The likelihood for traumatisation is highest when the critical incident is experienced by the victim him-/herself. If the critical incident has a personal impact on the victim, the risk of not coping with the event is greater. If a person's child is the victim of a critical incident or a child of similar age to your own child, there is a tendency of automatic identification with the victim, which improves the possibility of secondary traumatisation (Lewis, 1996: 54).

Question 3.3.7 of the client questionnaire relates to the psychological proximity. The results are given in Figure 30.

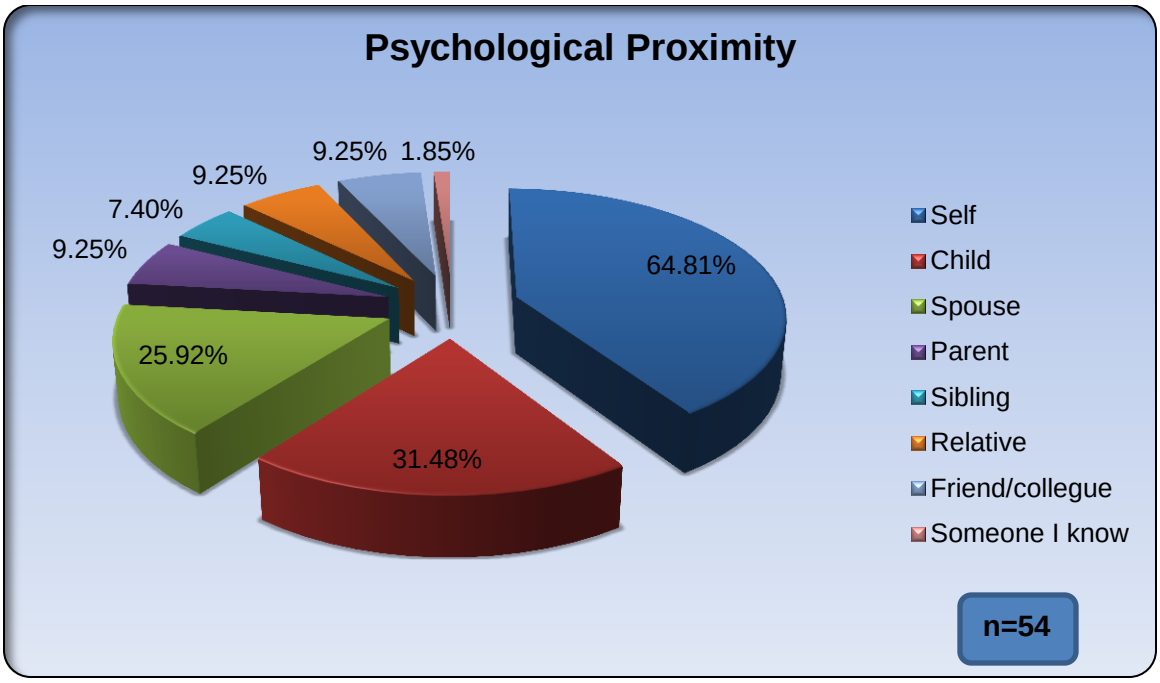


Figure 30: Psychological proximity

Discussion of data

The responses indicate that 64,81% respondents were affected by a critical incident themselves, indicating a high psychological proximity. Quite a number of respondents' children (31,48%), spouses (25,92%) and parents (9,25%) were traumatised as a result of a critical incident.

A close family member exposed to trauma also indicate a high psychological proximity due to the tendency to identify with the loved one or family member and seeing how the person is affected by the trauma can lead to transference of the reactions.

6.2.1.3.8 Stress associated with the incident

According to Lewis (1996:55), stress is cumulative; if there are many other losses, changes, or transitions in an individual's life, another crisis (especially dealing with trauma) may be the last straw. People under stress tend to be more prone to accidents, illness or other crisis and their capacity to resolve the crisis is diminished. This may become a vicious cycle, where stress leads to diminished capacity to cope with trauma, which may lead to more stressful events, which in turn further diminishes the person's ability to cope.

Question 3.3.8 of the client questionnaire relates to stress associated to the incident. The results are given in Figure 31.

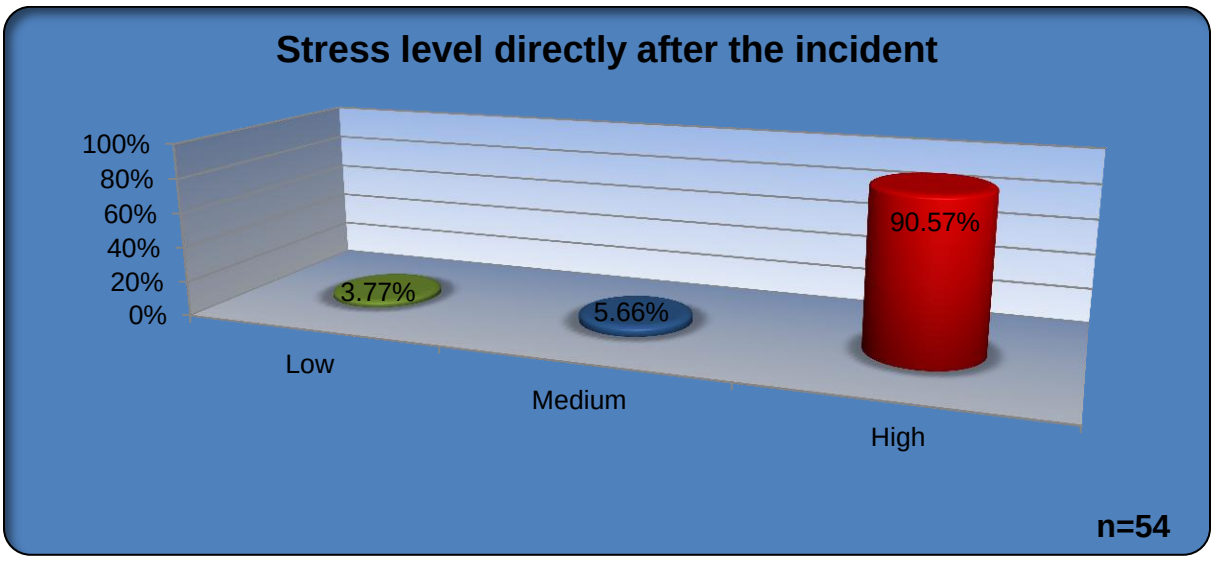


Figure 31: Stress level directly after the incident

Discussion of data

In the study, 90,57% of the respondents indicated that their stress levels were high directly after the critical incident. The fact that most respondents were already experiencing high stress levels directly after the critical incident is an indication of the impact of the trauma and that most respondents experienced it as quite severe.

6.2.1.3.9 Role and conflict overload

If a person is a victim of a critical incident, but professionally in the helping profession where he/she deals with trauma regularly, it may lead to a difficult emotional bind (Lewis, 1996:56). Being aware of the impact of the incident, and possibly being overloaded by critical incidents previously as a debriefer or therapist, it might lead to the surfacing of emotions that were not resolved and influence the person's coping ability in the present.

Question 3.3.9of the client questionnaire relates to role and conflict overload. The results are given in Figure 32.

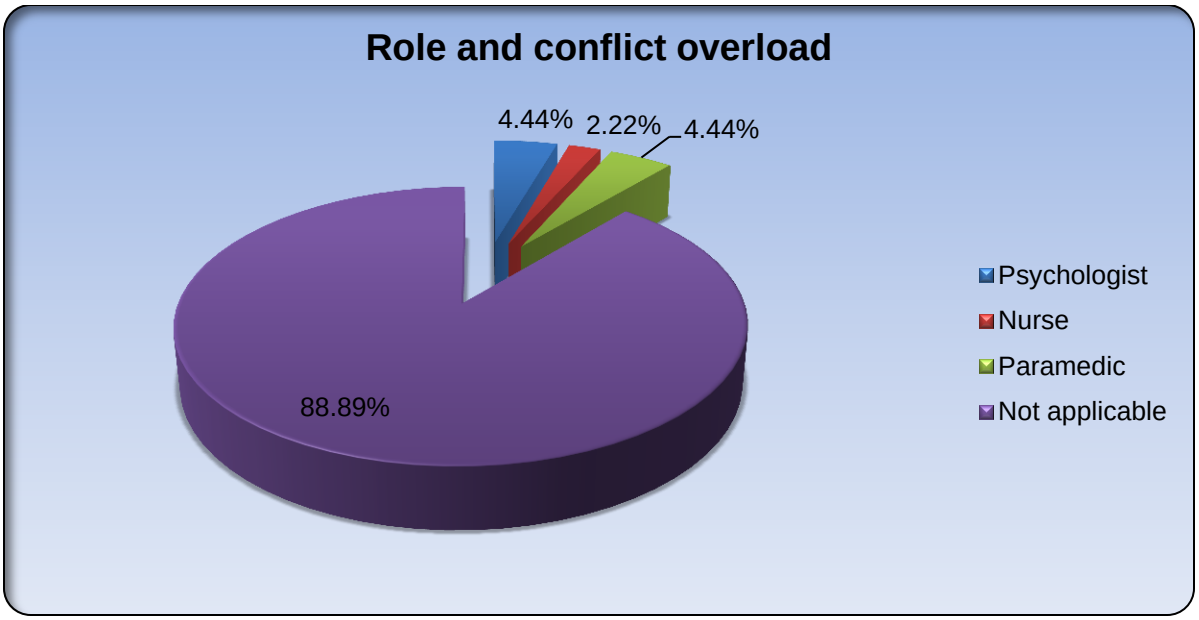


Figure 32: Role and conflict overload

Discussion of data

In the study, the majority of respondents felt that there was no role or conflict overload. In total a small percentage (11,1%) felt there was role and conflict overload due to the fact that they were exposed to critical incidents as a result of previous experience in their profession. A small percentage of the respondents were at risk of being affected as a result of role and conflict overload.

In summary, it seem that most situational factors were significant enough to have an impact on the severity of the reactions and the coping ability of the respondents and could have played a role in the development of PTSD at a later stage. The majority of respondents perceived the incident as sudden and unexpected, leaving them little time for physical and emotional preparation. In 86,45% of the cases it was man-made, indicating that they were traumatised as a result of the conduct of another human being. Half the respondents experienced the trauma as unbearable and 46,30% experienced it as severe. The physical proximity of the incident was perceived to be very close to them by the majority of the respondents. Most respondents experienced some feelings of guilt and 24,07% had intense feelings of guilt regarding the critical incident. The duration of the incident was perceived as longer than a day by more than half the respondents. The psychological proximity in terms of the critical incident was high as most of the respondents were directly involved in the

incident and the others were affected as a result of their children, spouses or parents being traumatised. The majority of respondents (90,51%) had high stress levels directly after to the incident. Role and conflict overload did not seem to have a major impact as only 11,1% of the respondents were in positions prior to the incident that could have led to role and conflict overload.

6.2.1.4 Post-trauma risk factors

In terms of post-trauma risk factors, Lewis (1996:11) mentions some factors that encourage the development of resilience after a critical incident, especially in children. These factors include:

- The availability of a close loving relationship, with a supportive, available caregiver
- A stable, supportive family environment which provides a child with structure, clear rules and good supervision
- Sources of emotional support outside the family, for example community or religious leaders, neighbours, teachers or peers
- Role models who display positive problem-solving skills and who themselves may have lived through a critical incident.

Although these factors focus on how resilience can be developed in the children after a critical incident, it is also applicable to adults affected by a critical incident. The availability of a loving, supportive relationship, the structure of a family, the support of religious or community leaders and positive role models may help to minimise the risk of a critical incident and prevent the development of PTSD.

Question 3.4 of the client questionnaire relates to post-trauma risk factors. The results are given in Figure 33.

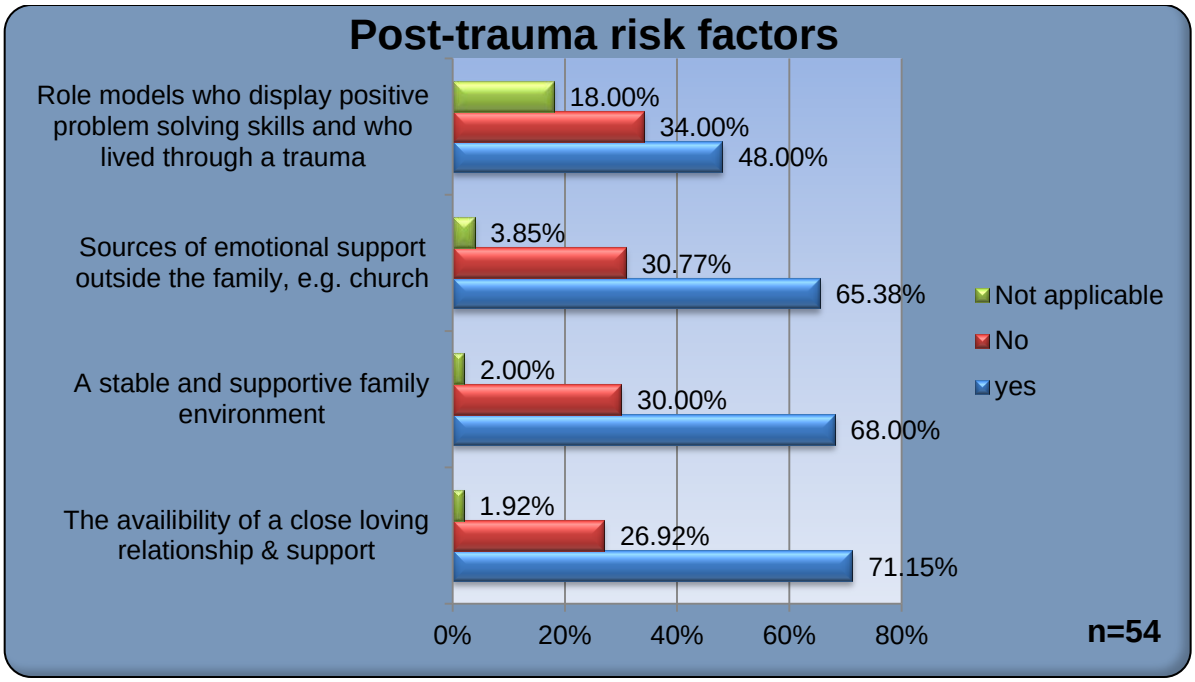


Figure 33: Post-trauma risk factors

Discussion of data

According to the responses in this study, it seems that post-trauma risk factors were supportive in terms of providing resilience and support to enhance recovery. Most (71,15%) of the respondents had the support of a loving relationship, 68,00%had a stable and supportive family environment, 65,38% had sources of support outside their family, for example a church, and 48,00% had positive role models who displayed positive problem-solving skills and who had lived through a trauma.

6.2.1.5 Reactions to a critical incident

The experience of a critical incident varies from person to person and from one event to another since differences in the individual variables affects the way in which stressful events are perceived and experienced. Trauma in itself can alter personal functioning in pathological ways and influence life-course development (Wilson, 1989:12). It must also be noted that trauma never occurs in a contextual vacuum. Critical incidents have the capacity to shatter the fundamental assumptions of survivors about themselves and their inner world, which forces them to confront their own vulnerability (Jannof-Bullman, 1997: 56). It is important to understand how a long-term response to an experience of trauma is shaped by a variety of

social, psychological and environmental processes that interact in complex ways to co-determine and construct an experience of trauma (Tedeschi & Calhoun, 1995:24).

Characteristic features of the reaction to a critical incident include fear, anger, recurrent distressing thoughts, guilt, depression, anxiety, bad dreams, irritability and generalised hyper-arousal.

The critical incident also activates certain processes in the individual. The process in the reaction to the critical incident is an emotional response. The first reaction is usually shock. The shock includes numbness, denial of the incident, sometimes withdrawal and at times hysteria. After the initial shock, normal emotional reactions such as anger, depression, sobbing and even praying and bargaining with God follows.

After the emotional processes, the behavioural process starts to play an important role. According to Schulz *et al.* (2000:32), the behavioural processes are initial attempts to cope with the reality of loss and what had happened. It might involve going back to work, or throwing out the clothes of the lost one or having sex for the first time after being raped. These attempts will probably be painful and unsatisfactory. It will take time to restore these behavioural processes to the state they were in before the critical incident. The final stage of these reactions is the cognitive or intellectual processes whereby a person starts to think and reason about what has happened to him/her. The person needs to reframe his/her experience in order to reach a stage of acceptance, adjustment and healing.

According to Friedman (2003:12), the *DSM-IV Diagnostic Criteria for Stress Disorders* refers to the time frame of the symptoms as an important determinant for establishing if the reaction is acute or chronic. "Acute" indicates that the duration of symptoms is less than three months and "chronic" indicates that symptoms lasted for three months or longer.

6.2.1.5.1 Physical symptoms

Dolan (1995:37) mentions that the victim of trauma feels worn out because of the extraordinary demands placed on his/her mental and physical resources, and he/she is drained below his or her former level of optimal and capable performance.

Question 3.5.1 of the client questionnaire relates to physical symptoms. The results are given in Figure 34.

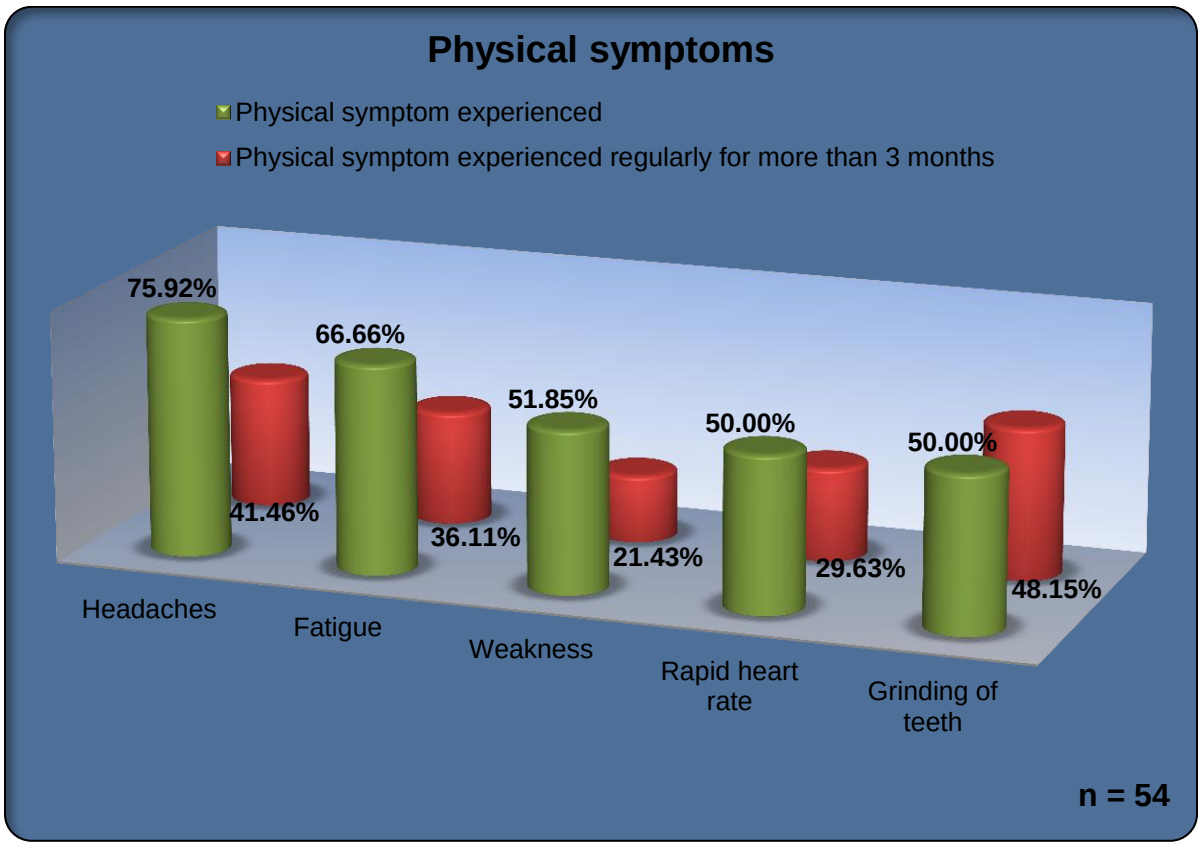


Figure 34: Physical symptoms

Discussion of data

The acute physical symptoms experienced by most of the respondents were headaches, fatigue, weakness, rapid heart rate and the grinding of teeth. Headaches were most common (75,92%), followed by fatigue (66,66%).

The most experienced chronic symptom was grinding of teeth which continued from an acute to a chronic reaction in 48,15% of the respondents. This was followed by headaches (41,46%) and fatigue (36,11%).

Although the symptoms reduced over time, it is evident from the responses that all these symptoms continued for longer than three months for some of the respondents.

6.2.1.5.2 Cognitive symptoms

Dolan (1995:39) mentions that the victims often feel confused and uncertain as they have to conceptualise the incident on a cognitive level in order to make sense of it. This can be a process that usually starts immediately after the trauma but continues for a few months. Concentration and memory are mainly affected as a result of the fact that the individual is cognitively busy processing the event in an attempt to understand and accept it.

Question 3.5.2 of the client questionnaire relates to cognitive symptoms. The results are given in Figure 35.

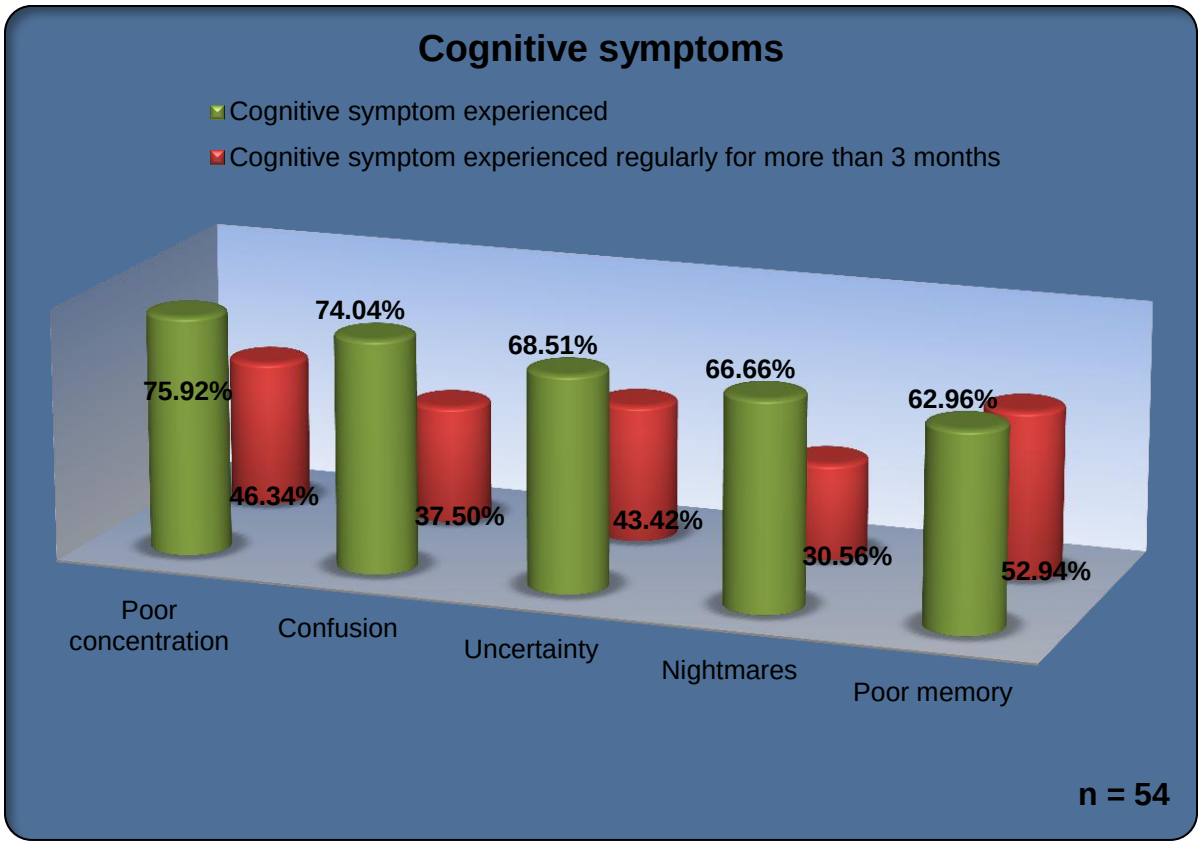


Figure 35: Cognitive symptoms

Discussion of data

The acute cognitive symptoms experienced by most of the respondents were poor concentration, confusion, uncertainty, nightmares and poor memory. Poor concentration was most common (75,92%), followed by confusion (74,04%) and uncertainty (68,51%). All of these symptoms continued for longer than three months. The most experienced chronic

symptom was poor memory, which progressed from an acute to a chronic reaction in 52,94% of the respondents. This was followed by poor concentration (46,34%) and uncertainty (43,42%).

6.2.1.5.3 Emotional symptoms

The process in the reaction to the critical incident is an emotional response. The first reaction is usually shock. The shock includes numbness, denial of the incident, sometimes withdrawal and at times hysteria. After the initial shock, normal emotional reactions such as fear, anxiety, anger and depression are common (Schulz *et al.*,2000:30).

Schulz *et al.* (2000:34) mention that depression is considered one of the more common reactions. Depression is said to be more likely to develop when circumstances involve significant loss.

Question 3.5.3 of the client questionnaire relates to emotional symptoms. The results are given in Figure 36.

