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AN IMPACT ASSESSMENT OF A CRITICAL INCIDENT ON THE PSYCHOSOCIAL FUNCTIONING AND WORK PERFORMANCE OF AN EMPLOYEE

by

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The grand essentials to happiness in this life

are something to do,

something to love,

and something to hope for.

- Joseph Addison

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Acronyms

EAP:	Employee assistance programme
PTSD:	Post-traumatic stress disorder
TIR:	Trauma incident reduction
CISM:	Critical incident stress management
CISD:	Critical incident stress debriefing
CIR:	Critical incident stress response
PFA:	Psychological first aid.

Summary

Title: "An impact assessment of a critical incident on the psychosocial functioning and work performance of an employee"

Candidate : Albert André van Wyk

Study leader : Prof L.S. Terblanche

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My purpose with the envisaged study was to determine the effect a critical incident have on employees and how their functioning, psychosocially and at work is affected. Furthermore the goal was to determine if the employees who was affected by a critical incident was exposed to Critical Incident Stress Management (CISM) intervention, and if so did it have an impact on their functioning (Psychosocial and work performance).

An extended literature study was conducted to comprehend the meaning of trauma, the different facets of trauma, how it can impact on an emotional, physical, cognitive and behavioural level. The literature study further focused on the impact of a critical incident on the work performance and family life of the employee. Attention was given to the models in CISM intervention, the role of Employee assistance programs as well as the perceived outcomes of interventions the respondents were exposed to.

In the study, data was collected in a qualitative as well as a quantitative manner. In the quantitative study two questionnaires were used as tool to collect information. In the qualitative study the researcher used clinical case notes as part of the document analysis as well as a semi structured interview with both the employee as well as the manager as data sources.

Respondents (therapists) were selected according to the probability sampling procedure for the quantitative study and respondents volunteered to participate in the qualitative study after participating in the quantitative study.

Participation in the study was voluntary and the participation rate in the quantitative study was 67.5% and in the qualitative study 22.22%

It was evident from the study that employees were affected by a variety of critical incidents divergent in severity, circumstances and duration. The impact on each individual was unique and responses ranged in terms of severity.

It was evident from the study that employees were affected by the critical incident and subsequently their work performance and psychosocial functioning was affected.

The study managed to provide sufficient evidence on the impact of the critical incident on the psychosocial functioning and work performance of the employee. The research proved that individual counselling is effective in working through the incident and improving the psychosocial functioning and work performance significantly.

The study also proved that intervention in the form of defusing, debriefing, individual counselling and aftercare is effective in addressing employees' reactions, supporting them to recover emotionally from the critical incident and improving their psychosocial functioning and subsequently their work performance.

Conclusions and recommendations were made in terms of the empirical findings. The researcher hope that these conclusions and recommendations will be of value and contribute to the study field of CISM and EAP and have a positive impact on employees exposed to critical incidents and their recovery process.

Key terms

Crises	Critical Incident
Critical Incident Stress management (CISM)	Debriefing
Employee Assistance Programme (EAP)	Defusing
Trauma Incident Reduction	Trauma
Psychosocial functioning	Work performance

Chapter 1

General Introduction

1.1 INTRODUCTION

Critical incidents are a reality facing everybody. South Africans are faced with incidents such as hijacking, armed robbery, rape, murder, suicide, housebreaking, divorce, death and other violent acts on a daily basis. Meichenbaum (1994:231) includes critical incidents such as rape, shooting incidents, car accidents or earth quakes as Type 1 traumas. A Type 1 trauma has the following characteristics: it is a single dangerous, overwhelming event, it is sudden and surprising, it has limited duration, it can lead to post-traumatic stress disorder (PTSD) and quick recovery is unlikely. The researcher is interested in the effect of critical incidents with Type 1 characteristics because of the general perception that there is a higher occurrence of these incidents in the South African society and to establish the effect of such incidents on the work performance of employees.

Crime statistics in South Africa indicates that "Recorded crime increased by 15% between 1994 and 1999, with an average year-on-year increase of 3% during this time" (Altbeker, 2002:7). According to Altbeker (2001:10), 217 out of every 100 000 people in Johannesburg and 148 out of every 100 000 people in Pretoria were raped during 1999. The number of assaults per 100 000 people were even higher and posed at 923 people in Johannesburg and590 in Pretoria. Car hijacking increased by 29% on a year-on-year basis, between 1994 and 1999. Murder increased by 2% and rape by 4% year-on-year between 1994 and 1999 in Gauteng. Although these figures are staggering, it seems that there is an improvement: "National and Provincial police crime figures indicate that crime to a certain extent, levelled off in the course of 2002. Murder continues to decline, as does vehicle theft. However, the trends for car hi-jacking are less positive" (Leggett, 2003:17). These statistics indicate that many people are directly or indirectly affected either as the victim or as family members, friends or colleagues of the victim.

According to Strydom (2002a:211), the prospective researcher can only hope to undertake meaningful research if he/she is fully up to date with existing knowledge on his/her prospective subject. A literature study is not only important for the clear formulation of the problem, but also for executing the planning and actual implementation of the investigation.