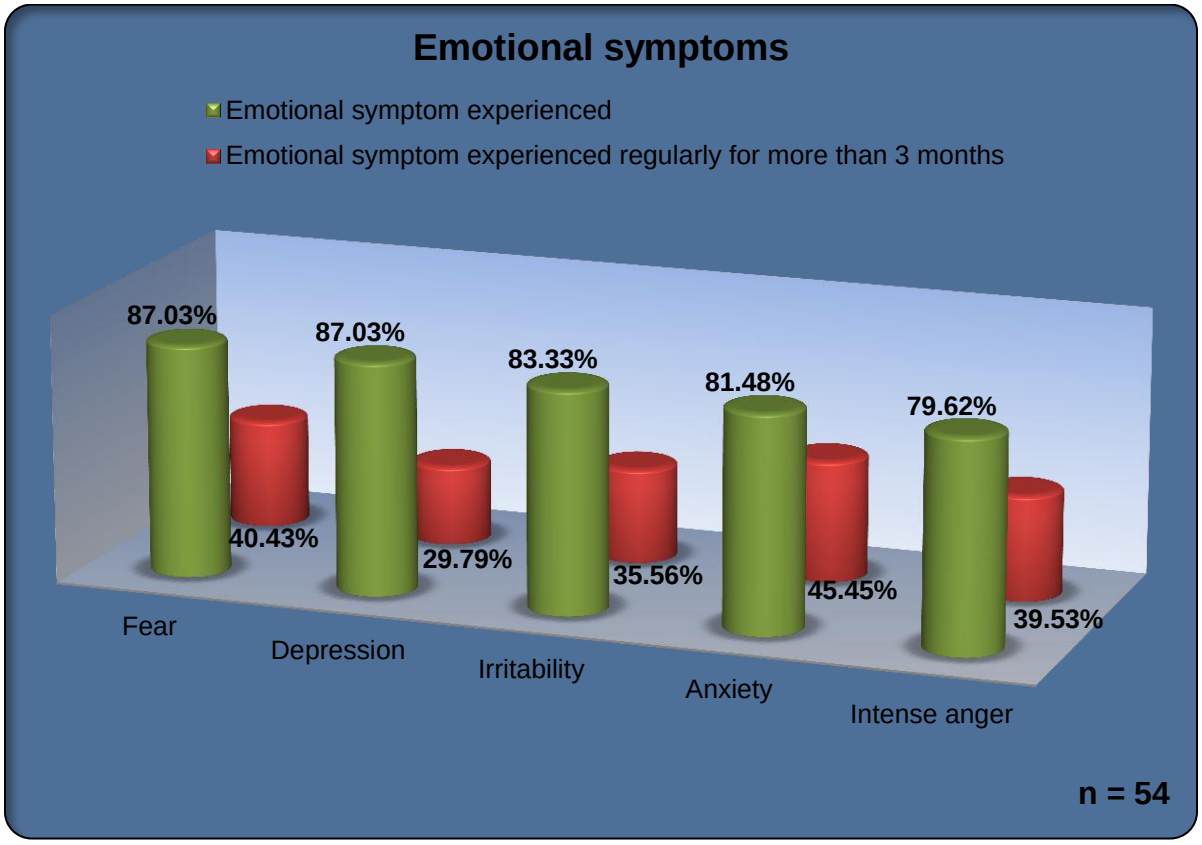


Figure 36: Emotional symptoms

Discussion of data

The acute emotional symptoms experienced by most of the respondents were fear, depression, irritability, anxiety and intense anger. Fear and depression were most common (87,03%), followed by irritability (83,33%), anxiety (81,48%) and intense anger (79,62%). All of these symptoms continued for longer than three months. The most experienced chronic symptom was anxiety, which progresses from an acute to a chronic reaction in 45,45% of the respondents. This was followed by fear (40,43%) and intense anger (39,53%). Depression was the lowest experienced symptom after three months, at 29,79%.

6.2.1.5.4 Behavioural symptoms

After the emotional processes, the behavioural process starts to play an important role. According to Schulz *et al.* (2000:32) the behavioural processes are initial attempts to create a sense of security and to cope with the reality of loss and what had happened.

Question 3.5.4of the client questionnaire relates to behavioural symptoms. The results are given in Figure 37.

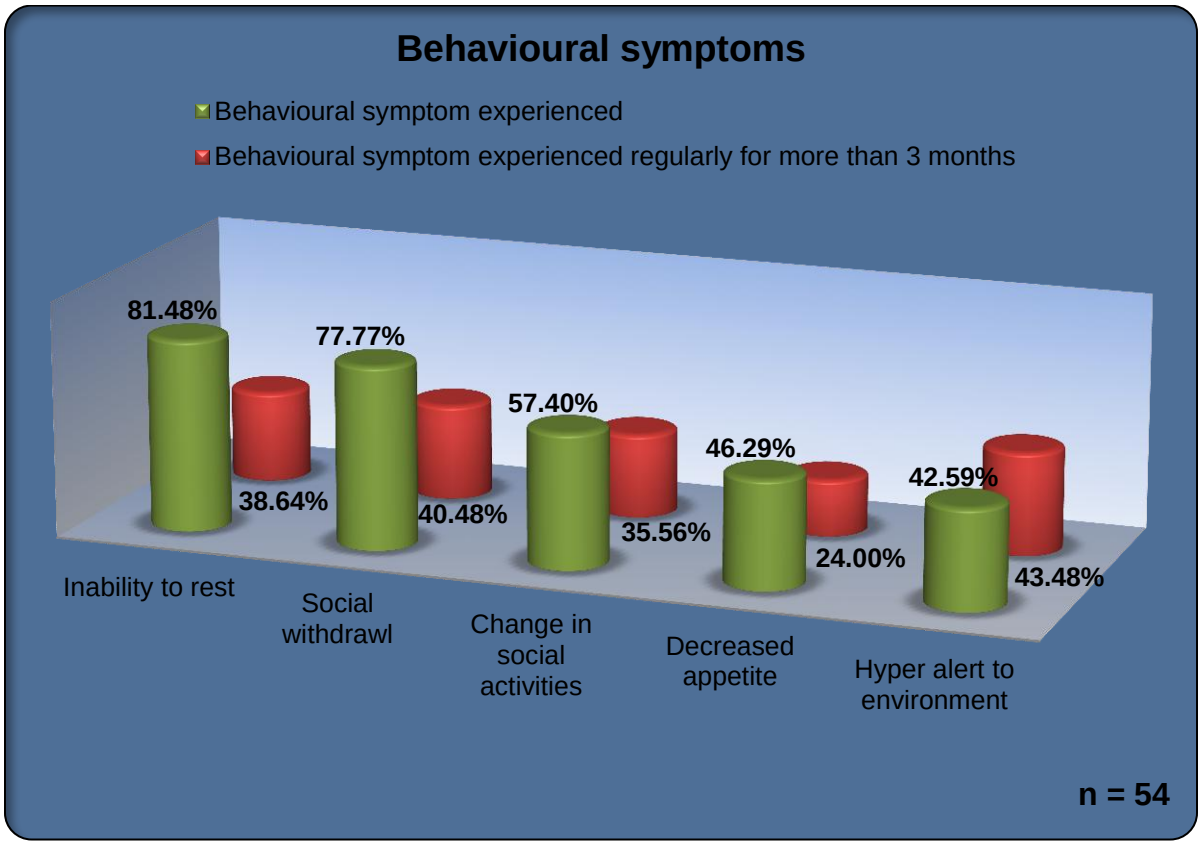


Figure 37: Behavioural symptoms

Discussion of data

The acute behavioural symptoms experienced by most of the respondents were inability to rest, as the most common (81,48%) symptom, followed by social withdrawal (77,77%), change in social activities (57,40%) and decreased appetite (46,29%). All of these symptoms continued for a period longer than three months. The most experienced chronic symptom was hyper-alertness to the environment, which progressed from an acute to a chronic reaction in 43,48% of the respondents. This was followed by social withdrawal (40,48%) and an inability to rest (38,64%). Decreased appetite was the lowest experienced symptom after three months, at 24,00%. The fact that hyper-vigilance remained highest after three months is an indication that respondents' sense of security was not fully restored and that they still felt unsafe and the need to be alert in order to protect themselves.

In summary it was evident that the acute symptoms experienced most by the respondents were emotional symptoms. The chronic symptoms experienced most by respondents were cognitive symptoms. Fear and depression was the most experienced acute symptom (87,03%) and poor memory the most experienced chronic symptom (52,94%).

"When the event has passed, it does not mean that the experience is over for those involved", according to Kleber and Brom (1992:2). The person affected by a critical incident has to face the after-effects for a long period.

6.2.1.5.5 Shattering of assumptions

According to Schulz *et al.* (2000:10), a critical incident shatters the life assumptions of the person who becomes a victim of such an incident. Each person constructs a cognitive and mental frame around reality that forms his/her assumptions about how the world should operate. Inside this frame his/her deepest hopes, expectations and dreams are placed. This frame is shattered when a person is exposed to a critical incident. A critical incident challenges and shatters a person's assumptions of the world– the world suddenly becomes crazy and does not make sense. The assumptions shattered by a critical incident are the following:

- **Assumption of invulnerability**

  A critical incident affects a person's sense of security. After a person has become a victim of a critical incident, he/she no longer sees the world as a safe secure place, but sees it as an unsafe dangerous environment in which he/she has to live. This leaves a person with a strong sense of vulnerability, as a result of the fact that his/her safe world has been intruded and violated (Schulz *et al.*, 2000:11).

- **Assumption of rationality**

  People live their lives assuming that the world they live in is a rational place. We expect the world to be an understandable and orderly place. When a person is exposed to a critical incident, the assumption that he/she lives in a rational world is shattered. A critical incident makes a person realise that the world and the people in it is not rational and predictable, this leaves a person with a sense of uncertainly and vulnerability. As rational beings we seek the rational in the critical incident; when no rational explanation is found it tends to heighten the traumatic blow (Schulz *et al.*, 2000:12).

- **Victim's sense of morality**

  A critical incident affects a person's sense of morality to a great extent. People have the assumption that they live in a fair and just world. The expectation exists that good people who do good things should be rewarded and bad people who do bad things should be punished. In the event of a critical incident, the sense of morality is disturbed. Morality no longer seems valid in the face of irrational and undeserved torture. This may lead to a conflict in a person's religious belief systems. When a person suffers injustice, he/she might feel that someone is to blame, and somehow the justice has to be restored. The urge to retribution may be an uncommon emotional response and may lead to conflict in a person's belief system (Schulz *et al*., 2000:16).

- **Assumption of self-identity**

  Every person has a certain picture of who he/she is. This includes an idea of his/her capabilities and assets and also of his/her shortcomings. The traumatisation of a critical incident changes a person's self-perception. The person who used to carry him-/herself with a healthy sense of who he/she is, now views him-/herself differently. The person sees him-/herself as a victim. The person's self-perception has changed to that of a

victim. This new sense of cognisance changes how a person approaches life and relationships (Schulz *et al*., 2000:18–19).

Question 3.6 of the client questionnaire relates to the shattering of assumptions. The results are given in Figure 38.

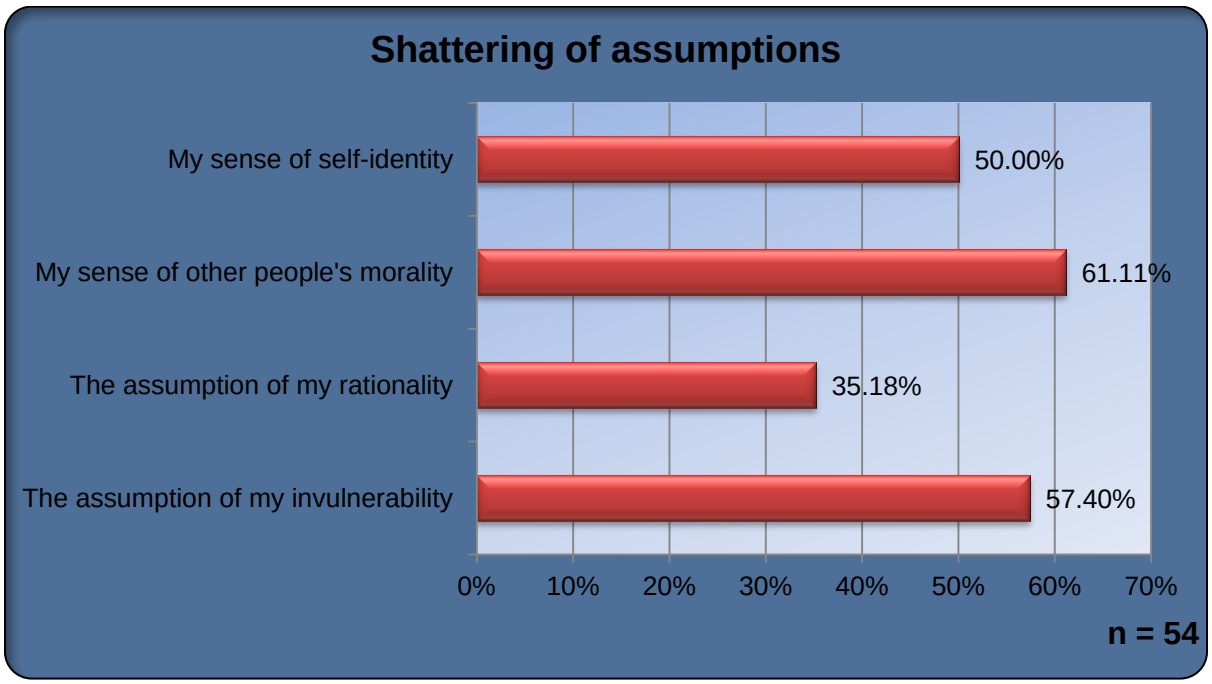


Figure 38: Shattering of assumptions

Discussion of data

The reactions of respondents in the study showed that their sense of other people's morality was shattered the most (61,11%), followed by their sense of vulnerability (57,40%). Their sense of self identity (50%) and assumption of rationality was also affected (35,10%).

The fact that respondents' life assumptions were shattered indicates their reaction to the impact of the critical incident. The degree to which life assumptions are shattered may differ from person to person and the time it may take to restore these assumptions also depends on the individual.

6.2.1.6 Interventions

6.2.1.6.1 Defusing

The goal of defusing is to lessen the impact of the event and to assess the needs of the group. The process is brief (usually 20 to 45 minutes). According to Du Toit (in Roos et al., 2003:108), there is a marked difference between trauma debriefing and trauma defusing. Defusing refers to "dealing with traumatized people on the scene of the incident or immediately after the critical incident". The process of defusing creates support mechanisms and procedures before, during and immediately after a critical incident with the aim of providing a positive and supportive atmosphere and to re-establish the solidarity of the meaning to be a successful and happy human being (Schulz et al., 2000:152).

The goal of defusing is to lessen the impact of the event at the scene and to create a supportive network to assist employees who may need further assistance.

Question 4.1 of the client questionnaire relates to defusing.

Discussion of data

Only 16 (29,62%) of the respondents were defused after the critical incident. The majority did not receive any defusing (70,38%).The fact that only a small portion of respondents were defused might have had an impact on their trauma reactions and functioning after the incident.

6.2.1.6.1.1 Impact of defusing

The aims of the defusing process are to:

- Understand the process of intervention
- Regain control and routine
- Deal with practical and physical issues
- Provide emotional support
- To clarify what happened
- Clam down
- Rebuild confidence
- and to recover a sense of safety.

Questions4.1.1 to 4.1.8 of the client questionnaire relate to the impact of defusing. The results are given in Figure 39.

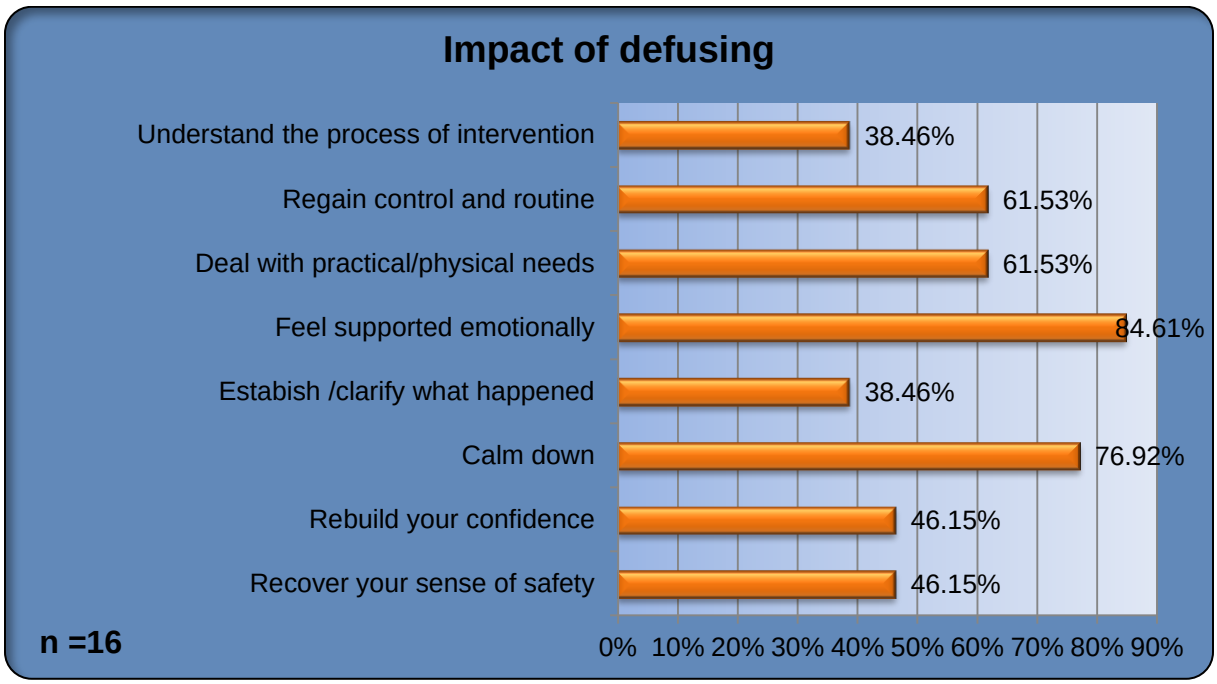


Figure 39: Impact of defusing

Discussion of data

Data on the impact of defusing are based on the responses of the 16 respondents who participated.

Only 16 of the 54 respondents (29,62%) received defusing after the critical incident. They perceived the defusing process as beneficial and felt that some of the aims of defusing were met. Referring to the impact of defusing, a feeling of being supported after the defusing (84,61%) was pointed out as the strongest reaction, followed by "felt calmed down after the process" (76,92%).They also felt that they had dealt with practical and physical issues (61,53%) and regained control and routine (61,53%).

6.2.1.6.2 Debriefing

The primary goal of debriefing is to mitigate the impact of a critical incident on those who have been primary, secondary or tertiary victims of the event, and to facilitate the recovery process of those experiencing stress reactions.

According to Harbert (2000:400), CISD is a technique used with a group of individuals who suffered a critical incident. Ideally it has to be done between 24 to 72 hours after the incident or after the individuals have left the scene. This time frame is essential for decreasing the psychological impact on the victim. The reality of a critical incident that has happened normally starts to dawn on the victim within 24 to 36 hours of the incident (McWhirter & Linzer, 1994:404).

Questions4.3 of the client questionnaire relates to debriefing.

Discussion of data

Most of the respondents (55,56%) indicated that they were not debriefed after the critical incident. Only 44,44% of respondents were debriefed after the incident.

6.2.1.6.2.1 Impact of debriefing

The aims of the debriefing process are to:

- Create a safe harbour
- Establish the principle of normality
- Regain control
- Cognitive redefinition
- Prevention of PTSD
- To prepare participants for possible emotional after-effects.
- To begin the process of moving those involved from victim to survivor status.

In addition to this, McWhirter and Linzer (1994:390) and Wilson *et al*. (2004:21) mention that debriefing provides the following:

- Education about stress reactions
- Emotional ventilation
- Promotion of cognitive organisation through clear understanding of both events and reactions
- Reassurance that the stress response is controllable and that recovery is likely
- Intervention to assist in recovery from traumatic stress
- Decrease in individual and group tension

- Mobilisation of resources within and outside the individual or group
- Preparation for experiences such as symptoms or reactions which may arise
- Screening for people who may need additional support.

Questions4.3.1 to 4.3.7 of the client questionnaire relate to the impact of debriefing. The results are given in Figure 40.

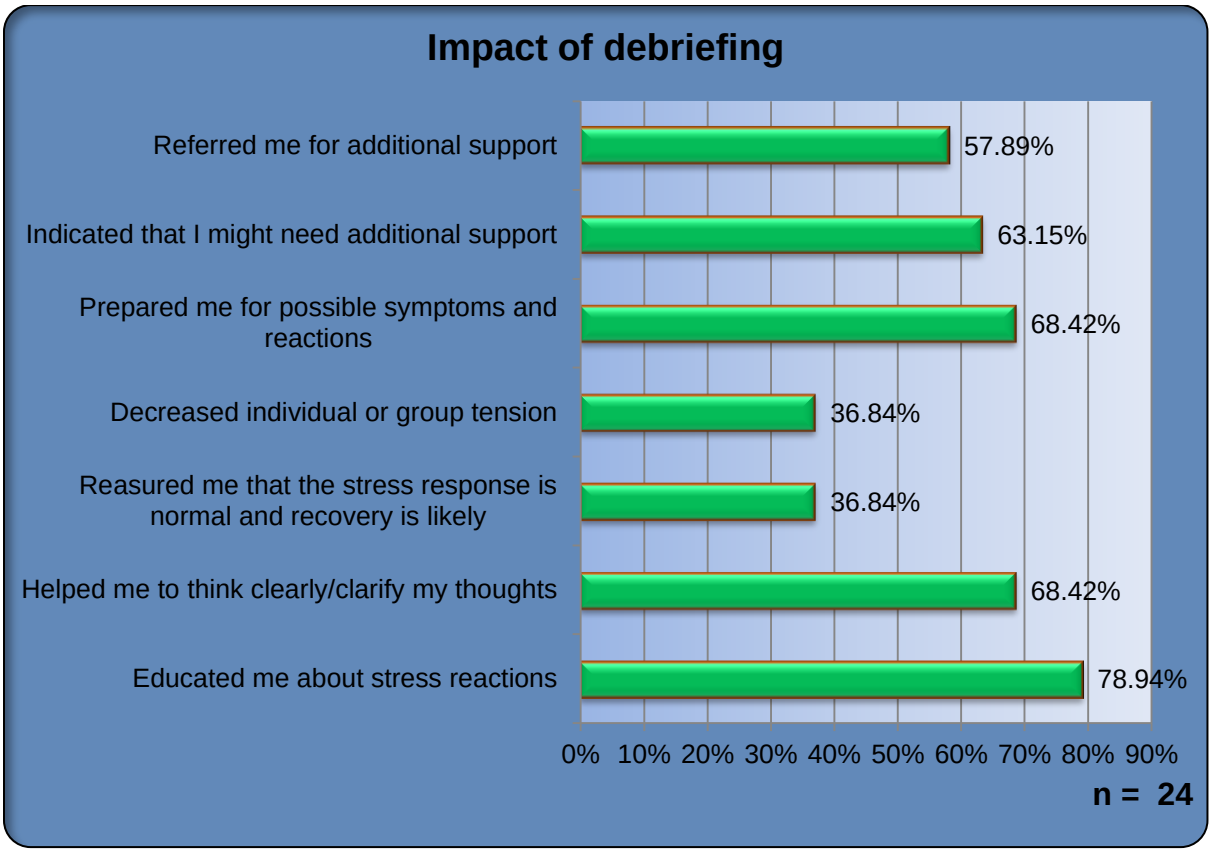


Figure 40: Impact of debriefing

Discussion of data

Data on the impact of debriefing are based on the responses of the 24 respondents who participated.

Taking into account that only 44,44% of the respondents received debriefing after the critical incident, they felt that some of the aims of debriefing were met. Most of them indicated that they were educated in terms of normal stress reactions (78,94%).Secondly, they felt that they were prepared for symptoms and reactions they might expect (68,42%) and it helped

them to clarify their thoughts (68,42%).They also felt that they were informed that they might need additional support (63,15%) and was referred for additional support (57,87%). The outcomes of the debriefing were mostly beneficial for respondents and contributed to the recovery of respondents after the trauma.

6.2.1.6.3 Aftercare

6.2.1.6.3.1 Support after the debriefing process

The debriefer should be able to critically assess if a client in the CISD procedure will be able to incorporate the event into his/her life and make an emotional recovery. If there is any doubt or if the client is at risk, he/she should be referred for aftercare.

Schulz et al. (2000:167) indicate when a client needs to be referred for aftercare:

- If there are any extreme reactions, for example complete withdrawal and no reaction or over-reaction and the inability to control him-/herself
- Inappropriate reaction and no contact with reality
- Clients who meet the criteria for PTSD or any other disorders (e.g. anxiety disorders, depression or dependency)
- Inclination towards suicide
- Clients who have experienced serious problems in the past as a result of an inability to deal with stress and trauma
- Clients who demand to be referred for therapy or other professional help.

The process of aftercare is focused on supporting the client and helping the client to understand and integrate what has happened to him/her.

Questions4.4.1 to 4.4.3 of the client questionnaire relate to support after the debriefing process. The results are given in Figure 41.

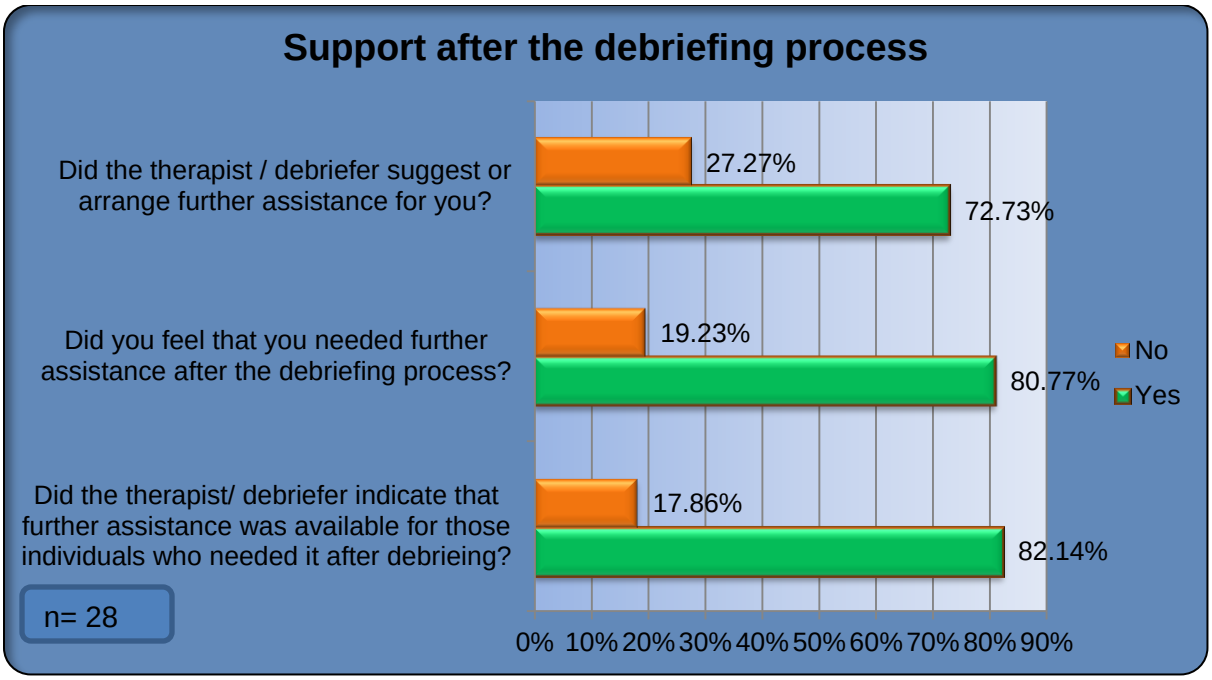


Figure 41: Support after the debriefing process

Discussion of data

Data on the support after the debriefing process are based on the responses of the 28 respondents who participated.

In the study, it was evident that most respondents (72,73%) were referred for aftercare and the majority of respondents (82,14%) were made aware that further assistance is available. The high number of respondents who were referred for further assistance corresponded with the respondents' feelings that they needed further assistance. In the study, 80,77% of the respondents indicated that they felt they needed further assistance.

It can be concluded that aftercare was needed by most respondents after being traumatised by a critical incident and that aftercare was an integral part of the recovery process.

6.2.1.6.3.2 Referral for further assistance

Referral for assistance after debriefing can be to a variety of professions or community organisations according to the needs of the person. At times it is not only the victim of the incident who is affected but also the family members of that individual. Figley (1994:23) suggests that traumatic events have a much wider systematic impact than only on the individual in isolation. Family members appear to suffer anxiety and bereavement and their

lives may be disrupted as a result of the injury to their loved one. The literature presented by Engelbrecht (1997:110) suggests that the family system needs to be recognised in the recovery process.

Question 4.4.3 of the client questionnaire relates to referral for further assistance. The results are given in Figure 42.

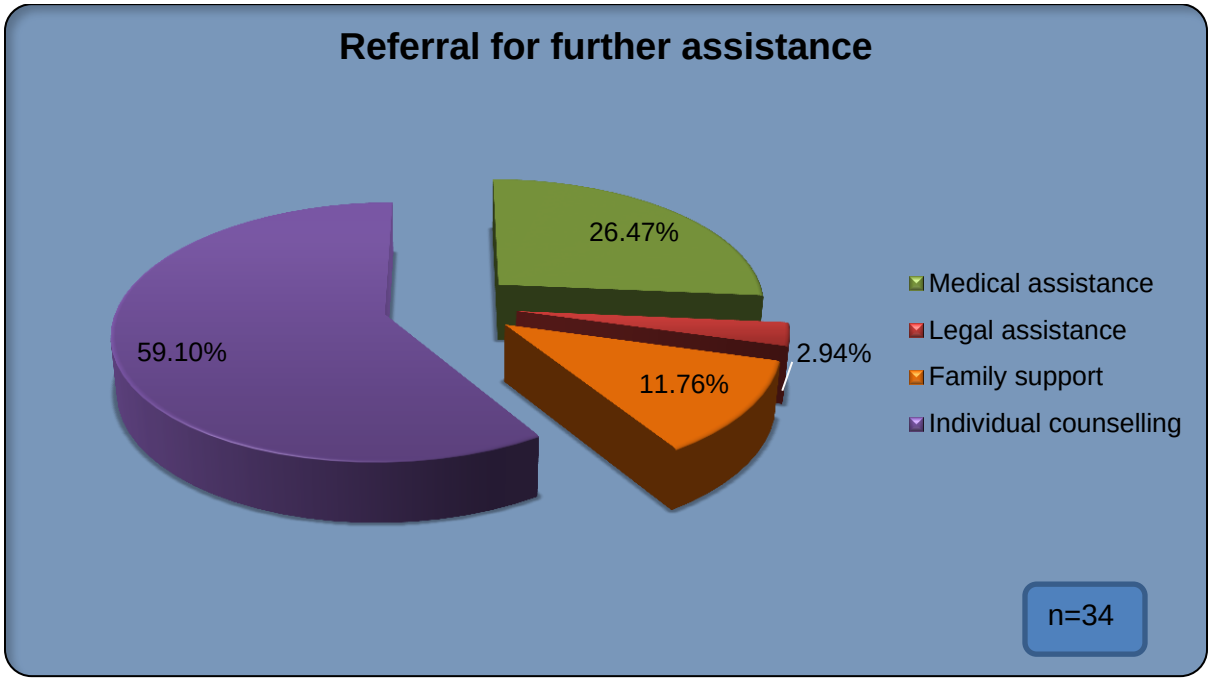


Figure 42: Referral for further assistance

Discussion of data

Data on the referral for further assistance are based on the responses of the 34 respondents who participated.

In this study the majority of respondents were referred for individual counselling (59,10%) after debriefing. This was followed by referral for medical assistance (26,47%), for family support (11,76%) and for legal assistance (2,94%).

It is evident from the responses that some family members were also affected as a result of the trauma their loved ones were exposed to and the family as a unit was referred for family support. As indicated, the inclusion of family members in the recovery process was crucial as

the impact not only affected the victim of the critical incident but his/her family too. The fact that only 11,76% of respondents were referred for family support could be detrimental in the recovery or the lack thereof of the respondent. Family members could continue to be affected after the affected individual had resolved issues relating to the matter or family members could be oblivious to the individual's recovery process and, therefore, be lacking in their support.

6.2.1.6.3.3 Further assistance

Critical incident response can accomplish psychological closure, prevention and mitigation of traumatic stress, and promote return to normalcy, benefiting the individual, organisation and the community at large (VandePol *et al*., 2006:120).

Questions4.4.4 to 4.4.5 of the client questionnaire relate to further assistance. The results are given in Figure 43.

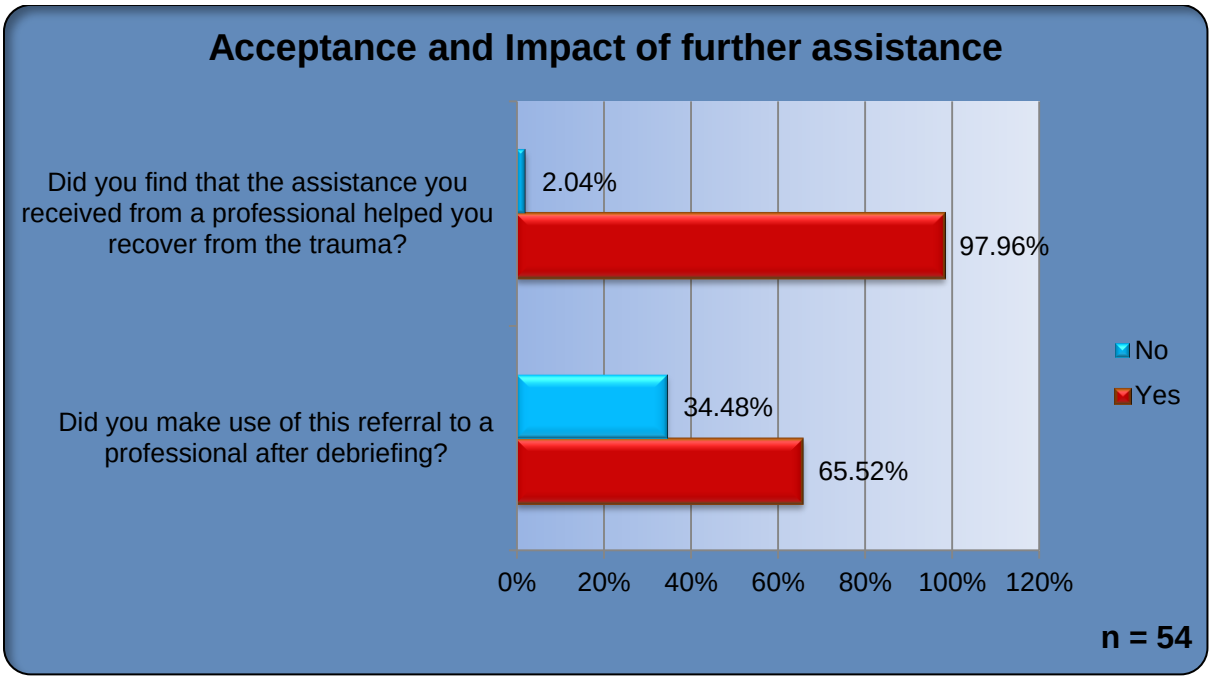


Figure 43: Acceptance and impact of further assistance

Discussion of data

In the study, 65,52% of the respondents who were referred for further assistance did consult a professional after being referred. Of those respondents who complied with the referral

procedure, a vast majority (97,96%) were of the opinion that the professional help they received assisted them in their recovery process.

It can be assumed from the responses of the respondents that the intervention was effective and benefited the respondents in the recovery process.

6.2.1.6.4 Experience of individual counselling

According to a review by the National Institute of Mental Health (2002:2), "Early, brief, and focused psychotherapeutic intervention can reduce distress in bereaved spouses, parents, and children".

Question 4.4.6 of the client questionnaire relates to the experience of individual counselling. The results are given in Figure 44.

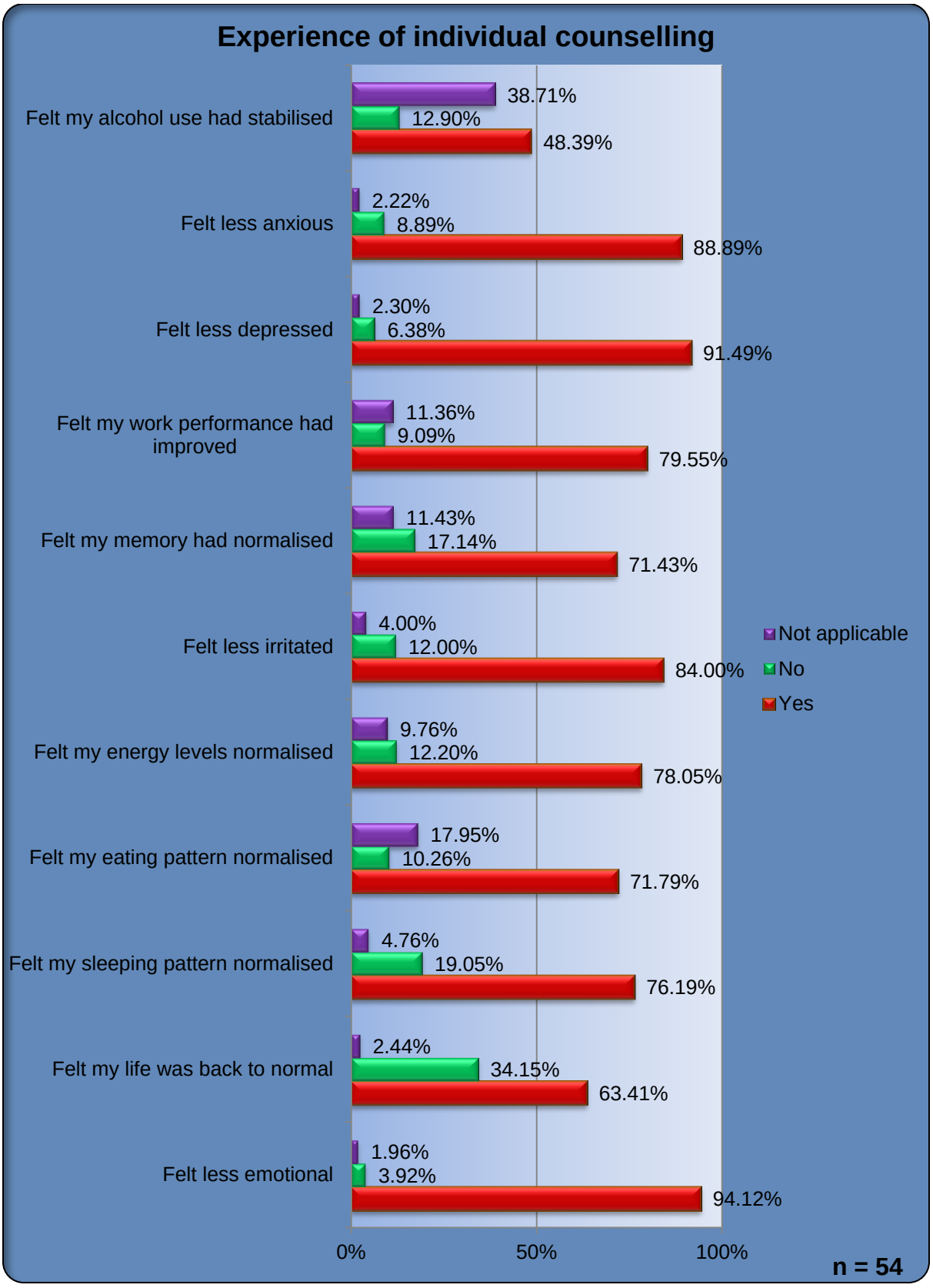


Figure 44: Experience of individual counselling

Discussion of data

In the study, the overwhelming response of respondents to the ways individual counselling impacted on them was "yes". Individual counselling helped them in various ways. The majority of respondents (94,12%) indicated that they felt less emotional after the counselling, followed by feeling less depressed (91,49%), feeling less anxious (88,89%), feeling less irritated (84,00%), experienced improved work performance (79,55%) and their energy levels normalised (78,05%).

Therefore the assumption can be made that individual counselling was effective in dealing with trauma and assisting the individual in the recovery process. This is in agreement with the literature that indicates that individual therapy is effective.

The conclusion from these reviews is that critical incident response services (including individual therapy), when properly delivered, are helpful in reducing the symptoms of severe stress that affect individuals who have experienced a workplace trauma or other critical incident (Everly, Flannery & Eyler, 2002; Everly & Flynn, 2006; Flannery, 2001; Flannery & Everly, 2004; Flannery, Everly & Eyler, 2000).

6.2.1.6.5 Value of individual counselling

Many employers provide access to CIR services because it is the "right thing to do" and thus may not require a formal business case to justify providing the services (Claussen, 2009:49). CIR services are provided primarily for the reason of improving the clinical recovery of the individuals affected by the trauma or crisis experience. In the process of this recovery, however, there can also be other outcomes that can benefit the organisation. The business value for employers from the proper use of CIR services from EAPs is most likely to be found in the outcomes of reduced worker health care costs, reduced disability claim costs, reduced workers' compensation claim costs, reduced worker absence days, reduced worker turnover and from increasing the number of employees who can successfully return to work after being on disability due to experiencing a traumatic event (Smith & Rooney, 1999:354).

Question 4.4.7 of the client questionnaire relates to the value of individual counselling.

Discussion of data

The overwhelming majority of respondents (98,04%) indicated that they benefited from individual counselling; only 1,96% was of the opinion that they did not benefit from individual counselling.

The overwhelming response from respondents that they benefited from the intervention was a further indication that individual counselling was an effective tool for dealing with the reactions to trauma. This was not only beneficial to the employee but also to his/her family and the company he/she worked for.

The high percentage (98,04%) of positive responses regarding the value of individual counselling should be considered in terms of return on investment as the employer companies would have gained an indirect economic benefit through means of the EAP intervention.

6.2.2 Data on clients being exposed to a critical incident, as provided by the therapist (part 2)

Part 2 of the questionnaire (see Appendix 4) was completed by the therapists whom had been consulted by the employees/clients after their critical incident. Therapists all had a minimum qualification of a master's degree in either Social Work or Psychology with a minimum of five years' experience in private practice. Therapists were familiar with the terms used in the questionnaire and the symptoms and classifications of trauma and anxiety disorders, with specific reference to PTSD and acute stress disorder.

The questionnaire requested the therapist to indicate the reactions and symptoms presented by the client as a result of exposure to a critical incident, based on the indicators suggested by the DSM IV for PTSD and acute stress disorder.

The goal of this questionnaire was to assess the impact of exposure to a critical incident on the psychosocial functioning and work performance of employees. The goal was not to make diagnosis in terms of PTSD, acute stress disorder or any other disorders, but rather to reflect on some of the symptoms related to these disorders.

6.2.2.1 Trauma reactions associated with PTSD

Trauma reactions include symptoms of re-experiencing the trauma through nightmares, obsessive thoughts and flashbacks (feeling as if you are actually in the traumatic situation again).There is an avoidance component as well, where the individual avoids situations, people and/or objects that remind him/her about the traumatic event (e.g. a person experiencing PTSD after a serious car accident might avoid driving or being a passenger in a car).Finally, there is increased anxiety in general, possibly with a heightened startle response (e.g. being very jumpy or easily startled by noises).

Trauma reactions are based on the reactions and symptoms as specified by the DSM IV in the classification of PTSD and acute stress disorder.

6.2.2.1.1 Trauma exposure

Questions 1.1 to 1.6 of the therapist questionnaire focus on the reactions typically associated with PTSD.

The DSM-IV Diagnostic Criteria for PTSD with regard to exposure are the following (Friedman, 2003:12):

A. The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual death or threatened death or serious injury, or a threat to the physical integrity of self or others
2. The person's response involved intense fear, helplessness, or horror.

When a person falls victim to a trauma it can be an experience in person (primary) or as a result of another person being traumatised (secondary). The impact of secondary trauma, specifically when significant others are affected, can be just as severe as in the case of primary traumatisation. De Vries *et al.* (1999:1294) support the notion that trauma is a family experience, with the members' reactions to the trauma being closely interwoven and interrelated. Figley (1994:23) suggests that traumatic events have a much wider systematic impact than affecting only the individual in isolation. According to Smith (2005:1–3), family dynamics can be affected in the short, medium and long term as a result of trauma.

Questions 1.1 to 1.2of the therapist questionnaire focus on trauma exposure. The results are given in Figure 45.

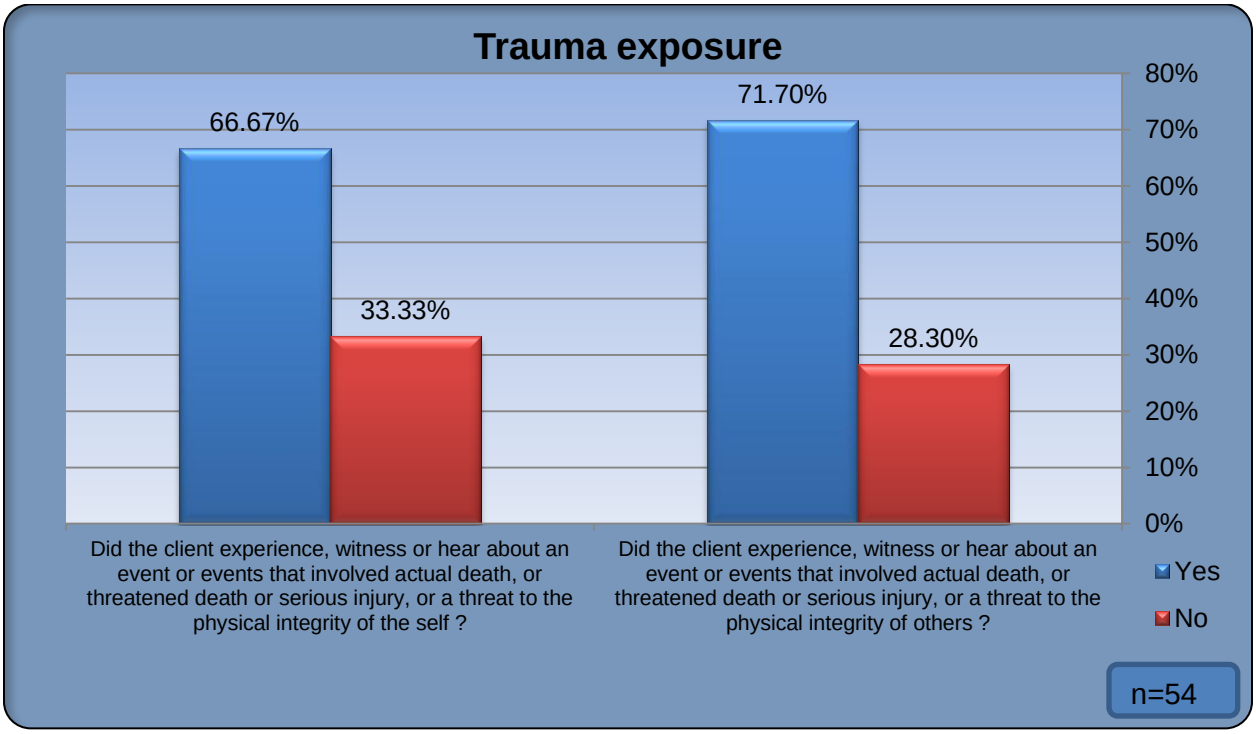


Figure 45: Trauma exposure

Discussion of data

According to the responses of respondents it seems that the majority of clients experienced primary as well as secondary trauma, although secondary trauma was slightly higher than trauma to the self. The fact that respondents were traumatised themselves, as well as affected as a result of the trauma experience of others, increases the impact of the trauma, the possibility of traumatisation and PTSD.

6.2.2.1.2 Initial response to trauma

Horror, fear and helplessness are responses typically associated with trauma immediately after a critical incident had happened. Gilliland and James (1993:45) explain that psychic trauma is a process initiated by an event that confronts an individual with an acute, overwhelming threat. The individual's mind is unable to effectively answer basic questions of

how and why it occurred, and what it means. This initial shock is associated with an intense fear, horror and helplessness.

Question 1.3 of the therapist questionnaire focuses on the initial response to trauma. The results are given in Figure 46.

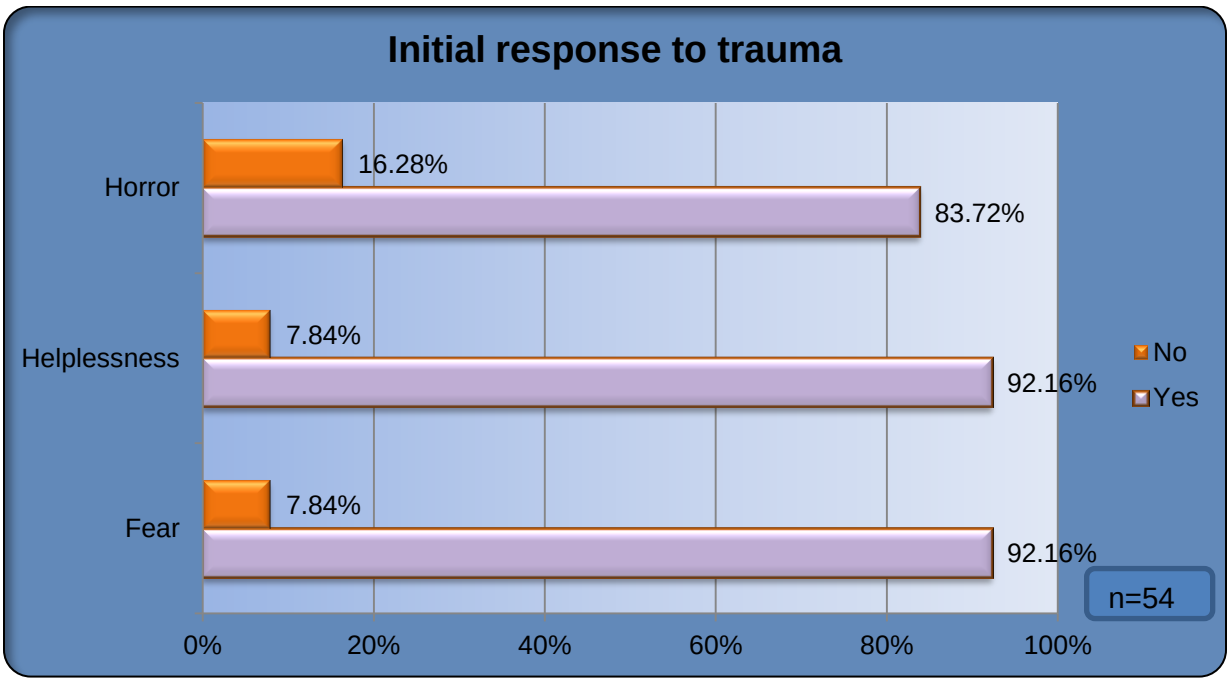


Figure 46: Initial response to trauma

Discussion of data

In the study, it was evident that clients' initial responses involved horror (83,72%), helplessness (92,16%) and fear (92,16%), indicating the impact and severity of their reaction shortly after the critical incident had happened.

6.2.2.1.3 Re-experiencing the event

The DSM-IV Diagnostic Criteria for PTSD with regards to re-experience are the following (Friedman, 2003:12):

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
2. Recurrent distressing dreams of the event

3. Acting or feelings as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissocialise flashback episodes)
4. & 5.Intense psychological distress or physiological reactivity on exposure to internal or external clues that symbolise or resemble an aspect of the traumatic event.

According to Friedman (2003:14), one of the major symptoms of PTSD is that the victims re-experience the event. Re-experiencing the traumatic event might take place in the form of either nightmares or having flashbacks of the event. Flashbacks are normally triggered by something (such as a smell or sound) that is associated with the traumatic event. Whenever the person re-experiences the event, it is normally with the same intensity of emotions that the person has experienced during the actual event.

Questions 1.4.1 to 1.4.5 of the therapist questionnaire focus on the re-experiencing of the event. The results are given in Figure 47.

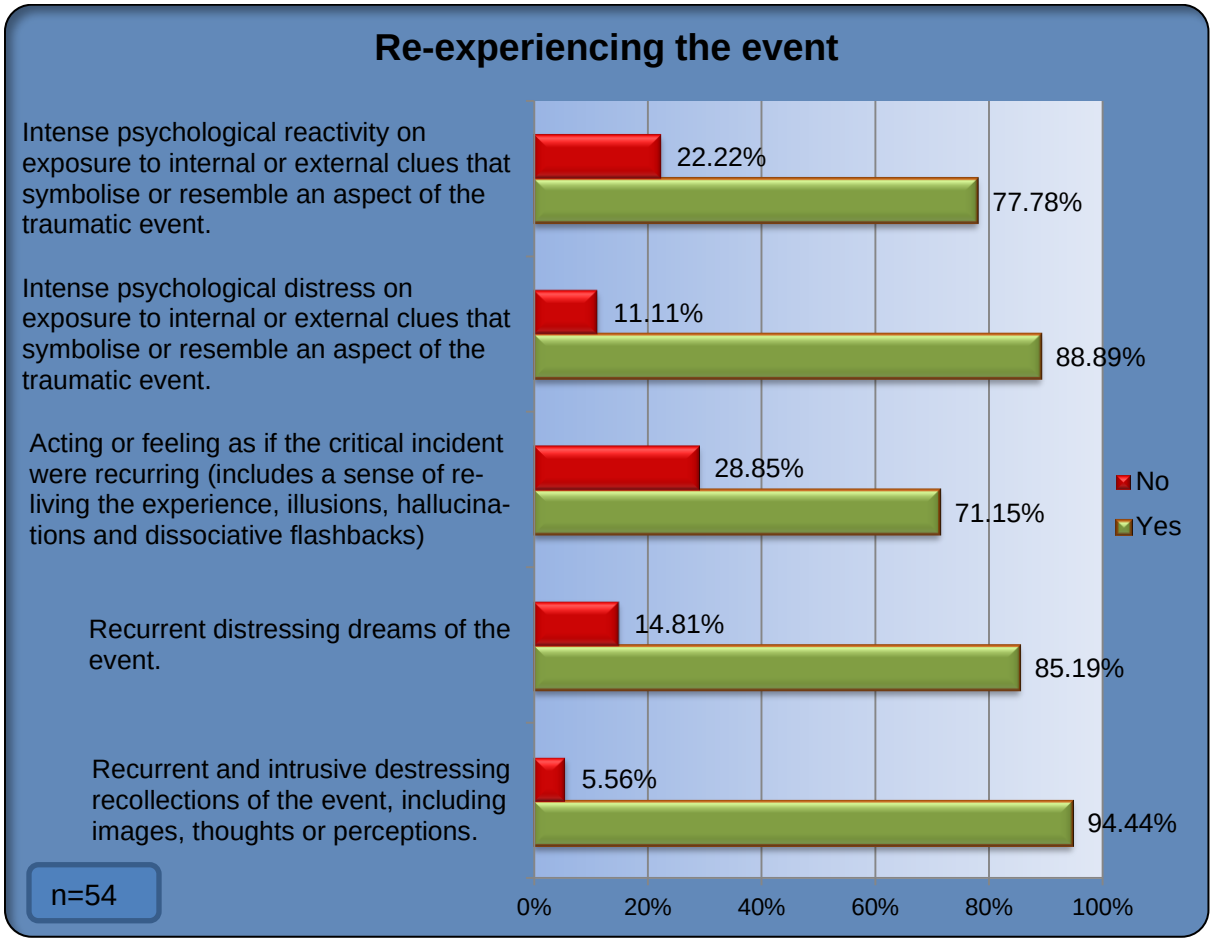


Figure 47: Re-experiencing of the event

Discussion of data

In the study, respondents indicated that the majority of their clients re-experienced the event. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions, were experienced by 94,44% of the clients. A large proportion (88,89%) experienced intense psychological distress on exposure to internal or external clues that symbolise or resemble an aspect of the traumatic event. In 85,19% of the cases, respondents reported the re-experience of recurrent distressing dreams of the event. Respondents reported intense physiological reactivity on exposure to internal or external clues that symbolise or resemble an aspect of the traumatic event in 77,78% of their clients. Only 71,15% of the respondents reported acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes).

The respondents indicated that the majority of clients re-experienced the event in a number of ways, but did experienced recurrent and distressing recollection of the event

6.2.2.1.4 Duration of re-experiencing the event

Duration of re-experiencing the event is critical in determining and diagnosing a person with PTSD. Re-experiencing, together with avoidance and increased arousal reactions, should last longer than one month before a diagnosis of PTSD can be considered. If duration of symptoms is less than three months, it is considered as an acute condition and if duration of symptoms is three months or longer, it is considered as a chronic condition.

Question 1.4.6 of the therapist questionnaire focuses on the duration of re-experiencing the event. The results are given in Figure 48.

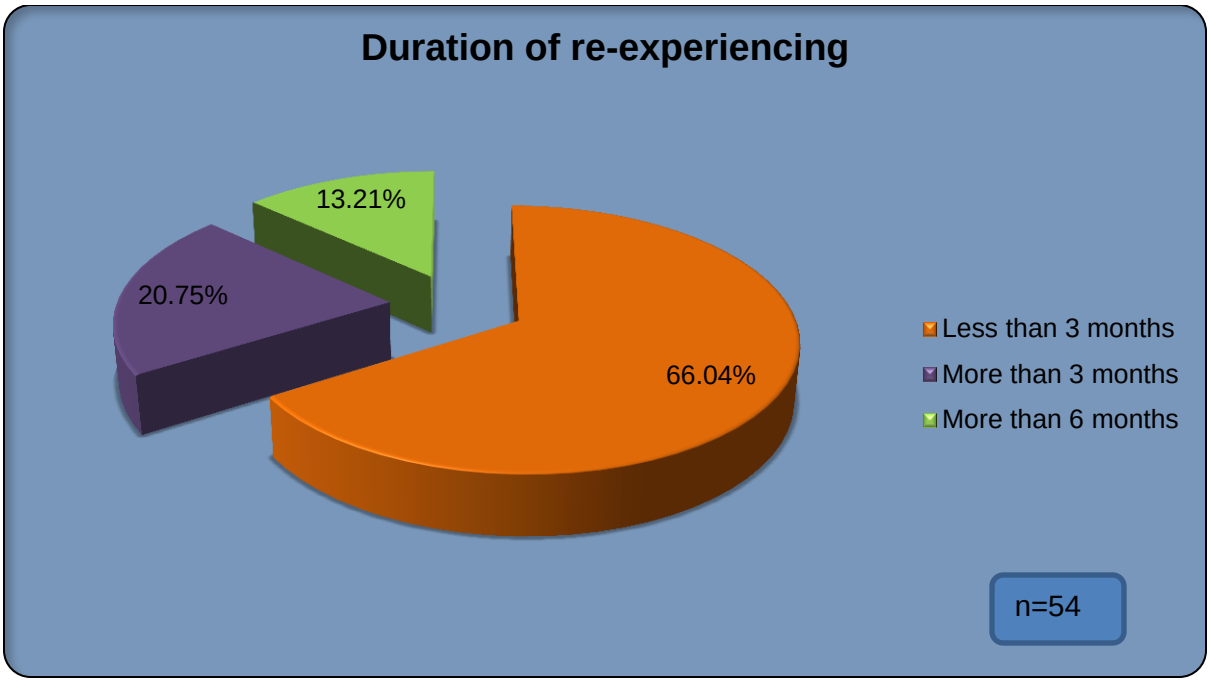


Figure 48: Duration of re-experiencing the event

Discussion of data

The majority of clients (66,04%) experienced the re-experiencing of events for less than three months. The respondents indicated that 20,75% of the clients re-experienced the events for more than three months and 13,21% of their clients re-experienced events for more than six months.

6.2.2.1.5 Avoidance of the event

According to the DSM-IV (TR) (2000:210), the second major symptom of PTSD is avoidance and denial. The person persistently avoids any stimuli associated with the trauma.

Friedman (2003:15) mentions that efforts to avoid thoughts, feelings or conversations about the trauma may be typical. Thoughts and the memories about the critical incident evoke intense emotional and physiological reactions. It is, therefore, common that victims of a critical incident make specific effort to avoid activities, places and people associated with the trauma.

The DSM-IV Diagnostic Criteria for PTSD with regard to avoidance are the following (Friedman, 2003:12):

C. Persistence avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following.

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people who arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g. unable to have loving feelings)
7. Sense of shortened future (e.g. does not expect to have a career, marriage, children, or a normal life span).

Friedman (2003:15) mentions that avoidance reactions are very common and typical, and a way to avoid thoughts, feelings or conversations about the trauma. This response is an indication that the critical incident evokes such intense emotional and physiological reactions that avoidance reactions present as a way of dealing with these emotions.

Questions 1.5.1 to 1.5.7 of the therapist questionnaire focus on avoidance of the event. The results are given in Figure 49.

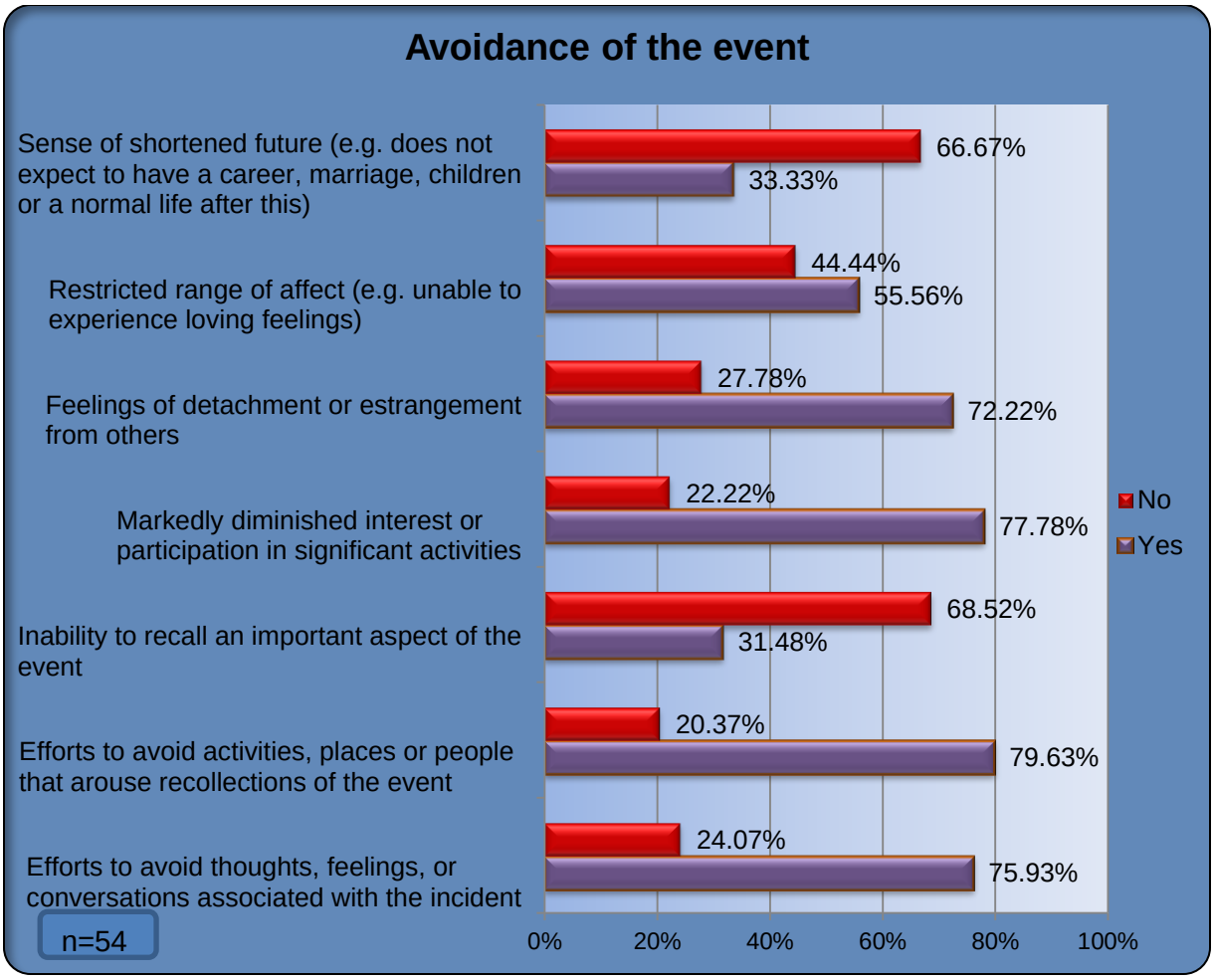


Figure 49: Avoidance of the event

Discussion of data

The majority of respondents indicated that their clients experienced avoidance reactions as a result of the critical incident. Efforts to avoid activities, places, or people who aroused recollections of the trauma was the avoidance reaction experienced most by clients (79,63%), followed by a markedly diminished interest or participation in significant actives (77,78%). Respondents indicated that 75,93% of their clients attempted to avoid thoughts, feelings, or conversations associated with the trauma. In 72,22% of the cases, respondents reported that clients experienced feelings of detachment or estrangement from others. The inability to recall an important aspect of the trauma was experienced by 68,52% of the clients and 55,56% of the clients experienced restricted range of affect (e.g. being unable to have loving feelings). Only 33,33% of respondents reported that their clients experienced a sense of

shortened future (e.g. does not expect to have a career, marriage, children, or a normal life span).

Avoidance reactions seemed to be very common with most of the respondents. Most of the avoidance reactions were present in most of the respondents indicating that avoidance of the event was a typical reaction in most of the respondents. The fact that avoidance was present is a further indication intensity of emotional and physiological reactions and that respondents used it as a way of dealing with these reactions.

6.2.2.1.6 Duration of avoidance of the event

Duration of the avoidance is critical in determining and diagnosing a person with PTSD. Avoidance together with re-experiencing and increased arousal reactions should last longer than one month before a diagnosis of PTSD can be considered. If duration of symptoms is less than three months, it is considered an acute condition and if duration of symptoms is three months or longer, it is considered a chronic condition.

Question 1.5.8 of the therapist questionnaire focuses on the duration of avoidance of the event. The results are given in Figure 50.

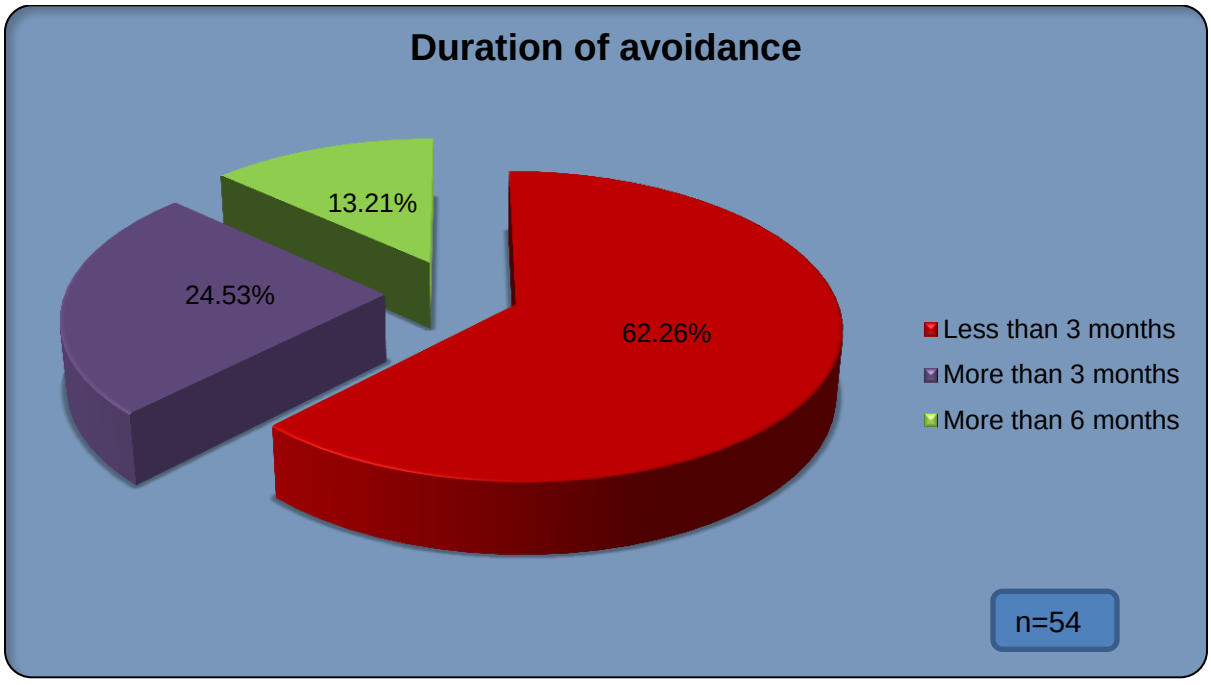


Figure 50: Duration of avoidance

Discussion of data

Most of the clients (62,26%) experienced the avoidance of events for less than three months. The respondents indicated that 24,53% of the clients experienced avoidance for more than three months and 13,21% of their clients experienced avoidance for more than six months.

6.2.2.1.7 Increased arousal

Another major symptom of PTSD is physiological arousal. Research has discovered that neurotransmitters, hormones, cortical areas of the brain and the nervous system play a much greater role in PTSD than was previously suspected (Gilliland & James, 1993). When a person is exposed to severe stress, neurotransmitters, hormones and, specifically, cortical functions designed to deal with the emergency are activated. Although the person may be removed from danger after the traumatic event, the nervous system may continue to function in an elevated and energised state as if the emergency were still continuing. This may cause the individual extreme physical and psychological distress long after the traumatic event but also explain why people do not "get over PTSD" (Gilliland & James, 1993). This could be easiest explained to the victim that his/her body is full of adrenaline as a result of the trauma.

According to Friedman (2003:17), survivors of a critical incident may exhibit irritability or outbursts of anger, difficulty concentrating, hyper-vigilance or an exaggerated startle response and difficulty falling and staying asleep as a result of the date of arousal.

The DSM-IV Diagnostic Criteria for PTSD with regard to increased arousal are the following (Friedman, 2003:12):

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. Difficulty in falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty in concentrating
4. Hyper-vigilance
5. Exaggerated startled response.

Questions 1.6.1 to 1.6.6 of the therapist questionnaire focus on increased arousal. The results are given in Figure 51.

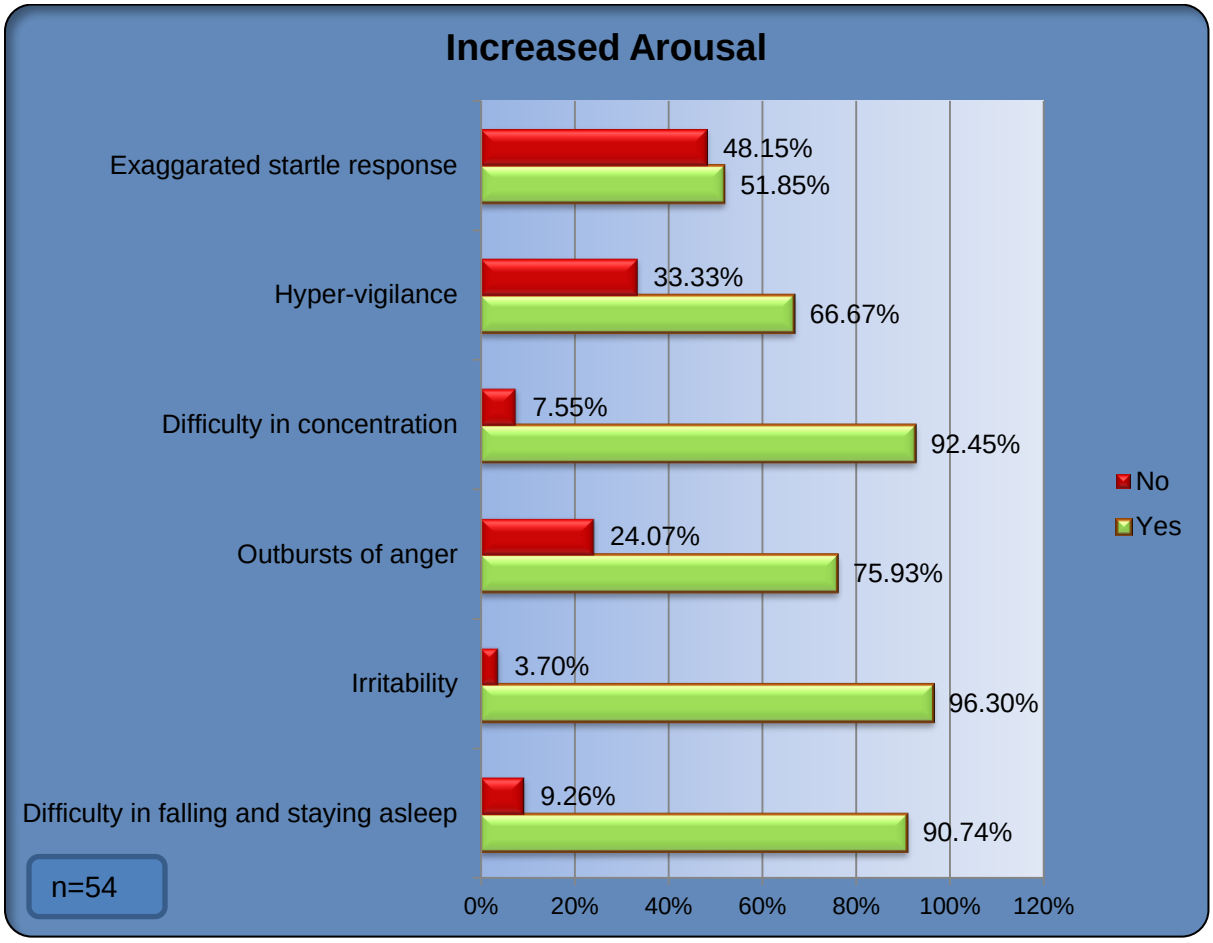


Figure 51: Increased arousal

Discussion of data

In the study, the majority of respondents indicated that their clients experienced increased arousal reactions as a result of the critical incident. Irritability was experienced by 96,30% of the clients and difficulty falling and staying asleep by 96,30%.Concentration difficulties presented in 92,45% of the clients. Outbursts of anger were experienced by 75,93% of the clients and 66,67% experienced reactions of hyper-vigilance. Exaggerated startled responses were only experienced by 51,85%.

6.2.2.1.8 Duration of increased arousal

Duration of the increased arousal is critical in determining and diagnosing a person with PTSD. Increased arousal together with re-experiencing and avoidance reactions should last longer than one month before a diagnosis of PTSD can be considered. If duration of

symptoms is less than three months it is considered an acute condition and if duration of symptoms is three months or longer it is considered as chronic.

Question 1.6.7 of the therapist questionnaire focuses on the duration of increased arousal. The results are given in Figure 52.

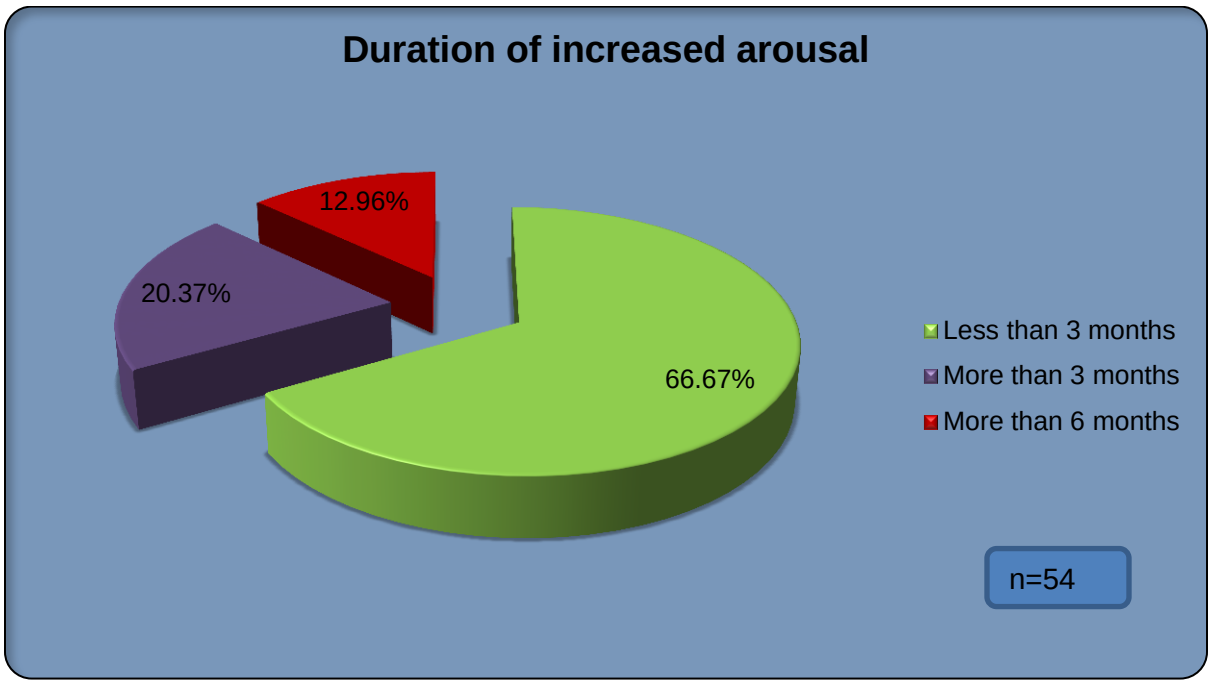


Figure 52: Duration of increased arousal

Discussion of data

The majority of clients(66,67%) experienced the increased arousal after the event for less than three months. The respondents indicated that 20,37% of the clients experienced increased arousal for more than three months and 12,96% of their clients experienced avoidance for more than six months.

In summary, taking this information in consideration, it can be concluded that the majority of clients were severely affected by the incident as the assessment of the therapists indicated that most of the reactions were present in the majority of respondents. Furthermore, it was indicated that the symptoms lasted for less than three months for the majority of the clients.

The American Psychiatric Association, according to Friedman (2003:12), emphasises that the duration of the symptoms must be for at least one month before a person can be diagnosed as suffering from full-blown PTSD. If the symptoms have not been experienced for a full month as yet, the person is traumatised, but is not suffering from PTSD as yet. As it is not clear for exactly how long the clients had experienced the reactions, only that it was for less than three months, it can be concluded that the majority of the clients were only traumatised. In 33,96% responses clients re-experienced the incident for more than three months, 37,74% of the clients experienced avoidance for longer than three months and 33,33% of clients experienced increased arousal for more than three months. According to Friedman (2003:12), the DSM-IV indicates that if reactions remain for more than three months, chronic PTSD is the appropriate diagnosis.

As the purpose of the study was not to diagnose, it can be concluded that just more than a third of the study presented with symptoms associated with chronic PTSD as assessed by the therapists.

6.2.2.1.9 Disturbance caused by critical incident

The DSM-IV Diagnostic Criteria for PTSD with regard to disturbance caused by a critical incident are the following (Friedman, 2003:12):

F The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Extreme critical incident stressors can even result in personal crises, traumatic stress and PTSD. In addition to their human toll, organisational crises are disruptive to both corporate business and workplace operations. Productivity, quality, profitability and other key performance measures are adversely affected by such events (VandePol & Beyer, 2009:11).

Question 1.7 of the therapist questionnaire focuses on the disturbance caused by a critical incident. The results are given in Figure 53.

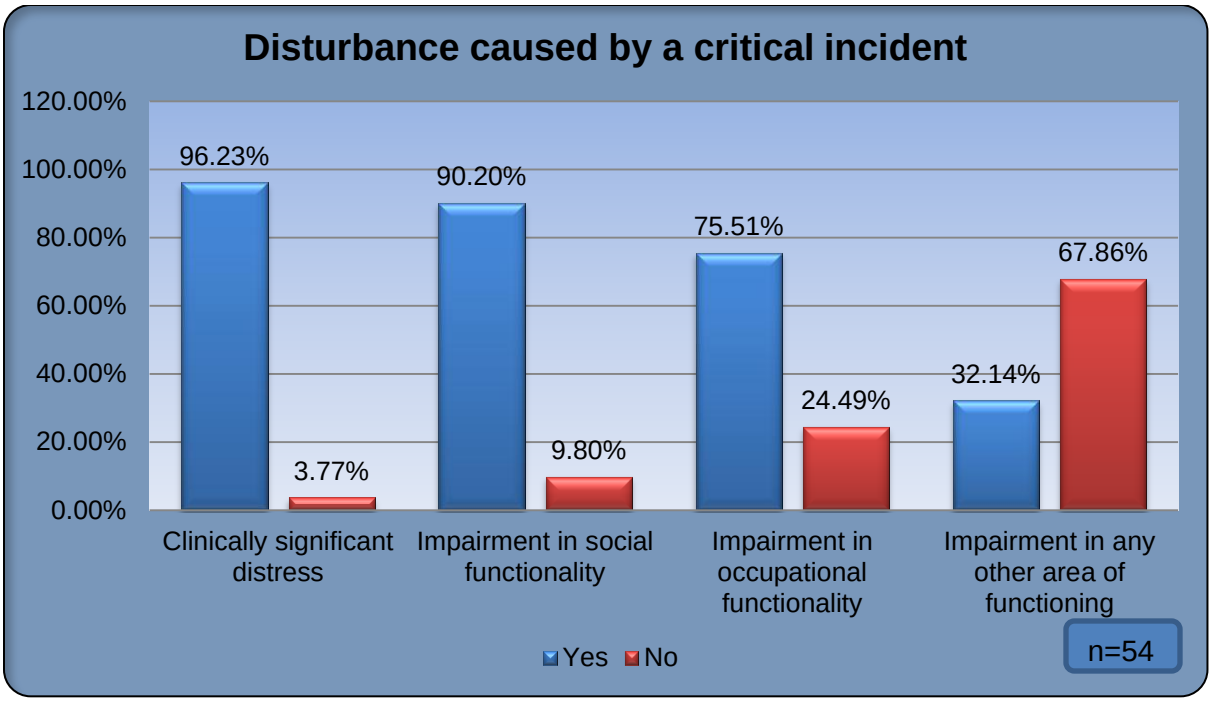


Figure 53: Disturbance caused by a critical incident

Discussion of data

In this study, the majority of respondents indicated that their clients were disturbed by the critical incident. The most prominent disturbance experienced by clients were clinically significant distress (96,23%), 90,20% of the clients experienced impairment of their social functioning and 75,51% experienced impairment in their occupational functioning. The majority (67,86%) of respondents indicated that their clients did not experience impairment in any other area of functioning.

It is evident from the study that the critical incident caused severe distress and impaired the social and occupational functioning of the majority of clients. This impact reached further than only the individual; it also affected the family and the workplace of the traumatised individual.

6.2.2.1.10 Symptoms associated with complex PTSD

Friedman (2003:19) indicates that many clinicians who have worked with victims of longstanding trauma, for example torture or hostage victims, believe that the victims present with complex PTSD. Complex PTSD has the following symptoms together with those of PTSD:

- Behavioural problems, for example impulsiveness, aggression, sexual acting out, eating disorders, alcohol or drug abuse and self-mutilation
- Emotional problems, for example emotional instability, angry outbursts, panic attack and depression
- Cognitive problems, for example fragmented thoughts, dissociation and amnesia.

The argument against this diagnosis is that the majority of clients with complex PTSD already fulfil the criteria for PTSD and an additional diagnosis is unnecessary.

Pearlman (in Wilson *et al*., 2004:205) says that, in addition to the symptoms of PTSD that include intrusive experiences, avoidance and arousal, complex PTSD includes dissociation, relationship difficulties, re-victimisation, affect deregulation and disruption of identity.

Lewis (1996:16–17) mentions that complex PTSD is a result of prolonged, repeated and severe traumas. A survivor of a critical incident with complex PTSD exhibits the symptoms of PTSD but also presents with a dulled, a "frozen" appearance, dissociation, problems with concentration or memory, anger, self-mutilated behaviour, depression, anxiety and rational problems.

6.2.2.1.10.1 Behavioural reactions to a critical incident

Bisson's (1995:718) study states that any traumatic event, including violent crime, may precipitate an acute psychological response. Characteristic features of this response include fear, anger, recurrent distressing thoughts, guilt, depression, anxiety, bad dreams, irritability and generalised hyper-arousal. The results of the aforementioned study propose that such responses should be considered normal, immediately after a violent crime. Behavioural reactions such as self-mutilation, sexual acting out and eating disorder are less common but can be prompted or increased as a result of the trauma.

Question 1.8.1 of the therapist questionnaire focuses on the behavioural reactions to a critical incident. The results are given in Figure 54.

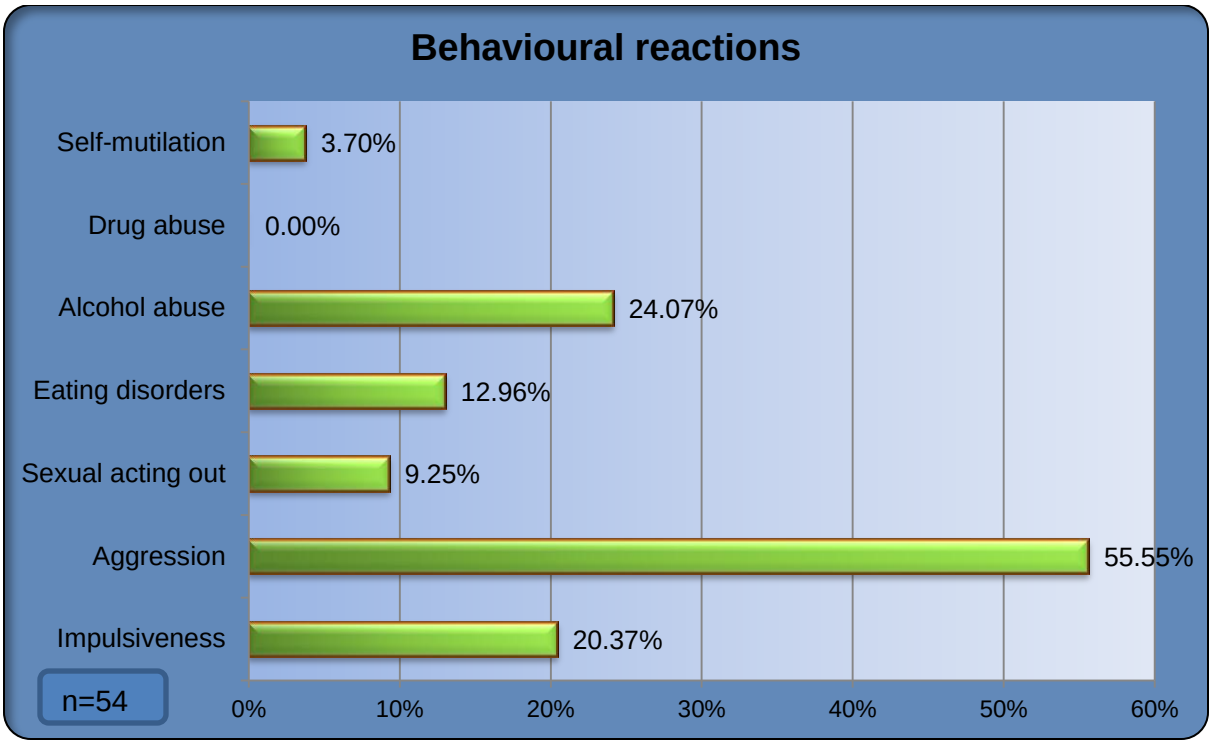


Figure 54: Behavioural reactions

Discussion of data

Behavioural reactions, as indicated in Figure 54, in addition to normal PTSD symptoms, may indicate complex PTSD. In the study, respondents indicated that their clients presented with some behavioural symptoms that can indicate complex PTSD. Aggression was the behavioural symptom experienced by most clients after the critical incident (55,55%). Some of the clients abused alcohol as a behavioural reaction to the critical incident (24,07%). Impulsiveness also featured as a behavioural response (20,37%). Other behavioural reactions clients presented with were eating disorders (12,96%), sexual acting out (9,25%) and self-mutilation (3,70%). In general, the behavioural reactions in addition to the normal PTSD symptoms seemed low and were only experienced by a small portion of the population.

6.2.2.1.10.2 Emotional reactions to a critical incident

Question 1.8.2 of the therapist questionnaire focuses on the emotional reactions to a critical incident. The results are given in Figure 55.

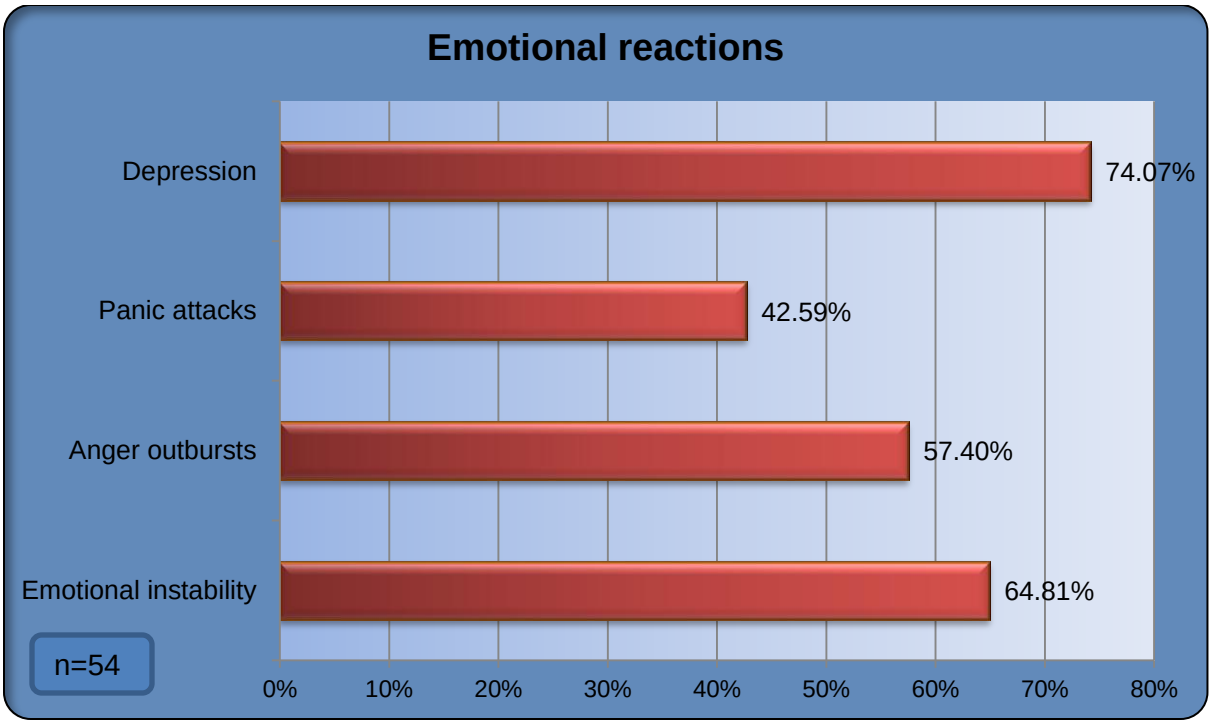


Figure 55: Emotional reactions

Discussion of data

Emotional reactions, as indicated in Figure 55, in addition to normal PTSD symptoms may indicate complex PTSD. In the study, respondents indicated that their clients presented with some emotional symptoms that could indicate complex PTSD. Depression was the emotional symptom experienced by most clients after the critical incident (74,07%). Some of the clients also experienced emotional instability as an emotional reaction to the critical incident (64,81%). Anger outbursts (57,40%) and panic attacks (42,59%) also featured as emotional responses. In general, the emotional reactions in addition to the normal PTSD symptoms seemed moderate to high and were experienced by a significant portion of the population.

6.2.2.1.10.3 Cognitive reactions to a critical incident

Question 1.8.3 of the therapist questionnaire focuses on the cognitive reactions to a critical incident. The results are given in Figure 56.

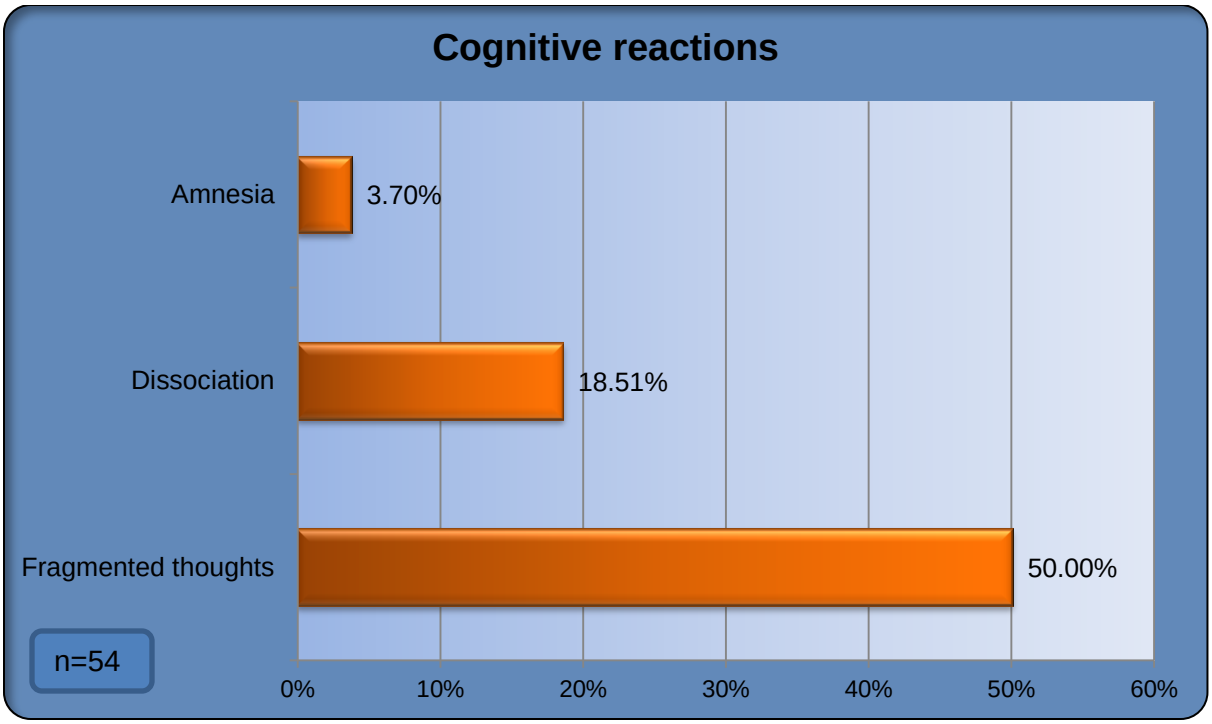


Figure 56: Cognitive reactions

Discussion of data

Cognitive reactions, as indicated in Figure 56, in addition to normal PTSD symptoms may indicate complex PTSD. In the study, respondents indicated that their clients presented with some cognitive symptoms that could indicate complex PTSD. Fragmented thoughts were the cognitive symptom experienced by most clients after the critical incident (50,00%). Some of the clients also experienced dissociation (18,51%) and amnesia (3,70%) as a cognitive reaction to the critical incident. In general, the cognitive reactions in addition to the normal PTSD symptoms seemed low and experienced by a small portion of the population.

It seems that, in addition to normal PTSD symptoms, of the reactions that can indicate complex PTSD emotional reactions were the most prevalent and experienced by the largest proportion of the population, followed by behavioural and thereafter cognitive reactions.

Lewis (1996:16–17) mentions that complex PTSD is a result of prolonged, repeated and severe traumas. A survivor of a critical incident with complex PTSD exhibits the symptoms of PTSD but also presents with a dulled or "frozen" appearance, dissociation, problems with

concentration or memory, anger, self-mutilated behaviour, depression, anxiety and rational problems.

Most authors argue against the diagnosis of Complex PTSD as the majority of clients with complex PTSD already fulfil the criteria for PTSD and an additional diagnosis is unnecessary.

It is, however, worthwhile to mention that, with the exception of the emotional reactions that were prevalent in the majority of respondents, behavioural and cognitive reactions associated with complex PTSD were only present in some cases.

In conclusion it seems that additional reactions associated with complex PTSD were present in some clients only and to some degree only, making it difficult to determine clearly if they suffered from complex PTSD or PTSD.

6.2.2.2 Symptoms associated with acute stress disorder

According to Friedman (2003:17), acute stress disorder is diagnosed directly after the trauma and up to, and including, a maximum period of one month after the trauma. Acute stress disorder must be present for a minimum of two days. Here the emphasis is on the re-experiencing, avoidance and hyper-arousal symptoms but dissociative symptoms must also be present.

6.2.2.2.1 Dissociative symptoms

Friedman (2003:4) defines dissociation as "an abnormal psychological state in which one's perception of oneself and/or one's environment is altered significantly". Dissociation is further viewed as "a mechanism involving the segregation of any group of mental or behavioral processes from the rest of the person's psychic activity. It may entail the separation of an idea from its accompanying emotional tone, as seen in dissociative disorders." (Kaplan & Sadock, 1988:312)

According to Friedman, three of the following five dissociative symptoms must be present in order to diagnosed acute stress disorder:

6.2.2.2.2 Numbing

This is the subjective experience of numbing, detachment or absence of emotional reactions. Question 2.1.1 of the therapist questionnaire focuses on numbing. The results are given in Figure 57.

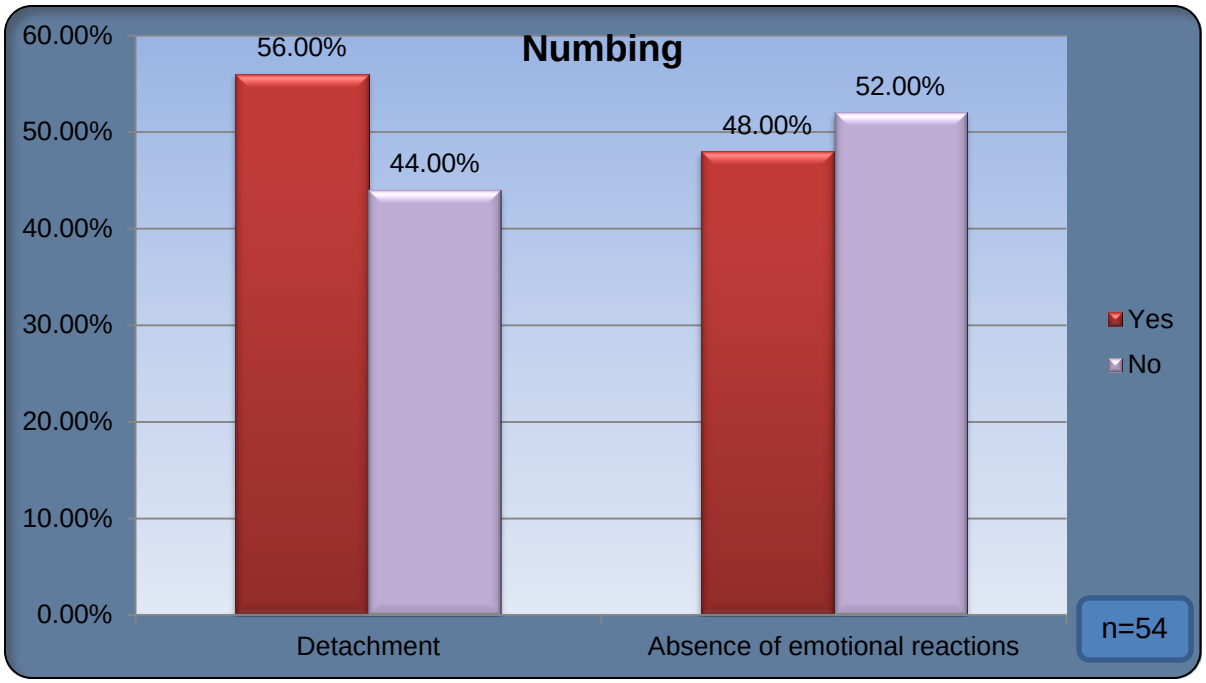


Figure 57: Numbing

Discussion of data

In the study, respondents reported that numbing as a dissociative reaction was part of their clients' reactions. Detachment was experienced by more clients (56%) than the absence of emotional control (48%). The experience of numbing was not very high as a dissociative reaction.

6.2.2.2.3 Dissociative amnesia

This is the inability to remember important aspects of the trauma.

Question 2.1.2 of the therapist questionnaire focuses on dissociative amnesia. The results are given in Figure 58.

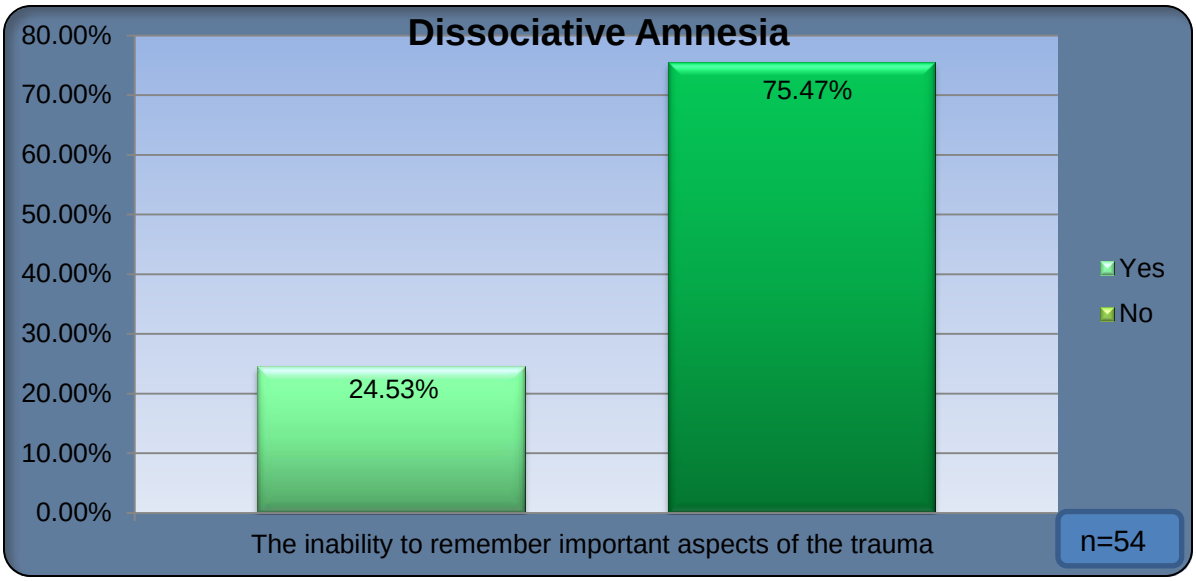


Figure 58: Dissociative amnesia

Discussion of data

In this study, respondents indicated that clients experienced the inability to remember important aspects of the trauma as a dissociative reaction. The majority of clients (75,47%) experienced that they were unable to remember important aspects of the trauma.

6.2.2.2.4 Reduction in awareness

This is the lack of attention or response to the immediate environment. It may appear to an onlooker that the individual is in "a daze" or in "a world of his/her own".

Question 2.1.3 of the therapist questionnaire focuses on reduction in awareness. The results are given in Figure 59.

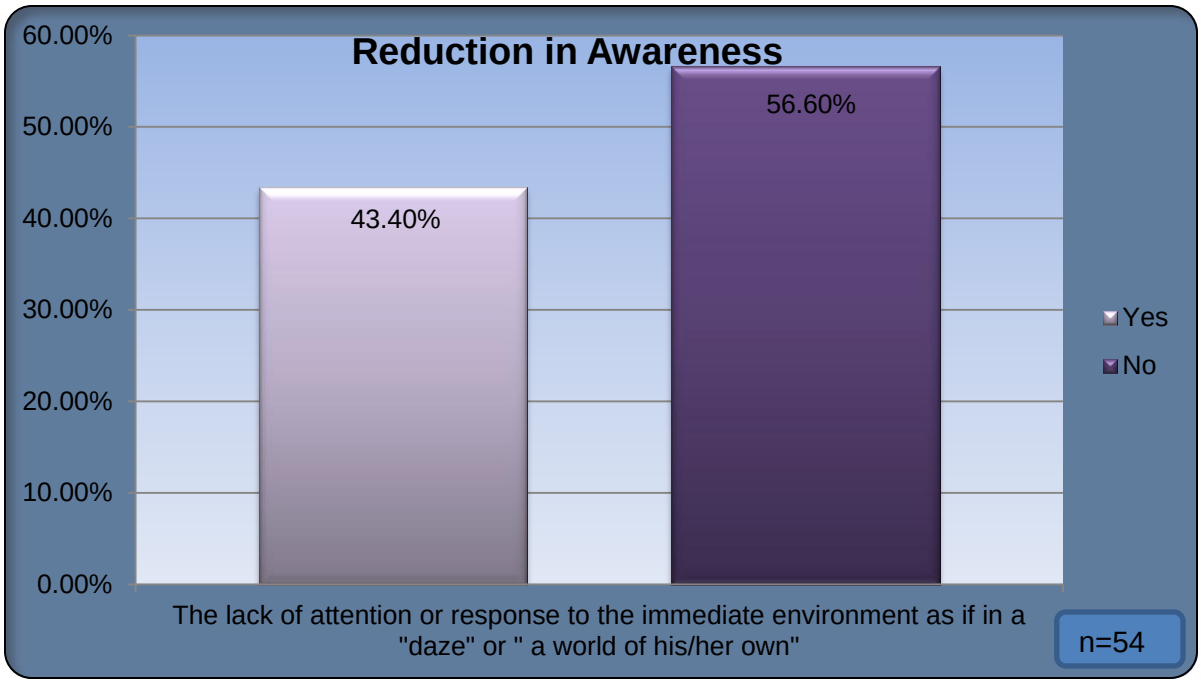


Figure 59: Reduction in awareness

Discussion of data

Respondents reported that clients did experience a reduction in awareness. It was, however, evident that the largest part of the client population (56,60%) did not experience a lack of attention or response to their immediate environment.

6.2.2.2.5 Derealisation

Derealisation refers to a feeling that the world a person has always known has dramatically changed. The person feels estranged or detached from the environment and has a sense that the environment is unreal.

Question 2.1.4 of the therapist questionnaire focuses on derealisation. The results are given in Figure 60.

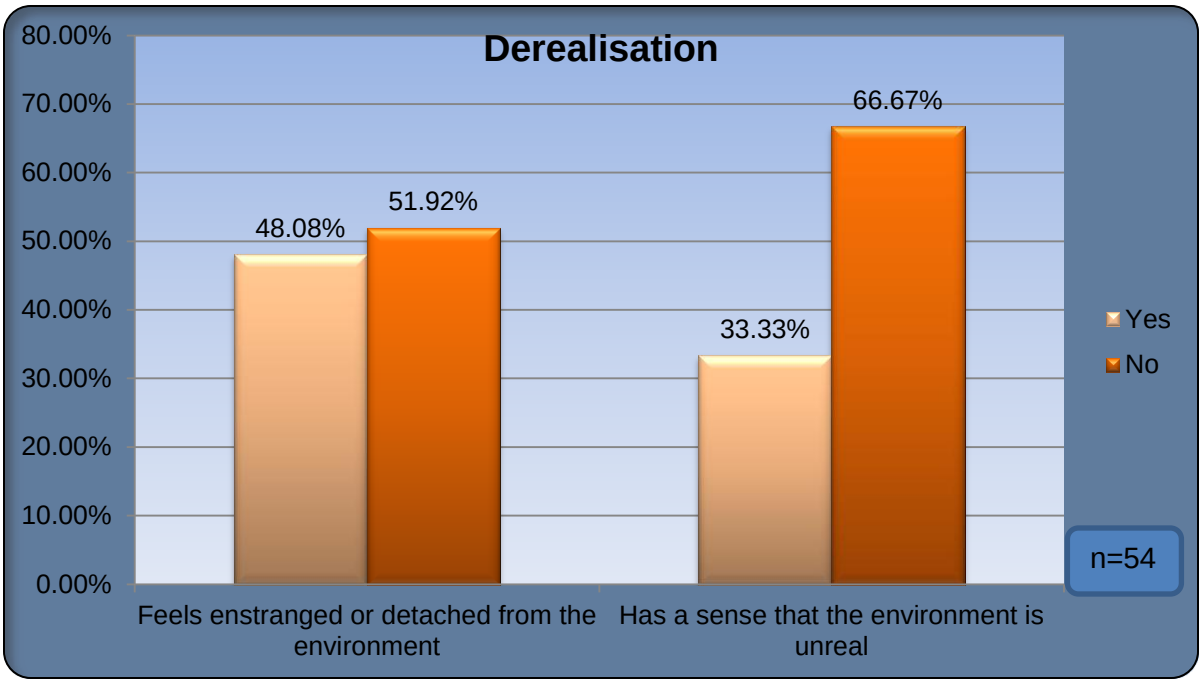


Figure 60: Derealisation

Discussion of data

Respondents indicated that clients experienced some kind of derealisation but the majority of the clients were not affected in this way. Only 33,33% of the clients experienced a sense that their environment was unreal and 48,08% felt estranged or detached from their environment.

6.2.2.2.6 Depersonalisation

Depersonalisation may manifest as a distorted perception of one's body, one's identify or oneself as a coherent entity The person, for example, feels that his/her body has been divided into sections.

Question 2.1.5 of the therapist questionnaire focuses on depersonalisation. The results are given in Figure 61.

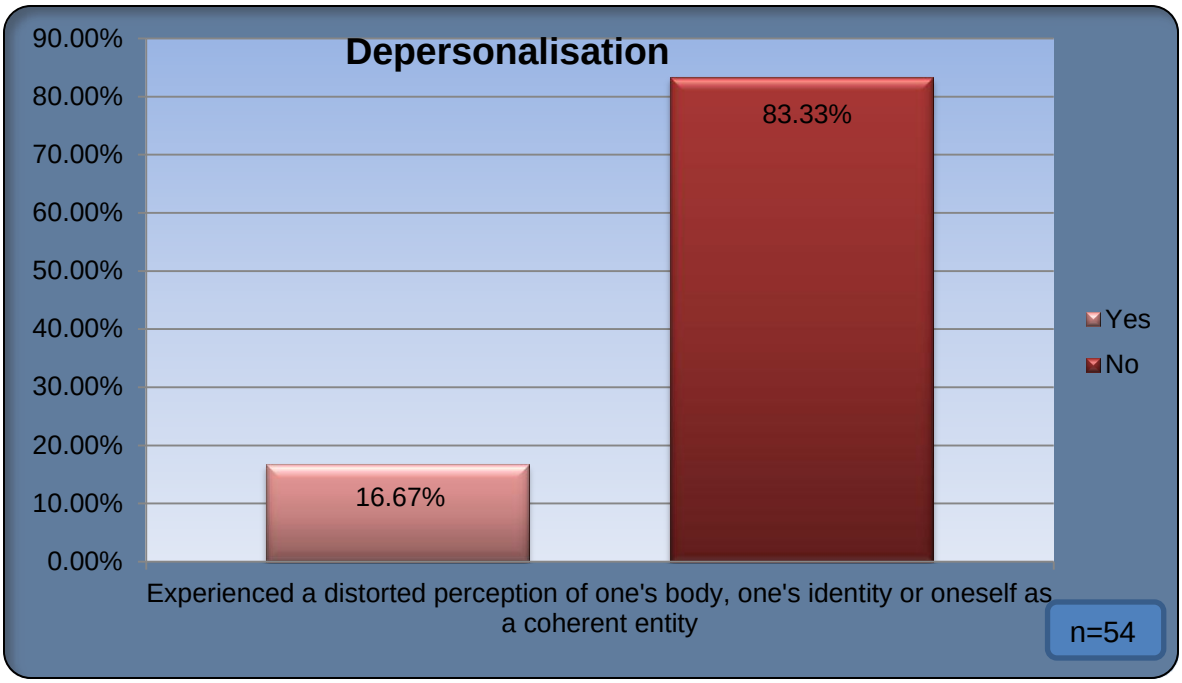


Figure 61: Depersonalisation

Discussion of data

In the study, respondents' major response was that their clients did not experience depersonalisation as a dissociative reaction. The majority of clients (83,33%) did not experience a distorted perception of their body, their identity or themselves as a coherent entity.

According to Friedman (2003:17) acute stress disorder is diagnosed directly after the trauma and up to, and including, a maximum period of one month after the trauma. Acute stress disorder must be present for a minimum of two days. Here the emphasis is on the re-experiencing, avoidance and hyper-arousal symptoms but dissociative symptoms must also be present.

It was evident from the empirical data that the majority of clients experienced re-experiencing, avoidance and arousal symptoms indicating traumatisation, but only some clients experienced dissociation. With the exception of dissociative amnesia and numbing, which were high, other dissociative symptoms were experienced by less than half of the clients.

Although the purpose of the study was not to diagnose, it can be concluded that some clients fitted the criteria for acute stress disorder as they experienced re-experiencing, avoidance and arousal symptoms in combination with dissociative symptoms.

6.2.2.3 Intervention

CIR refers to an integrated comprehensive, multi-component crisis intervention approach for addressing the psychological consequences of critical incidents. Over the past 25 years a general model of CIR group debriefing has been developed which can be used to accelerate recovery from traumatic workplace events (VandePol *et al.*, 2006:120). CIR can accomplish psychological closure, prevention and mitigation of traumatic stress, and promote return to normalcy, benefiting the individual, organisation and the community at large.

6.2.2.3.1 Outcome of individual counselling

Question 3.1 of the therapist questionnaire relates to the outcome of individual counselling.

Discussion of data

Respondents indicated that the majority of clients (98,15%) benefited from individual counselling; only 1,85% indicated that they did not benefit from the individual counselling received from the therapist.

The outcome of the individual counselling was based on the responses of the therapists after the therapy process. The purpose of this question was to determine if the therapist felt that the client benefited from the therapeutic process or not. According to the responses of the therapists, it seemed that a large majority (98,15%) of the therapists felt that their clients benefited from the therapeutic process. Only 1,85% of the therapist felt their clients did not benefit from the therapeutic process.

As individual counselling was an integral part of the crisis intervention after the critical incident, it seemed that therapists felt that individual counselling was effective in dealing with respondents' responses to trauma.

6.2.2.3.2 Reaction to the individual counselling

Question 3.3 of the therapist questionnaire relates to the reaction to individual counselling. The results are given in Figure 62.

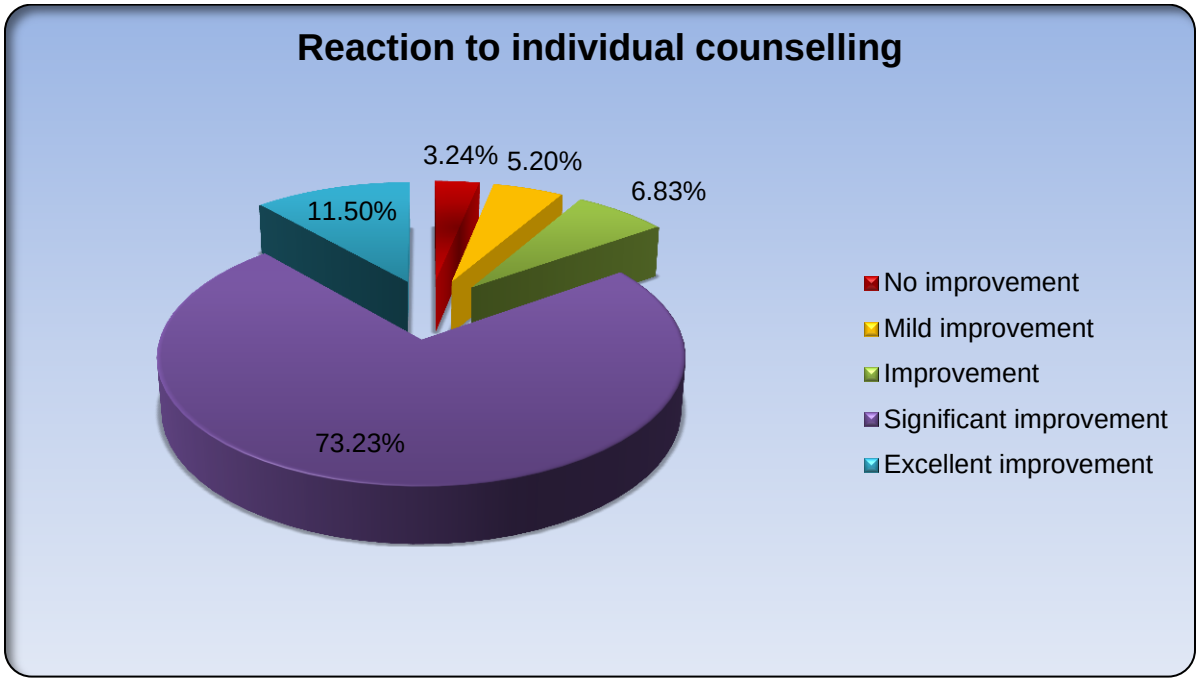


Figure 62: Reaction to individual counselling

Discussion of data

The reaction to the individual counselling is based on the responses of the therapists after the therapy process. The purpose of this question was to determine the impact of the individual counselling on the employee with relation to the trauma reactions. In the study, the majority of therapists felt that their clients showed significant improvement (73,23%), followed by 11,50% who showed excellent improvement. Only 3,24% of the respondents showed no improvement and 5,20% showed mild improvement.

In summary it seems that therapist felt their clients benefited from the therapeutic process and that the majority of the clients showed significant and excellent improvements (84,73%).This confirms that individual counselling mitigated the impact of trauma, assisting the client to achieve psychological closure and returning to a normal state of functioning.

6.2.3 Document analysis–data on the clinical notes of therapists

The document analysis formed part of the **qualitative** study. The phenomenological design was applied as a way of data collection and analysis in order to establish how employees'

psychosocial function and work performance were affected as a result of the critical incident and what impact the intervention had on their work performance. With their permission, records of their assessments and interventions (called "session notes") kept by The Careways Group were utilised for document analysis. Records of all 54 employees who participated in the study are reflected in 6.2.3.

While often cumbersome and time-consuming, session notes within the EWP context serve a number of purposes. From the therapists' point of view they are, first of all, as for any other client, a method of recordkeeping. Should there be a query about a particular client, session notes offer an easily accessible source of reference. Secondly, session notes provide information on a particular event, such as personal details, the initial assessment at the time of call and of the therapeutic process in terms of the progress towards set goals and objectives. The writing of session notes also provides the therapists an opportunity to verbalise their understanding of the process (as opposed to content) considerations of a particular session and to reflect on the dynamic interactions he/she has had with a client.

In the document study, the session notes of the 54 clients as completed by the therapists were studied to determine what the original presenting problem was, how the client was affected in the first session, progress throughout the therapeutic process and outcome of the therapeutic process. The following information, as reflected in the session notes, is discussed below:

- Intervention classification
- Work impact
- Emotional distress
- Emotional post-event assessment.

6.2.3.1 Intervention classification

The intervention classification described below has been developed and is used by The Careways Group. The rationale for the intervention classification is to encapsulate the classification of all calls managed by the Careways call centre. The classification assists in determining appropriate interventions and serves as the basis on which the client feedback report is developed.

Initially there are ten main reasons-for-call areas from which to select (at call centre consultant level), with greatly expanded options under each of the main areas. In the first session, the therapist is requested to complete the intervention classification based on his/her clinical diagnosis of the assessed problem. All the categories are reflected in Table 6 below to provide a framework for the options for intervention classification.

Table 6: Reason for call categories

A:Work related	
Reason	**Description**
Absence	Employee is absent from work due to sick leave or leave
Absenteeism	Failure of employees to report to work when they are scheduled to be at work. This excludes scheduled leave, i.e. annual leave, study leave
Presenteeism	The problem of employees being on the job but, because of medical conditions, they are not fully functioning
Sick leave	Leave owing to medical and/or psychological reasons
Adapted work	When employees return to work but not at their full capacity. They may return to work at a percentage of the required hours or in a different role, doing a different job until they have fully recovered and are able to return to their normal job
Work overload	Role overload occurs as a result of either a very high volume of work over a prolonged period of time or a situation where the individual is under-qualified or lacks experience to perform the job. This often occurs as companies downsize and the load is spread across fewer people
Role confusion	Role confusion exists when the parameters and requirements of the job are not clearly defined or when there are differing expectations of what is required of a person
Underutilisation	Underutilisation refers to a situation where a person experiences a lack of stimulation, challenge or interest in work as a result of insufficient use of his/her skills and expertise
Lack of support at work	A supportive work environment is essential to the attainment of stated objectives. A lack of support, either direct (e.g. assistance) or indirect (e.g. opportunities to discuss and brainstorm issues), can create additional stress in the workplace

Adapting to organisational change (restructuring etc)	Rapid organisational change experienced in the context of broader environmental change can add considerably to overall stress levels. The adjustment required by ongoing change can be stressful for people, even when they are instigating the change themselves or understand the need for it
Peer relationship problems	Peers can have an effect on stress levels and work performance. Factors such as trust, confidence, support and regular constructive feedback can enhance the quality of working relationships. Where such factors are absent, high stress levels can result
Problems with relationship with management	Managers can have an effect on stress levels and work performance. Factors such as trust, confidence, support and regular constructive feedback can enhance the quality of work relationships. Where such factors are absent, high stress levels can result
Disciplinary issues	Any matters related to disciplinary processes in the company
Discrimination	Any issues related to discrimination in the workplace (employee being discriminated against; employer being accused of discrimination, colleagues indicating discrimination, etc)
Job dissatisfaction	When the employee feels demotivated, unhappy, bored or overwhelmed by his/her work, which may lead to absence
Lower productivity	The employee does not perform at his/her optimum level of productivity
Poor motivation	The employee is not motivated to do his/her job at his/her optimum level
Lack of focus/concentration	The employee is experiencing problems with concentration or focus on work
Redundancy: actual or threat	The employee being made redundant. The employer who has to deal with the redundancy. Colleagues are feeling insecure/threatened due to redundancy of a colleague
Retrenchment	The employee is being retrenched. The employer who has to deal with the retrenchment. Colleagues are feeling insecure/threatened due to retrenchment of colleague
Sexual harassment	Victims of sexual harassment. Employers of victims who have been sexually harassed. Colleagues of victims who have been sexually harassed

Victimisation	Any kind of victimisation within the company (including bullying)
Career choice (career path issues)	Employees needing guidance regarding career choices/decisions/development within the company
Medical issues	Any matters dealing with incapacity/medically boarded or injury on duty
B: Personal emotional	
Reason	Description
Anxiety	Excessive anxiety, worry and feelings of apprehensive expectation. Restlessness, feeling keyed up and on the edge. Difficulty concentrating, irritability, muscle tension, sleep disturbance and being easily fatigued. Could be generalised anxiety, acute anxiety or post-trauma related
Bereavement	Involves the normal process of grieving over the loss of a loved one where the focus is the reaction to the loss. Usually symptoms of bereavement decrease with time and noticeable improvement can usually be seen within two months of the loss
Depression	Classified as a mood disorder. Could present with the following symptoms: depressed mood, diminished interest or pleasure in daily activities, significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or inappropriate guilt, diminished ability to concentrate, recurrent thoughts of death or suicidal ideation
Health related	Any health related condition that impacts on employees' mental and psychological state and thereby their productivity (issue is not about the health per se)
Homicidal risk	Any risk of harm to others or harm to self by another person
Suicidal risk	Any risk or threat of self-harm
Identity problems	Sexual orientation and behaviour
Sexual abuse	Adult survivor of sexual abuse
Phase of life/adjustment difficulties	Major adult development life cycle changes causing adjustment difficulties and/or depression
Spiritual/religious concerns	Crises/questions, e.g. loss of faith/change of faith/questioning of faith. Existential
Traumatic event	Recent incident of traumatic nature, e.g. hijacking/robbery/rape,

	etc
Stress	Loss of ability to function optimally in certain situations because of high levels of stress
Burnout	Ongoing symptoms of stress and anxiety with high levels of work pressure that can lead to burnout, or the employee is already burnt out
C: Couple and family related	
Reason	Description
Couple relationship	All concerns with regard to quality of couple relationship
Child behavioural problems	Disruptive behaviour displayed by children of various ages
Parental guidance	Parents seeking advice on parenting issues such as discipline, sibling rivalry, parent–child relationship issues
Extended family issues	Problems related to extended family structure, e.g. grand parents, in-laws
Domestic violence	Spouse, partner, children exposed to risk or practice of physical or mental abuse
Sexual abuse	Sexual abuse or suspected sexual abuse of child/children
Divorce	All concerns with regard to a couple going through a divorce (e.g. either partner needs support through the process, children need assistance in dealing with the divorce). NO CUSTODY ISSUES TO BE DEALT WITHIN THE EAP
D: Dependency problems **Persistent and recurrent maladaptive behaviour. Preoccupation with the problem behaviour, and repeated unsuccessful attempts to stop or control the behaviour, may lead to financial or legal difficulties**	
Reason	**Description**
Chemical dependency (not alcohol)	Dependency on any chemical substance other than alcohol, prescription medication, over the counter medication and illegal substances
Alcohol dependency	Dependency on alcohol
Psychological dependency	Including gambling, pornography, Internet
E: HIV/Aids related	
Reason	**Description**
Infected	HIV-positive individual requesting education and informational support to deal with the condition

Affected	Dealing with concerns of those affected by the positive diagnosis of a significant other, e.g. family member, spouse, child. Individuals requesting testing are included in this category
Pre- and post-test counselling	
VCT (individual)	
Well-being support programme	All positive employees who are enrolled in a support programme
Opportunistic diseases	Absence as a result of one of the opportunistic diseases
Anti retroviral therapy	Absence could result from having to attend a clinic or hospital to receive ARVs
Disease management	
F: Financial issues	
Reason	**Description**
Financial planning	
Loans	
Mortgage	
Taxation	
Redundancy	
Early retirement	
Debt advice	
Investment advice	
G: Legal Issues	
Reason	**Description**
Consumer issues	
Criminal	
Family (incl. custody, maintenance **and matters affecting children)**	
Insolvency	
Insurance disputes	
Litigation	
Matrimonial (incl. traditional, co-habiting relationships)	
Neighbour disputes	
Personal injury	
Property/landlord/tenant	

Taxation	
Vehicle-related issues	
Social security	
Wills and succession	
H: Health and wellness	
Reason	**Description**
Clinical emergency	All assistance involving ambulances, emergency services, poisoning and motor vehicle accidents (MVAs)
Medication	All education and advice regarding any form of medication, supplement and nutraceuticals
Condition education	All education and advice regarding diseases, hospitalisation and conditions
Self-care	All education to assist the individual to take personal responsibility for a specific health problem
Referral/resource	Information and referral detail for the use of third party or community resources
Diet	All education and advice related to diet and nutrition
Exercise	All education and advice related to exercise
I: CISM	
Reason	**Description**
Accident	Occupational accidents
Trauma	Robbery, hijacking, shooting, death of an employee
Business event	Retrenchment, relocation, conflict resolution, stress management interventions
J: Information	
Reason	**Description**
Health and wellness related	
Family related	
HIV/Aids related	
Services (offered by Careways)	
Service satisfaction	

Through document analysis, the intervention classification was determined for this study. The results are given in Figure 63.

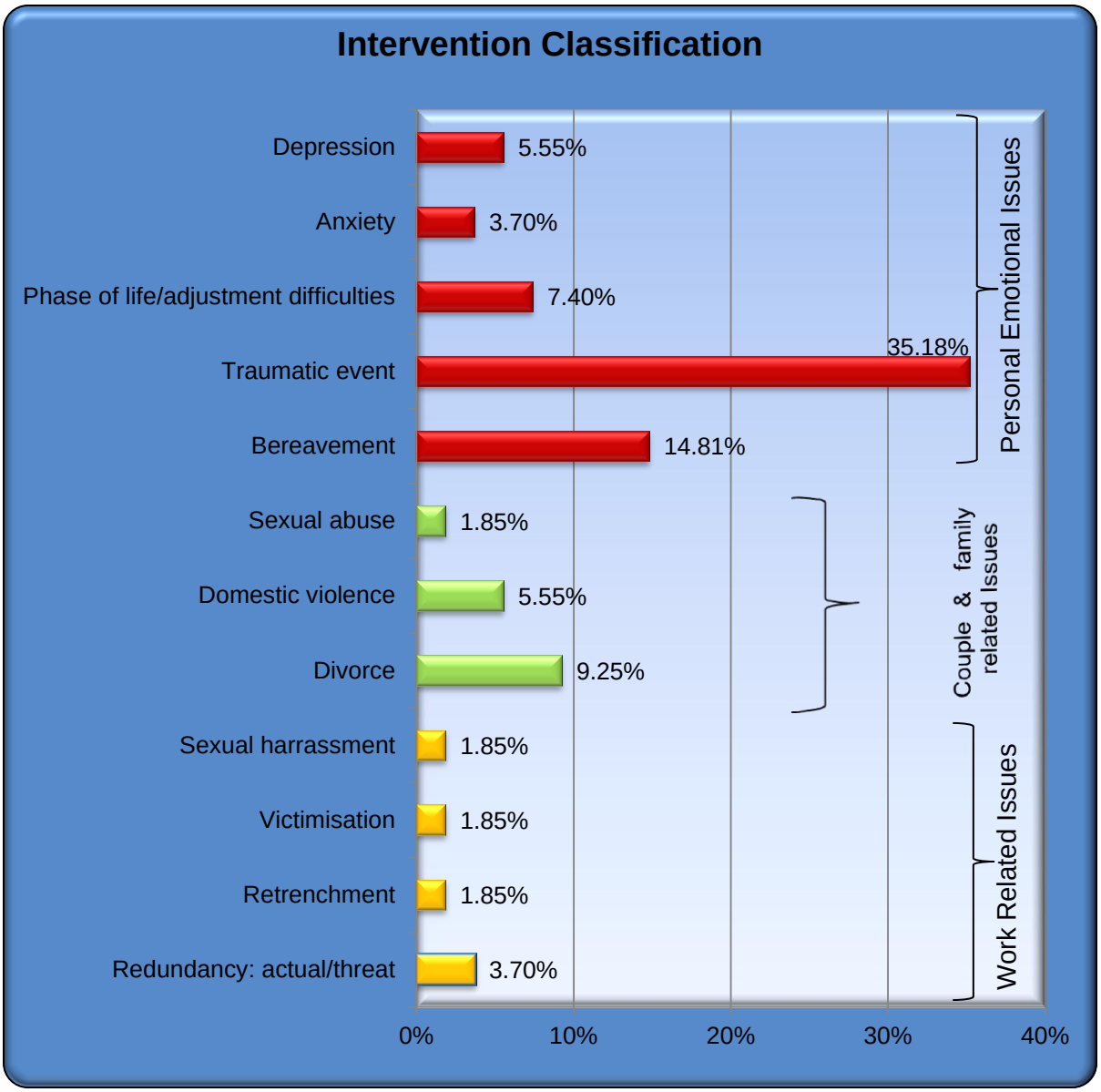


Figure 63: Intervention classification

Discussion of data

Based on the therapist's clinical assessment of the employee in the first session, an intervention classification was made. Although there were 10 main intervention classifications (A to J in Table 6), employees were only classified within three of the intervention classifications, namely work-related issues, couple- and family-related issues, and personal emotional issues. Clients were mainly classified as being effected on the personal emotional level, with traumatic events the highest (35,18%), followed by bereavement (14,81%), phase of life/adjustment difficulties (7,40%), depression (5,55%) and

lastly anxiety (3,70%). Following personal emotional issues, employees mostly had couple and family-related issues. Responses indicated that9,25% of employees presented with divorce as the intervention classification, followed by domestic violence (5,55%) and sexual abuse (1,85%). Work-related issues also presented as an intervention classification, with redundancy (actual or threat) as the most prominent at (3,70%). This was followed by sexual harassment, victimisation and retrenchment, all at 1,85%. According to the abovementioned classification, respondents were mostly affected by the critical incident on a personal emotional level, then in terms of couple- and family-related issues and then work-related issues. This correlates with the Careways call centre annual statistics that indicate that personal emotional issues are prominent (Careways Icare Report, 2009).

6.2.3.2 Work impact

As a work-based programme and management tool, within the EAP context, the impact of personal challenges or problems on work functioning remains a primary assessment screen. This prompt keeps the assessment contextual, can be used as an indicator of progress and can provide feedback to the employer in the case of formal referrals.

The assessment tool described hereafter is a tool developed and used by The Careways Group. The impact of the trauma on work performance is assessed by the therapist in the first and last session, according to the following eight questions.

Does this problem affect your functioning at work?

○Never ○ Sometimes ○ Regularly ○ All the time

Does the problem impact on your ability to do your job?

○Never ○ Sometimes ○ Regularly ○ All the time

Does the problem impact on your attendance?

○Never ○ Sometimes ○ Regularly ○ All the time

Does the problem impact on your relationship with the people that you work with?

○Never ○ Sometimes ○ Regularly ○ All the time

Does the problem impact on your concentration at work?

○Never ○ Sometimes ○ Regularly ○ All the time

Does the problem impact on your job satisfaction?

○Never ○ Sometimes ○ Regularly ○ All the time

Does the problem impact on your motivation at work?

○Never ○ Sometimes ○ Regularly ○ All the time

Does the problem impact on your relationship with management?

○Never ○ Sometimes ○ Regularly ○ All the time

The initial assessment of the work impact, as found in this study, is given in Figure 64.

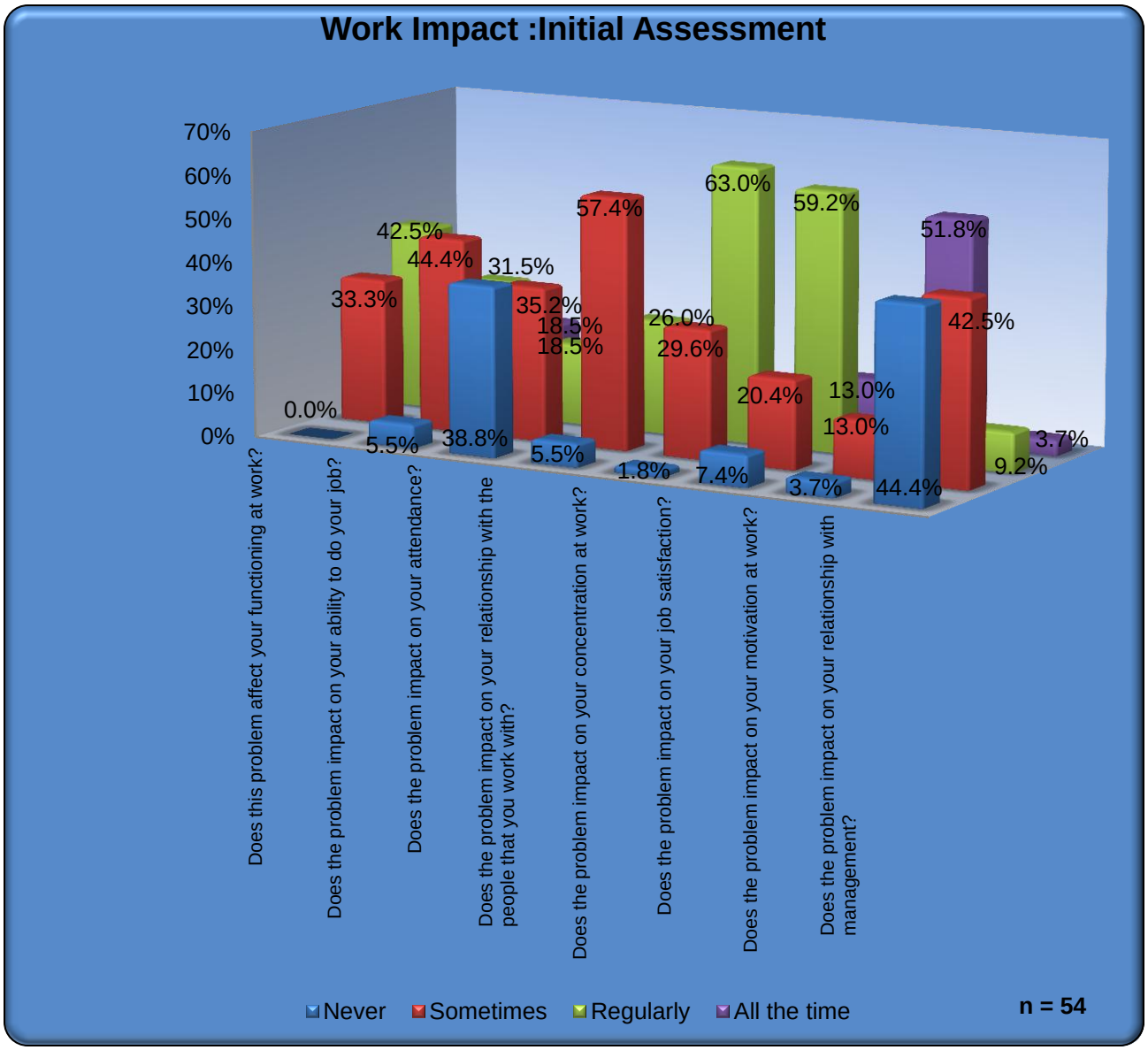


Figure 64: Work impact: initial assessment

Discussion of data

The therapists' assessment of the impact of the trauma on clients' work performance according to the eight standard questions in the first session is as follows:

All the clients functioning at work was affected in some way or another; 24,1% indicated that their functioning was affected all the time, 42,5% indicated regularly and 33,3% sometimes. The majority of the clients indicated that the trauma affected their ability to do their work (18,5% all the time, 31,5% regularly and 44,4% sometimes). A large proportion (38,8%) of the

clients' work attendance was not affected by the trauma, only 7,4% clients' work attendance was affected all the time and 18,5% clients' work attendance was affected regularly. The majority of client' (57,4%) relationships with other people at work were affected at times, 26,0% clients indicated that their relationships at work were affected regularly as a result of the trauma and 11,1% clients indicated their relationships were affected all the time. The majority of clients' (63,0%) concentration was affected regularly and only 5,5% clients' concentration was affected all the time. The majority of clients' (59,2%) work satisfaction was affected regularly and 13,0% clients' work satisfaction was affected all the time. Most of the clients' motivation was affected; 51,8% clients' motivation was affected all the time and 31,4% clients' motivation was affected regularly. The majority of clients' relationships with management were not affected as a result of the trauma, 44,4% relationships with management were never affected and 42,5% relationships with management were affected at times.

After assessment in the first session, it seemed that all the clients' work was affected in some way or another. Most clients' responses were that they were affected on all categories sometimes and regularly. Clients' concentration and motivation were affected the most; their work attendance and relationship with managers were affected the least. Overall, clients' functioning at work was affected. It can, therefore, be assumed that a critical incident had a negative impact on these employees' work performance.

Another assessment was done on termination of the therapeutic process. The results of this assessment are given in Figure 65.

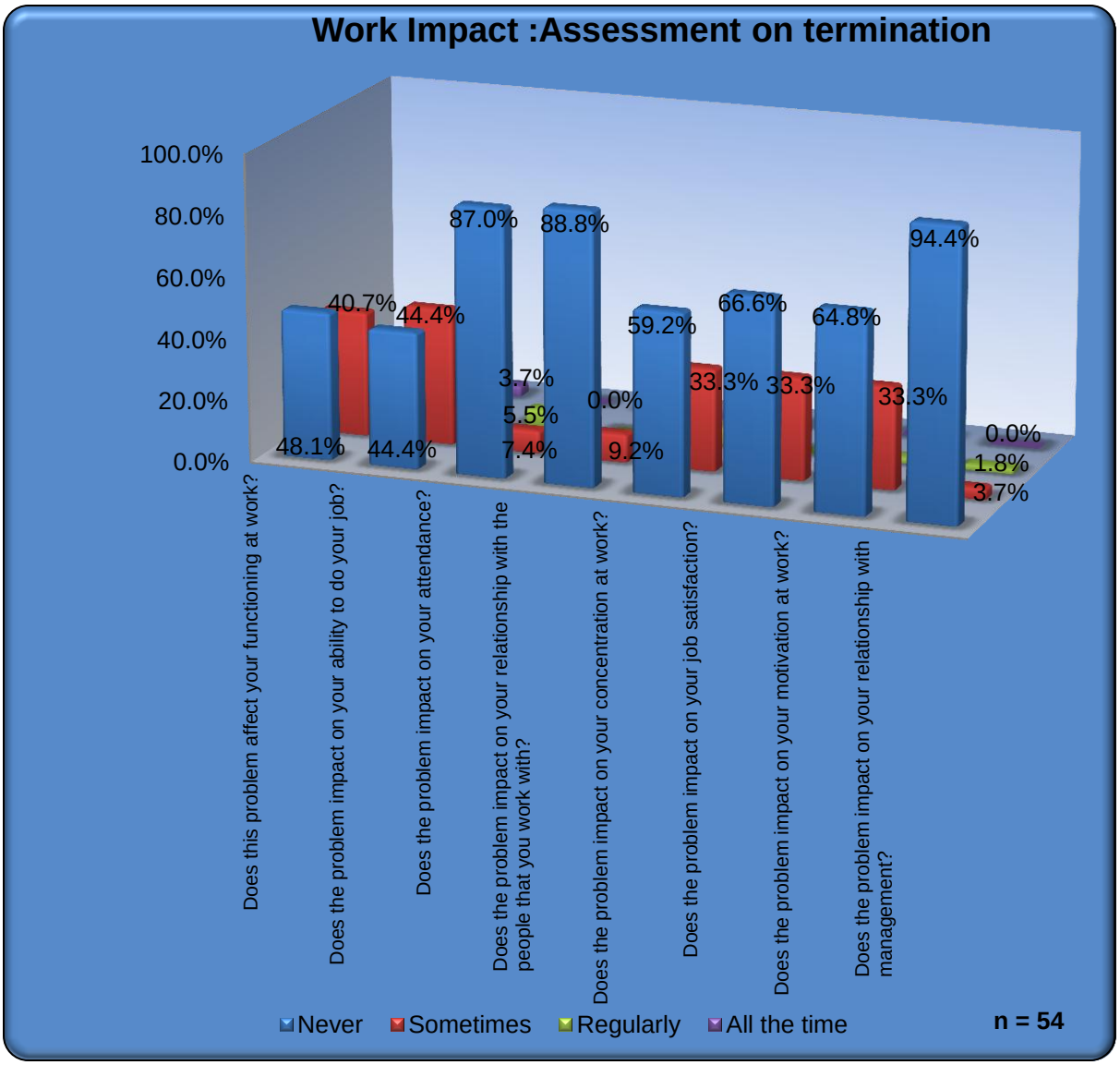


Figure 65: Work impact: initial assessment

Discussion of data

The therapists' assessment of the impact of the trauma on clients' work performance according to the eight standard questions at termination of the therapeutic process is as follows:

The majority of clients'(48,1%) functioning at work was not affected and 40,7% clients indicated that their functioning was sometimes affected. At termination of therapy, a large proportion of the clients indicated that the trauma did not affect their ability to do their work (44,4%), while 44,4% of clients were still affected at times. The majority of clients'(87,0%)

work attendance was not affected by the trauma at the termination of the sessions. The majority of clients'(88,8%) relationships with other people at work were not affected at termination of the therapy. Concentration was still affected at times with 33,3% of the clients, while 59,2% clients' concentration was no longer affected at all as a result of the trauma. At termination of the therapy, thirty six (66,6%) clients' work satisfaction was not affected at all as a result of the trauma. Most of the clients' (64,8%) motivation was not affected as a result of the trauma and 33,3% clients' motivation was affected at times as a result of the trauma. The majority of clients'(94,4%) relationships with management were not affected as a result of the trauma, at termination of the therapy process.

The impact of the traumatic incident on the work performance of clients significantly decreased from the first session to termination of the therapy process. Assessment of work impact after termination of the therapeutic process indicated that the majority of clients were not affected on all eight questions relating to work impact. In conclusion it can, therefore, be assumed that the therapy process contributed to the resolving of issues relating to the trauma that impacted on the work performance of the employees and that clients' work performance normalised in the process of therapy in the majority of cases.

6.2.3.3 Emotional distress

6.2.3.3.1 Emotional rating scale

In the first and consecutive sessions, the therapist is requested to assess the client's emotional functioning by completing an emotional rating scale. This scale converts his/her answer into a statistical figure from which The Careways Group can draw reports for any particular client company, indicating clinical effectiveness. It is an important indicator of progress and therefore, should the client still be uncontained at the time of case closure (no remaining sessions existing), a clear referral plan of action can be put in place.

The emotional rating scale consists of six measures indicating emotional distress. The therapist is required to choose only one that best reflects the client's emotional status at the time of assessment:

Emotional distress (choose only one)

- No cause for concern. Contained, content and functioning. May have long-term issues to work on
- Unhappy but contained, has coping resources and supports, functioning

- Distressed but able to use support to cope, functioning
- Initially uncontained, responds to counselling, anxious and significant distress. Needs support to cope, functioning less than usual
- Uncontained, distress serious, needs immediate support, coping skills and resources almost absent. Poor functioning at home and at work
- In crisis, extreme distress and unable to cope with situation. Not functioning at all, needs immediate intervention and care.

For the purposes of the study, therapists' responses for the first and the last session in terms of emotional distress are reflected. The results are given in Figure 66.

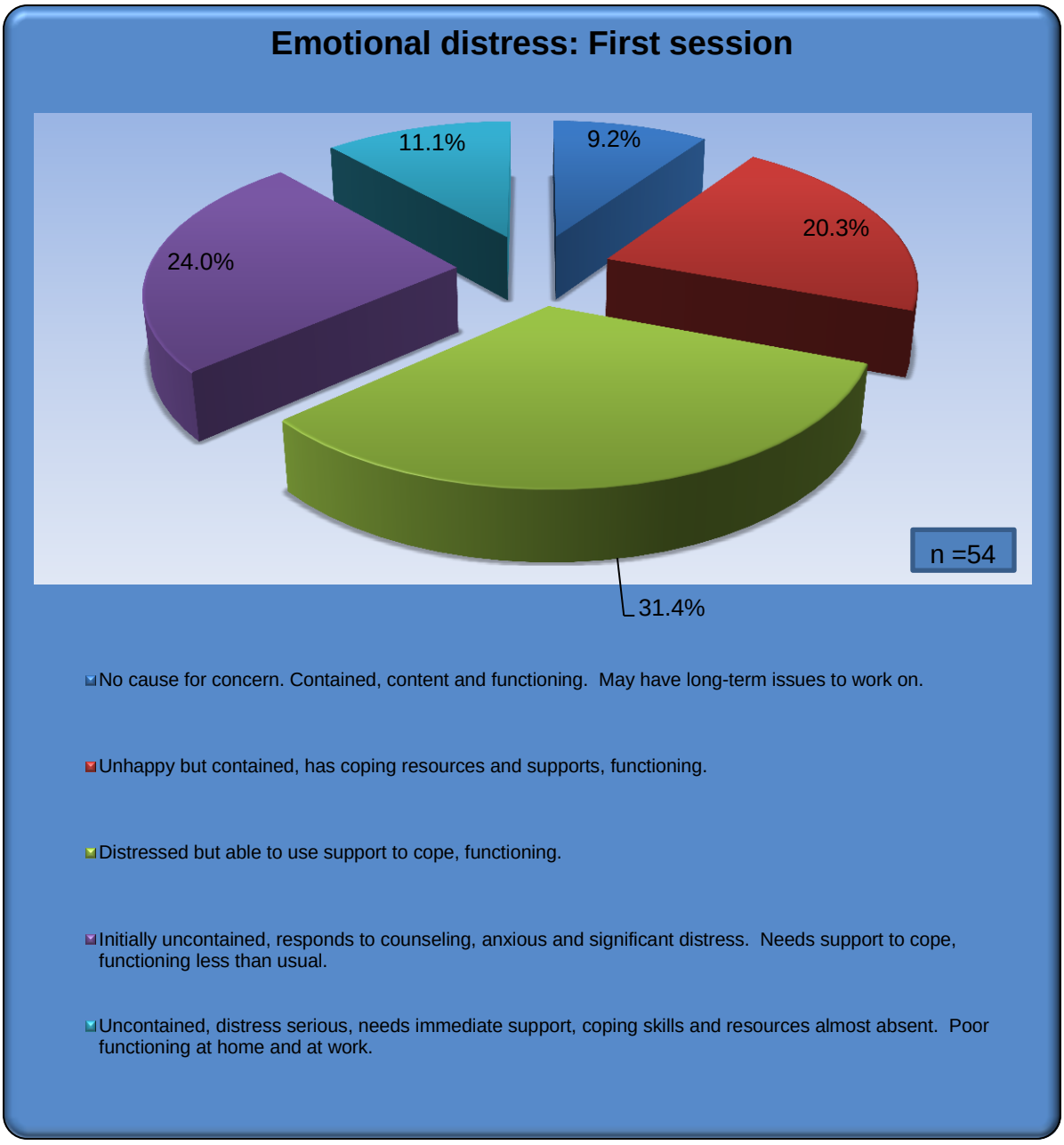


Figure 66: Emotional distress: first session

Discussion of data

The therapists' assessment of emotional distress in the first session based on the six measures as indicated before, reflects that the majority of clients (31,4%) were initially uncontained, responded to counselling, were anxious and showed significant distress, needed support to cope, and their functioning was less than usual. This was followed by 24,0% clients who were uncontained, showed serious distress, needed immediate support

and lacked coping skills and resources. Their functioning at home and at work was poor. Six (11,1%) clients were in crisis, experienced extreme distress and were unable to cope with the situation. They were not functioning at all and needed immediate intervention and care. Eleven (20,3%) clients were distressed but able to use support to cope and to improve functioning. The majority of clients experienced significant distress and impairment of functioning in the first session.

The results of the situation at the time of the last session are given in Figure 67.

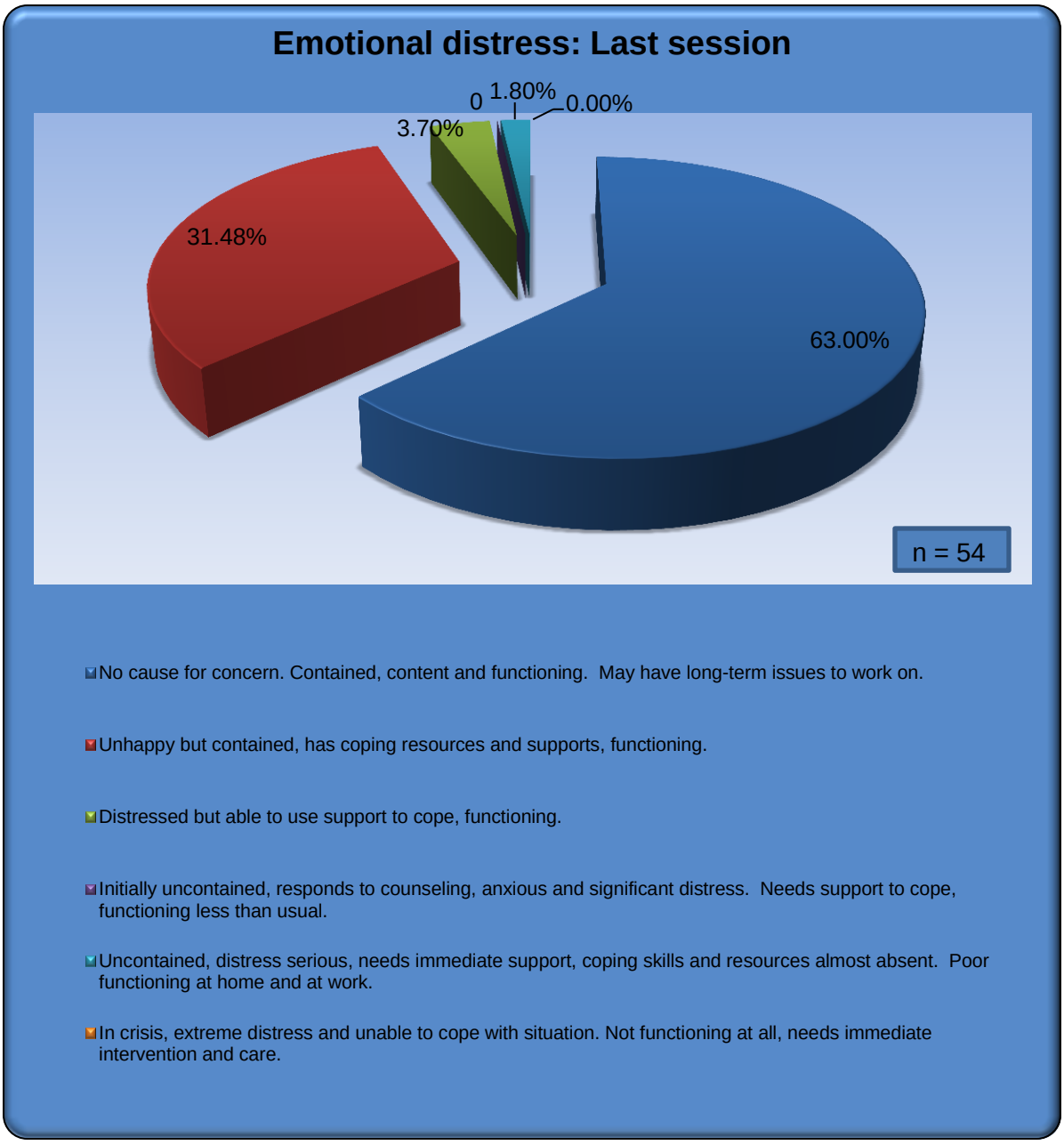


Figure 67: Emotional distress: last session

Discussion of data

The therapists' assessment of emotional distress in the last session, based on the six measures as indicated before, reflects that with the majority of clients(63,0%) there were no cause for concern. They were contained, content and functioning, but may have long-term issues to work on. Of the clients, 31,4% were unhappy but contained, had coping resources and supports and were functioning. Only 1,8% clients were uncontained, seriously

distressed, needed immediate support in the absence of coping skills and resources, were functioning poorly at home and at work, a situation that continued until closure.

The majority of clients recovered from having experienced significant distress and impairment of functioning, as reported in the first session, to where they were contained, content and functioning without any concern in the last session. The fact that clients' level of distress and functioning significantly improved from the first to the last session was an indication that the intervention was successful in assisting the employee to resolve issues relating to the trauma and to normalise functioning.

6.2.3.3.2 Mental status indicator

Mental status is assessed in the first session by the therapist. The mental status assessment questions review seven general areas of functioning and provide an indication of the extent to which certain concerning behaviour and symptoms are present. The therapists indicate if a specific area of functioning is affected by ticking a text box.

The results of these mental status assessment questions are given in Table 7.

Table 7: Mental status indicator

	Affected in the first session
General presentation	
Hygiene/grooming	16,6%
Clothing/attire	5,5%
Posture	0,0%
Distractible	44,4%
Cooperative	83,3%
Agitated	31,4%
Psychomotor retardation	0,0%
Involuntary movements/tremors	11,1%
Guarded/suspicious	9,2%
Speech	
Tone of voice	1,8%
Rate and pressure of speech	22,2%
Rhythm	14,8%

Poverty of speech	7,4%
Affect	
Restricted	33,3%
Blunted/flat	27,7%
Inappropriate to content	3,7%
Labile	25,9%
Mood	
Depressed/sad	66,6%
Anxious	76,0%
Irritable	87,0%
Angry	79,6%
Elevated	22,2%
Euphoric	0,0%
Expansive	0,0%
Anhedonic	20,3%
Intellectual functioning	
Attention/concentration	88,8%
Memory	63,0%
Judgment	7,4%
Intelligence	0,0%
Comprehension	31,4%
Thought/content	
Delusions	0,0%
Obsessions	0,0%
Ideas of reference	0,0%
Tangential thought	26,0%
Compulsions	14,8%
Illogical thought	0,0%
Circumstantial thought	38,8%
Loose associations	0,0%
Flight of ideas	16,6%
Hallucinations	0,0%
Organic	
Orientation x 4	35,2%
Alert	87,0%
Confused	50,0%

Discussion of data

According to therapists' responses, clients' general presentation mostly indicated cooperativeness. Some of the clients seemed distractible (44,4%) and agitated (31,4%). In terms of speech, rate and pressure of speech were mostly affected, indicating that clients either spoke slower or faster with some strain. In terms of affect, the majority of clients' affect seemed to be restricted (33,3%) in the first session, indicating emotional constraint in the first session. Mood indicators that were most prominent in the first session were irritability (87,0%), anger (79,6%) and anxiousness (76,0%). Intellectual functioning was mostly affected in terms of attention or concentration (88,8%) and memory (63,0%). In terms of thought processes, circumstantial thought was most prominent; indicating that thought was preoccupied with the incident in the first session. Clients' organic state indicated they were mostly alert (87,0%) and confused (50,0%) after the incident.

The mental status indicators reveal that clients were affected in all the areas of functioning. Mood and intellectual functioning seemed to be affected the most. Mood and intellectual functioning can be determining factors in work performance as well as psychosocial functioning. The fact that clients were affected in this way as a result of the trauma leaves room to assume that employees' work performance and psychosocial functioning was affected.

6.2.3.4 Emotional – post-event assessment

6.2.3.4.1 Treatment outcome

Treatment outcome refers to the reason for termination and can be any of the reasons mentioned below:

- ○treatment goals achieved
- ○Client referred
- ○Client dropped out – reason unknown
- ○Client moved
- ○Resistant to treatment: chemical
- ○Resistant to treatment: marital
- ○Resistant to treatment: formal
- ○Long-term issues
- ○Deceased
- ○Resigned
- ○Prevention of abuse of EAP
- ○Dissatisfied with service
- ○Unable to attend – health reasons
- ○Unable to attend – work circumstances
- ○Retired
- ○Client uncontactable
- ○Retrenched
- ○Parents did not bring child
- ○Client dismissed
- ○Repatriated

○Client not motivated for therapy ○Client not ready for therapy

The therapist ticks the appropriate reason for closure when the therapeutic process is terminated.

The results for this study are given in Figure 68.

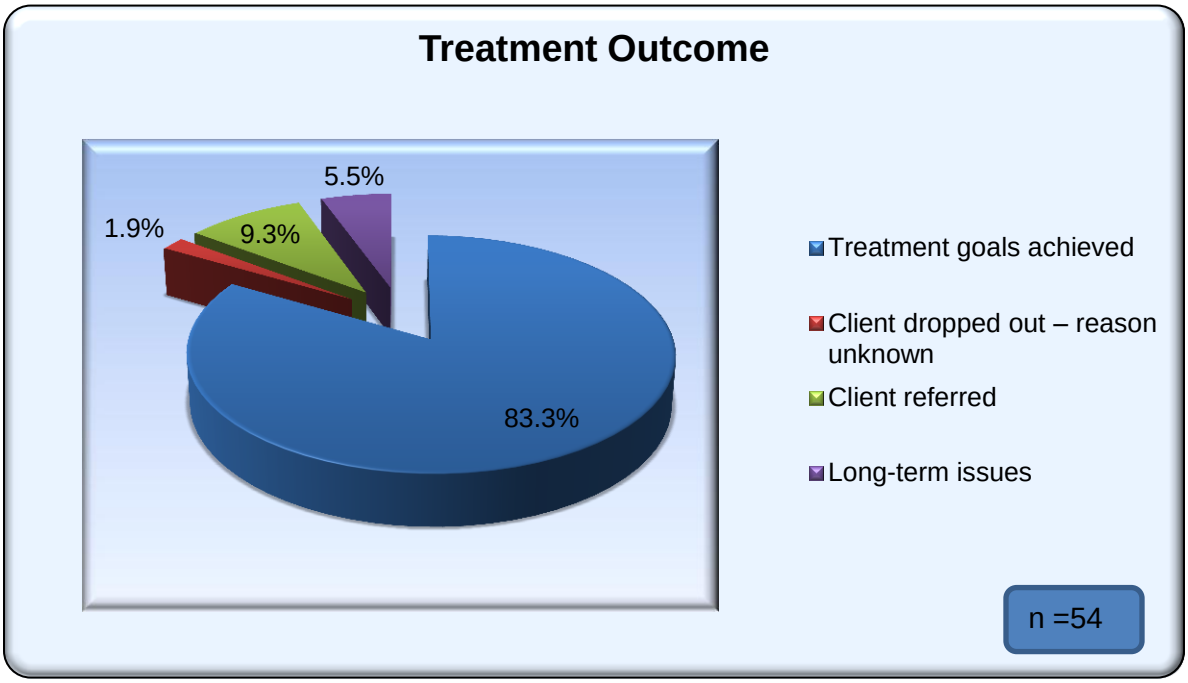


Figure 68: Treatment outcome

Discussion of data

The majority of therapists terminated treatment because the treatment goals were achieved (83,3%). In five cases (9,3%),clients needed further intervention and they were referred. In three cases (5,5%), the therapists indicated that the clients had long-term issues that cannot be addressed within the short-term solution focused brief therapy model and they were probably referred for longer-term therapy. One client did not return for therapy, without giving a reason.

As the majority of clients completed their treatment and achieved their therapeutic goals it can be assumed that therapy had the desired outcome and that therapy was effective in

supporting respondents to resolve the impact of trauma on their work performance and psychosocial functioning.

6.2.3.4.2 Overall client improvement scale

The overall client improvement scale is completed by the therapist, after completing the final session, by ticking one of the boxes below:

○No improvement ○Mild improvement ○Improvement
○Significant ○Excellent

The purpose of the overall client improvement scale is to determine the therapist's clinical view of the impact of individual counselling on the employee with relation to their trauma reactions.

The results for this study are given in Figure 69.

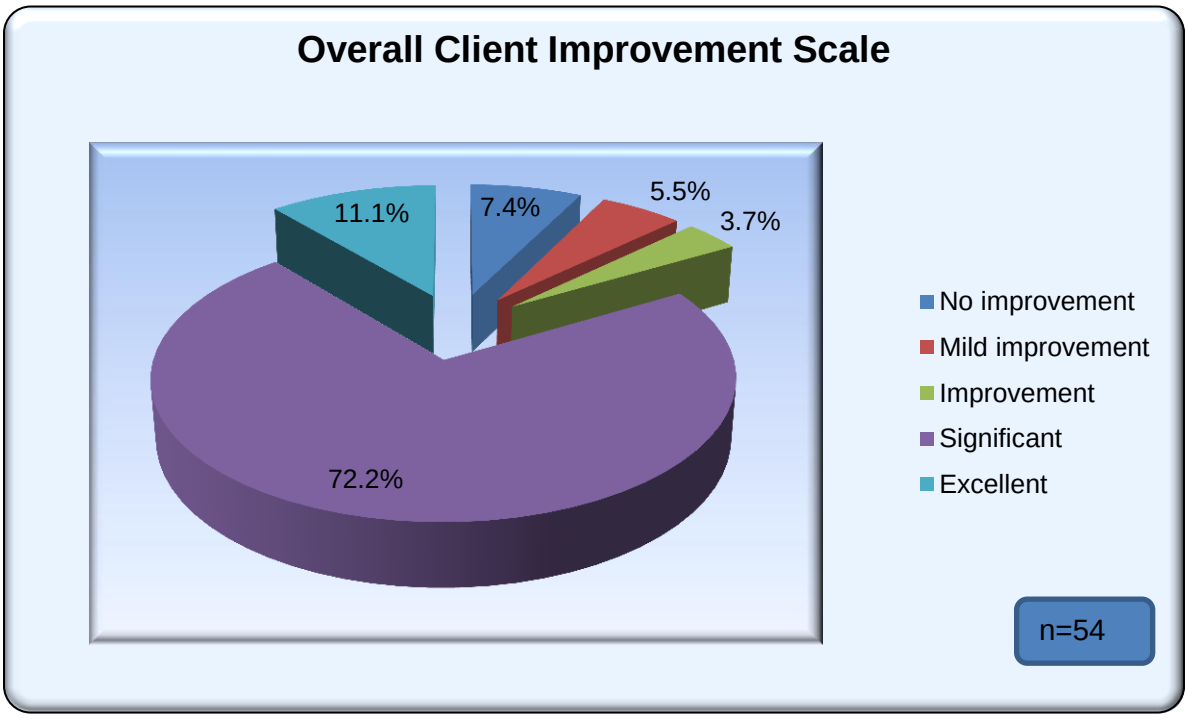


Figure 69: Overall client improvement scale

Discussion of data

The majority of therapists indicated that their clients had significant improvement (72,2%), followed by 11,1% who showed excellent improvement. Only 7,4% of the clients showed no improvement and 5,5% showed mild improvement.

In summary it seemed that therapists felt their clients benefited from the therapeutic process and that the majority of the clients showed significant and excellent improvement (83,3%).It can, therefore, be assumed that individual counselling was effective in dealing with the impact of trauma and assisting employees to restore work performance and psychosocial functioning.

6.2.4 Responses with regards to semi-structured interviews

In the **qualitative** study, the phenomenological design was applied as a way of data collection and analysis. The researcher's intention was to establish how employees' psycho-social functioning and work performance were affected as a result of the critical incident, and what impact the intervention had on their work performance.

During the quantitative study (client survey), the respondents were requested to indicate whether they were willing to participate in the qualitative part of the study. All respondents who had indicated that they were willing to participate in the qualitative part of the study then became part of the sample for the qualitative study.

The qualitative part of the study comprised a semi-structured telephonic interview with the participants and the participants' direct manager or supervisor. Each participant was requested to give permission to be contacted and that his/her manager could be contacted. Of the 54 respondents who participated in the study, 19 indicated that they were comfortable to be included in the semi-structured telephonic interview. However, only six participants indicated that they were comfortable that their manager or supervisor could be contacted and thus include them in the study.

6.2.4.1 Semi-structured interviews: employee (part 3)

The semi-structured interviews with employees were conducted telephonically between eight and 12 months after termination of the therapeutic process. Although 19 respondents

indicated that they were willing to take part in the qualitative study, only 12 participated (nine participated telephonically and three via e-mail). Seven participants were not available. The participation of employees in the semi-structured interviews is explained in Table 8 and their demographics in Table 9.

Table 8: Participation of employees in semi-structured interviews

Total number of respondents	Number of respondents successfully contacted	Replied via e - mail	Respondents not willing to participate	Contact number does not exist	Left messages on provided numbers at least 3 times
19	9	3	1	3	3

Table 9: Demographic information of participants

	Age	Sex	Qualification	No of years in the company	Time since the incident	Previous interven-tions
Participant 1	29	Male	Grade 12	4	12 months	No
Participant 2	36	Female	Grade 12	11	9 months	Yes
Participant 3	24	Female	Grade 10	2	14 months	No
Participant 4	37	Male	Diploma	14	8 months	No
Participant 5	26	Female	Grade 12 Certificate	5	24 months	Yes

Participant 6	54	Female	Degree	18	13 months	Yes
Participant 7	31	Female	Diploma	7	9 months	No
Participant 8	28	Female	Grade 12	4	11 months	No
Participant 9	36	Female	Degree	6	18 months	No
Participant 10	42	Female	Diploma	12	14 months	No
Participant 11	33	Male	Grade 10	6	12 months	No
Participant 12	27	Female	Grade 12	2	8 months	No

Discussion of data

The total response rate for employee participation in the semi-structured interviews was 63,15% compared to the number of employees who indicated that they were willing to participate in the qualitative part of the study. The majority of participants (47,36%) were interviewed telephonically, using the semi-structured questionnaire as a guideline, and 15,78% requested to complete the semi-structured questionnaire themselves and send it back via e-mail due to time and personal constraints.

Participants were briefed before the questions were posed to them in the following way: "Thank you for your willingness to participate in the qualitative part of this research study. Participation in this part of the study is confidential. I [the researcher] will only ask you a few

questions that you should answer as honestly as possible with the critical incident you received therapy for, through your company's employee assistance programme, in mind. Your answers to these questions will be recorded in writing and will be processed as part of my doctoral thesis. However, you will not be identified to anyone else and your name will not be used in the thesis."

Based on the responses of the 12 participants, the following results concluded from the semi-structured interviews with employees.

6.2.4.1.1 When were you traumatised by the critical incident? (Question 1)

"When the event has passed, it does not mean that the experience is over for those involved" (Kleber & Brom, 1992:2). The person affected by a critical incident has to face the after-effects for a long period. Time plays an important role in the healing process and can be a mediating factor in the recovery process. However, if a person's traumatic reactions do not improve over time, it can be an indication of more serious effects of the critical incident on the person.

The question above was posed to establish a timeframe and to establish if the respondent can remember the details of when it happened.

Discussion of data

Initially, participants' responses were uncertain and they had to think back to when exactly the incident had happened.

The responses of participants are as follow:

- The response of participant 5 was: "I cannot remember, was a very long time ago, if I have to think back it was about two years back".
- In the case of participant 4 and 12, the incident happened eight months ago,
- With regards to participant 2 and 7 the incident happened nine months ago.
- Participants 1 and 11 were exposed to the incident 12 months before.
- With regards to participant 8 it was 11 months before.
- With regards to participant 6 it happened 13 months before.
- Participant 3 and 10 were exposed 14 months ago.
- With participant 9 the incident occurred18 months back.

Participants were exposed to the critical incident between eight and 24 months before the research was conducted. Participants had an idea but could not remember directly and had to think a while before indicating how many months ago they were exposed to the critical incident. The fact that participants were affected eight months and more before the intervention could be a factor to consider. Participants sought help after this time, indicating that their reactions did not improve by itself in eight months' time and they probably felt a need for professional intervention.

6.2.4.1.2 Do you still feel affected as a result of the critical incident? (Please indicate in what way you feel affected, if applicable) (Question 2)

As indicated before, the semi-structured interviews with employees were conducted telephonically between eight and 12 months after termination of the therapeutic process.

Gilliland and James (1993:12) explain that psychic trauma is a process initiated by an event that confronts an individual with an acute, overwhelming threat. The individual's mind is unable to effectively answer basic questions of how and why it occurred, and what it means. This result in the individual experiencing a traumatic state that can last for as long as the mind has a need to reorganise, classify and make sense of the traumatic event.

If the event is not effectively integrated into the person's awareness, the initiating stressor will re-emerge in a variety of symptom logical forms, months or years after the event. This is referred to as delayed PTSD. Armfield (1994:48) emphasises that symptoms may begin immediately after the trauma, but often they lay dormant for weeks or even years after the trauma.

The responses of participants are as follow:

- Participant 2 mentioned that she still thought of the incident daily and "my life will never be the same after the incident".
- Participant 7 indicated "some days I feel my old self, but then there are days I realise I struggle and that I am thinking of what happened".
- The participants who indicated that they were no longer affected mentioned that they still thought of the incident, but was no longer affected. Participant 5, 6 and 11 indicated that they were no longer affected.

- Participant 11 mentioned: "I think of the incident from time to time, but don't linger on it too much, but I am not affected anymore."

Discussion of data

The fact that nine participants (75,0%) indicated that they still felt affected by the critical incident eight to 12 months after the incident might have been an indication that they did not fully integrate the incident and resolved all their emotions associated with the incident.

6.2.4.1.3 Did the critical incident ever affect your work performance? (Question 3)

Berker (2003:467) defines work performance as "the productivity, efficiency, effectiveness and quality of service with which an employee fulfils the requirements of the job".

The responses of participants are as follow:

- Eleven of participants felt that the critical incident impacted on their work performance.
- Only participant 4 indicated that the critical incident did not affect his work performance.

Discussion of data

As most of the participants indicated that their work performance was affected, the assumption can be drawn that a critical incident affected the majority of employees' work performance.

6.2.4.1.4 Describe in what way the critical incident impacted on your work performance? (Question 4)

According to Steers and Porter (1991:20), "employees who have suffered even temporary mental or emotional illness may have difficulty meeting his job requirements". The influence of social problems usually manifests itself in a range of different reactions due to a person's individual responses to stress and own uniqueness. The resulting impact on the work performance can be narrowed down to five broad categories:

- Poor work attendance

- Decreased productivity
- Deteriorating interpersonal relations
- Health issues
- Societal issues.

The responses of participants are as follow:

- Participants' reactions in terms of work performance varied but the majority of participants (7) felt that they were tired after the incident.
- Participant 3 indicated that "I was extremely tired a few days after the incident; I slept through a whole weekend".
- Participant 7 indicated that "I felt very tired, a sort of numbness, I could not do the things I usually did".
- Half of the participants felt irritable (6).
- Participant 6 indicated that she was "irritable with my family members and co-workers and only realised later it was as a result of the trauma".
- Some of the participants also suffered with poor concentration (5).
- Participant 4 indicated that "I could not focus; it took me much longer to perform a task I usually did quite quickly".
- Some of the respondents also felt stressed as a result of the incident and experienced negative feelings.
- The more exceptional reactions were feelings of racism (1) and incompetence (1).Participant 10 indicated that "when a black man enters, I lose my concentration, becomes very upset and extremely angry. I sometimes feel I hate black men for what they did". Participant 1 indicated: "I felt so affected at times, that I could not do my work, I felt totally incompetent."

Discussion of data

The critical incident affected all respondents in some way or another, confirming the impact of a critical incident and the potential impact it had on an employee's work performance and psychosocial functioning.

6.2.4.1.5 How would you describe your work performance at the present moment? (Question 5)

The responses of participants are as follow:

- Most of the participants (9) indicated that their work performance was affected by the critical incident (see paragraph 6.2.4.1.2).
- In response to question 5, most of the participants felt that their work performance at the present moment was good (7).
- One participant indicated that her work performance was excellent.
- Participant 6 indicated: "I always was a very hard worker who performed very well, I am glad to say my work is excellent."
- Participant 2 indicated that her work performance is poor. "I still feel affected and feel my work performance is poor, I used to perform much better."

Discussion of data

Most participants' (8) work performance seemed to have improved to a point where the respondents mostly felt satisfied with their own work performance.

6.2.4.1.6 Does the critical incident impact on your work attendance? (Question 6)

Absenteeism is a common response among workers, as a result of social problems and stress. It may be reflected in the workplace on a variety of different levels, namely lateness, excessive use of sick leave, absence from the work station (presenteeism) and the "long weekend syndrome", where employees tend to take leave of absence on a Monday or a Friday (Ramanathan, 1992:235–236).

The responses of participants are as follow:

- From the information provided by participants it seems that 10 participants felt that their work attendance was not affected as a result of the critical incident.
- Participant 5 indicated that "I did not feel like going to work, especially the first few days, but I did and I am glad as I think it helped me getting over the trauma much quicker".
- Participant 11 indicated that "I was affected but not to such an extent that I felt I should stay at home".

- Only two participants indicated that their work attendance was affected as a result of the critical incident.
- Participant 2 indicated: "Initially I was tired and felt so poorly that I did not go to work for a week, I still struggle to get up for work some days."
- Participant 1 indicated: "I struggle to go to work at times as I feel affected and I feel I am not able to do my work well."

Discussion of data

The number of participants who felt their work performance was affected was low in comparison to literature indicating that absenteeism after trauma or as a result of stress could be a common problem.

6.2.4.1.7 Did the critical incident ever affect your relationships with colleagues? (Question 7)

Prolonged personal problems usually affect the employee's relationships with his/her co-workers, especially the people with whom he/she works closely, who begin to notice that all is not well. This is usually frustrating for the problem employee, his/her co-workers and his/her supervisor. Carson and Butcher (1992:291) identify some interpersonal problems that may occur in the workplace, for example complaints from co-workers or customers, overreaction as a result of sensitivity to real or perceived criticism and unwanted grievances.

The responses of participants are as follow:

- Most of the participants (9) indicated that the critical incident did not impact on their relationship with colleagues at any stage.
- Some participants indicated that they found their colleagues supportive and it helped to talk about the incident at work.
- Participant 5 indicated that "I found my colleagues very supportive, especially a colleague I felt close to who had a very similar incident, I felt she understood me".
- Participant 3 indicated: "I struggled a lot and my colleagues at work were very supportive, they had a lot of patience with me."
- Only three participants indicated that they felt their relationships at work were impacted.

- Participant 6 indicated that "I was very irritable initially and realise that it affected relationships at work; where I usually like to chat with colleagues I became withdrawn".
- Participant 1 indicated that "I totally withdrew myself and my colleagues at one stage did not know how to deal with me; I could see they were getting impatient".

Discussion of data

Critical incidents has the propensity to affect relationships with colleagues, in this case most participants however felt it was not the case and indicate that there was support in the workplace. Where the relationships with colleagues were affected, it seems that symptomatic reactions like irritability and withdrawal played a role in the changed relationships.

6.2.4.1.8 Does the critical incident impact on your relationships with colleagues at the present moment? (Question 8)

The responses of participants are as follow:

- Nine of the participants indicated that that their relationships with colleagues were never affected (in paragraph 6.2.4.1.7) and only one of the participants indicated that his/her relationship with colleagues was affected at the present moment.
- This indicated that of the three participants who felt relationships with colleagues were affected, two had restored their relationships.
- Participant 1 indicated that relationships at work were still affected: "I am on my own at work, my colleagues tend to leave me alone and I prefer it that way".

Discussion of data

It seems that most of the participants' relationships with colleagues were not seriously affected and where they were affected in all but one case such relationships were restored.

6.2.4.1.9 Did the critical incident affect your family and family life? (Question 9)

It appears that trauma has the capacity to seriously affect the levels of functioning within the family. De Vries *et al.* (1999) support the notion that trauma is a family experience, with the members' reactions to the trauma being closely interwoven and interrelated.

Schulz et al. (2000:139–140) mention that the relationship with significant others may be affected in various ways as a result of exposure to incidents that cause post-traumatic stress.

Typical effects include the following:

- Changes in the way people see themselves, their spouse, partner or children. Relationships can become strained and difficult with a lack of ability to communicate.
- If a person is suffering, he/she may find it difficult to talk to his/her partner and retreat behind a wall of silence and suppressed anger.
- Inability to stop talking about the event. This can become irritating to family members.
- Nightmares and dreams. This can be disturbing and frightening to partners.
- Inability to make even simple decisions. Loss of concentration. Disinterest in family and friends can lead to feelings of anger and frustration to family members.
- Feelings of vulnerability, anxiety, confusion and disorientation can spill over to family members, leaving them with the same feelings.
- Pent-up feelings can result in anger and violence in the relationship.
- Loss of self-esteem and self-value can have a person feel worthless in a relationship.
- Loss of interest in work and hobbies resulting in changing jobs can cause upheaval in the family.
- Looking for new relationships or partners owing to dissatisfaction with the present partner or family
- Constant pre-occupation with the incident or avoidance of anything to do with the incident can be frustrating to family members.
- Feelings of fear, guilt, shame, being a complete failure and inability to cope affect the victim's self-esteem and the way he/she interacts with family members and friends.

Some of the participants' responses were the following:

- Participant 6 indicated: "I realised I was irritable with my husband and children. I withdrew myself from my husband and the more he wanted to help, the more withdrawn I became. I was hostile to my children and I felt guilty about my own behaviour."
- Participant 11 mentioned: "I felt an extreme anger and could not help myself, but was angry towards my family members, I was abrupt and unfriendly."

- Participant 1indicated: "I felt so overwhelmed that I could not perform my duties as a mother and wife, I was so tired and emotional I slept most of the time. Initially my family understood, but later they got angry and I felt very guilty."

Discussion of data

All the participants indicated that the critical incident impacted on their family and affected their family life. This reiterates the fact that trauma is a family experience and that the reactions to the critical incident are shared by family members although only one family member might have been the victim of such an incident.

6.2.4.2 Semi-structured interviews: Manager (part 4)

The semi-structured interviews with managers were conducted telephonically between eight and 12 months after termination of the therapeutic process. Although six respondents provided permission that their managers could be contacted as part of the qualitative study, only three managers participated. Semi-structured interviews were conducted with managers using the same interview schedule as with employees in order to compare the responses of employees with those of the managers as collateral information.

The participation of managers in the semi-structured interviews is explained in Table 10 and their demographics in Table 11.

Table 10: Participation of managers in semi- structured interviews

Total number of respondents	Number of respondents successfully contacted	Replied via e-mail	Respondents not willing to participate	Contact number does not exist	Left messages, provided numbers at least 3 times
6	3	0	1	1	1

Table 11: Demographic information of managers in semi-structured interviews

	Age	Sex	Qualification	Position at work	Years at company	Questions ans were d in terms of employee participant
Participant 1	40	Male	Grade 12 & Certificate	Supervisor	16	1
Participant 2	36	Female	Degree	Manager	5	4
Participant 3	41	Male	Diploma	Manager	8	5

Discussion of data

The total response rate for manager participation in the semi-structured interviews was 50% based on the number of employees who indicated that their managers could be contacted in the qualitative part of the study. All the participants were interviewed telephonically using the semi-structured questionnaire as a guideline.

Participants were briefed before the questions were posed to them in the following way: "Thank you for your willingness to participate in the qualitative part of this research study. Participation in this part of the study is confidential. The employee gave consent that you may be contacted as his/her manager and gave permission for you to answer these questions regarding his/her functioning. I [the researcher] will ask you a few questions and your honest answers will be appreciated. Your answers to these questions will be recorded in writing and will be processed as part of my doctoral thesis. However, you will not be identified to anyone else and your name will not be reflected in the thesis."

Based on the responses of the participants who participated, the following results were concluded from the semi-structured interviews with managers.

6.2.4.2.1 When was the employee traumatised by the critical incident? (Question 1)

The responses of participants are as follow:

- With regard to employee participants 1 and 4, two of the manager's (participants 1 and 3) responses were that it was more than a year back.
- With regard to employee participant 5, one manager (participant 2) indicated that it was in the last year.
- These responses correlated to some degree with the employees' responses in 6.2.4.1.1 where employee participant 1 indicated that the incident was 12 months ago, participant 4 indicated that the incident was eight months ago and participant 5 indicated the incident was 24 months ago.

Discussion of data

As Kleber and Brom (1992:2) indicate: "Time plays an important role in the healing process and can be a mediating factor in the recovery process. However, if a person's traumatic reaction does not improve over time it can be an indication of more serious affects the critical incident had on the person." This gives an indication of the time employees had to recover after the incident. According to the information above, the critical incidents happened at least eight months ago, leaving the employees with some time to integrate the incident.

6.2.4.2.2 Is the employee still affected as a result of the critical incident? Please indicate in what way you feel the employee is still affected (Question 2)

The responses of participants are as follow:

- Most of the participants' response was that employees were no longer affected as a result of the critical incident.
- Participant 2 indicated (with regards to employee participant 4) as follows: "He is no longer affected; he was not affected too much and recuperated quite fast".
- Participant 3 responded with regard to employee participant 5: "She was affected originally, but she is no longer affected".
- The response of participant 1 in terms of employee participant 1 was that "he was severely affected at first and is still affected".

Discussion of data

In paragraph 6.2.4.1.2, the majority of respondents indicated that they still felt affected by the critical incident eight to 12 months after the incident. This is in contrast with the managers' view as the majority of managers felt that the employees were no longer affected.

6.2.4.2.3 Did the critical incident ever affect the employee's work performance? (Question 3)

The responses of participants are as follow:

- All the participants indicated that the employees' work performance was affected as a result of the critical incident.
- Participant 1 indicated in terms of employee participant1: "His work performance was affected severely and is still affected."
- Participant 2 responded with regard to employee participant 4: "His work performance was mildly affected but he recovered quickly."
- Participant 3 responded with regard to employee participant 5: "She was affected at first, but coped well after a while."

Discussion of data

This finding correlated with the views of employees, where most of the participants (11) felt that the critical incident impacted on their work performance, as indicated in paragraph 6.2.4.1.3.

6.2.4.2.4 Describe in what way the critical incident impacted on the employee's work performance? (Question 4)

The responses of participants are as follow:

- All the participants indicated that employees were stressed, tired and their concentration was poor.
- Participant 1 indicated that employee participant 1 was "severely tired, concentration was affected and he was stressed; subsequently his work performance was also severely affected".
- Participant 3 indicated that employee participant 5 was "tired, irritable and stressed, looked angry and concentration was affected".

- Some of the employees also presented with feelings of anger and irritability (66,6%). This correlated with employees' reactions in paragraph 6.2.4.1.4, where the majority of respondents felt that they were tired after the incident (7), followed by feeling irritable (6) and poor concentration (5). Some of the respondents also felt stressed as a result of the incident.

Discussion of data

It seems that there was a similarity in terms of how employees felt they were affected and how managers perceived them as being affected. Both employees and managers felt tiredness and poor concentration was the way most respondents were affected.

6.2.4.2.5 How would you describe your employee's work performance at the present moment? (Question 5)

The responses of participants are as follow:

- The majority of participants (9) indicated, in paragraph 6.2.4.1.2, that their work performance was affected by the critical incident and this was confirmed by the views of managers (see paragraph 6.2.4.2.3) where it was reported that all employees were affected as a result of the critical incident. In paragraph 6.2.4.1.5, the majority of respondents indicated that their work performance was good (7) and one respondent indicated that his/her work performance was excellent (1), reflecting that respondents mostly felt satisfied with their own work performance.
- This was confirmed by the views of managers in response to question 5, where they indicated that employees' work performance was mostly good (2) and average (1).
- Participant 2 mentioned, with regard to employee participant 4, that "he is working like he used to; there is no sign that he was traumatised".
- Participant 1 mentioned, with regard to employee participant 1: "Although he is still affected, he improved a lot, he is doing his work."

Discussion of data

It can be concluded that both managers and employees felt that work performance was mostly restored at the time when the research was conducted.

6.2.4.2.6 Did the critical incident impact on the employee's work attendance? (Question 6)

The responses of participants are as follow:

- From the information provided by respondents in paragraph 6.2.4.1.6, it seems that the majority of respondents (10) felt that their work attendance was not affected as a result of the critical incident. Only two indicated that their work attendance was affected as a result of the critical incident. These responses correlated with the responses of managers where they indicated that work attendance of most employee participants was not affected.
- Only one participant indicated that work attendance was affected (Participant 1, with regard to employee participant 1):"His attendance was affected initially, he was tired and left early and some days were sick, more than he usually was."

Discussion of data

The fact that only three participants responded to this part of the study should be considered. The possibility exists that some other managers might have felt their employees' work performance was still affected, but they were not be included in this part of the study as the employee did not provide permission for their participation.

6.2.4.2.7 Did the critical incident ever affect the employee's relationships with colleagues? (Question 7)

The responses of participants are as follow:

- Participants indicated that the relationships at work of the majority of employee participants (2) were not affected as a result of the critical incident.
- Participant 1 mentioned that employee participant 1 was "irritable at times, withdrew him and I witnessed that colleagues became inpatient with him".

Discussion of data

This information correlates with the responses of employee participants in paragraph 6.2.4.1.7, where the majority of participants (9) indicated that the critical incident did not impact on their relationship with colleagues at any stage.

6.2.4.2.8 Does the critical incident impact on the employee's relationships with colleagues at the present moment? (Question 8)

The responses of participants are as follow:

- Participants' views with regard to employee participants were that their relationships were restored.
- Participant 1, with regard to employee participant 1, responded that "he is getting on well with his colleagues now; it is like it was before the trauma."
- Participant 2 and 3 mentioned that employees' relationships with colleagues at the moment were good.

Discussion of data

Although nine of the participants indicated that their relationships with colleagues were never affected (6.2.4.1.7), only one of the employees indicated that their relationship with colleagues was affected at the present moment (6.2.4.1.8). This indicated that of the three participants who felt relationships with colleagues were affected, one of those relationships was restored.

6.2.4.2.9 Did the critical incident affect the employee's family and family life? (Question 9)

The responses of participants are as follow:

- Participants 1 and 3 were aware that employees' family and family life were affected by the critical incident.
- Participant 1mentioned, with regard to employee participant 1,that "I am very aware that his family was affected, his wife contacted me at one stage and requested advice as she did not know what to do. I provided her with the EAP number to phone and seek assistance."
- Participant 2 mentioned, with regard to employee participant 5, that "she mentioned to me that her husband and kids is affected by what happened, they also struggle to sleep and has intense fear that it might happen again".
- Participant 2 was not sure whether the employee's family and family life were affected by the critical incident. Participant 2 responded with regard to employee

participant 4 that "he is a very private person and doesn't share a lot, but I would imagine that his family was affected by the incident".

Discussion of data

These findings correlate with the responses of participants in paragraph 6.2.4.1.9, where all the participants indicated that the critical incident impacted on their family and affected their family life. It can, therefore, be concluded that the impact of trauma did not only affect the person exposed to the trauma but his/her family members too.

6.3 CONCLUSION

In the study, empirical data were collected by using quantitative and qualitative data collection methods. The empirical data analysed for the purpose of this study are summarised in Table 12:

Table 12: Empirical data analysed for the purpose of this study

	Method of data collection	**Number of questionnaires distributed**	**Size of the Sample**	**Number of questionnaires analysed**	**Response Rate**
Quantitative study	Questionnaires to clients	80	54	54	67,5%
	Questionnaires to therapists	80	54	54	67,5%
		Number employees/managers requested to be part of the qualitative study	**Size of the Sample**	**Data Analysed**	**Response Rate**
Qualitative study	Document analysis	54	54	54	100%
	Semi-structured interview – employees	54	12	12	22,22%
	Semi-structured interview – managers/supervisors	54	3	3	5,55%

After the data had been analysed, it could be concluded that employees' work performance and psychosocial functioning were affected as a result of a critical incident, as confirmed by the outcome of the quantitative and qualitative study. Comparisons and recommendations on the results of the empirical data are discussed in Chapter 7.