This researcher used different sources such as books, journals, dissertations, theses and other documents to obtain the most recent information on the subject. The literature study focused on the following areas: critical incident, stress debriefing, crisis intervention, PTSD, work performance, psychosocial functioning and employee assistance programmes. For the purposes of the study, a short overview on critical incidents according to the literature is provided.

A critical incident refers to "an event that is extraordinary and produces significant reactions for the intervening person. It may be so unusual that it overwhelms the natural abilities of people that have to cope with difficult situations" (Lewis, 1996:15). A critical incident may lead to stress, burnout, or even PTSD that may be experienced almost immediately or may be delayed for days, weeks or months. According to Lewis (1996:18), a critical incident can lead to a range of physical, cognitive and emotional reactions. Physical reactions include fatigue, dizziness, nausea, and sleep and appetite disturbances. Cognitive reactions may include mental confusion, memory impairment, difficulty with decision making and intrusive thoughts. Emotional reactions may include fear, anxiety, depression, grief and irritability. These reactions have a significant impact on the work life and work performance of the victim and may even have an impact on the work life and work performance of people close to the victim.

According to Strydom (2002a:212), the wealth of knowledge in literature is only a section of the knowledge of the people in the specified field. It can be extremely valuable to consult these sources specifically for their experience. Strydom (2002a:213) further mentions that the researcher "should ensure that he approaches a representative number of experts whose experience and opinions can be utilized."

For the purpose of this study the researcher consulted the following experts to gain insight and knowledge for the proposed study:

- **Dr André van Jaarsveld – Director Group Affairs (The Careways Group) until March 2008**

  In a personal interview with Dr van Jaarsveld, he indicated that the mission of The Careways Group is to provide integrated and comprehensive health support solutions to at risk populations within organisations, thereby contributing to the business effectiveness

of these organisations and improving the quality of life of the people working for them (A van Jaarsveld, personal communication, March, 2004).

People exposed to and traumatised by a critical incident are at risk and their work performance and psychosocial functioning are affected. According to Lewis (1996:77), when a stressor becomes extremely threatening, overwhelming, or severe, it often produces a heightened state of cognitive, physical, emotional and behavioural arousal called traumatic stress. After having been exposed to traumatic stress, employees may experience a range of reactions including deterioration of job performance, personality change, anxiety states, relational problems, grief reaction, depression and suicidal ideation. It is, however, difficult to establish to what degree and for what period the work performance and psychosocial functioning of the employee will be affected.

Organisations are usually profit driven and if an employee's work performance is poor, it affects the organisation financially. The National Work Performance Institute indicates that during the first three months after a traumatic incident, a 25 to 45% decrease in work performance is noticeable in the work performance of a traumatised employee (National Work Performance Institute, in Retief, 2004:66). Organisations are not always aware of the impact that a critical incident may have on the work performance and the psychosocial functioning of an employee. Owing to this limited understanding of the impact of a critical incident, the employee does not get the appropriate care and support to recover fully in the shortest period of time. If organisations are aware of the effects of a critical incident in the workplace and understand the importance of effective intervention to improve work performance and psychosocial functioning, they will be more willing to purchase and support a programme that can improve the quality of life of their employees and ultimately improve their work performance. By offering these services to employees, the organisation gains in terms of increased work performance and business effectiveness.

- **Rev Barbara Louw – Managing Director, Inter Trauma Nexus**
  Rev Louw is an expert in the field of trauma debriefing. She focuses on individual and group trauma debriefings. Rev Louw (personal communication, March, 2004) is of the opinion that a critical incident is a single incident that not necessarily leads to traumatisation. A trauma is more severe and has a longer-term effect on the victim. A

person can be the primary victim of a trauma (indicating that the person was directly traumatised) or secondary victim (not directly traumatised) who witnessed the trauma or is closely related to the victim. The history of a victim in terms of previous traumas is important. Friedman (2003:21) refers to pre-trauma risk factors which may determine to what extent a person is traumatised by a specific critical incident. These risk factors include adverse life events, for example divorce, loss of a job and financial problems, previous exposure to traumas as a child or as an adult, health problems and a history of psychiatric problems. If a person has been exposed to critical incidents or traumas previously, it may have an effect on the way a person reacts to the most recent trauma. This refers to accumulated trauma, which determines a person's stress response, and ultimately how the person's work performance, psychosocial functioning and work performance are affected. Owing to the fact that the effects of traumas accumulate, the possibility for the development of PTSD increases.

Rev Louw (2004) is of the opinion that a trauma is not determined by the severity of the incident, but rather by the individual's reaction to the incident. Friedman (2003:27) tends to disagree and states that "the higher the severity (dose) of trauma the greater the magnitude of trauma exposure, the greater the likelihood of being traumatized". A critical incident includes incidents such as divorce, retirement, the migration of children and other events that are experienced as traumatic by the victim.

- **Ms Anine van Zyl – Employee Assistance Professional/Psychologist at the University of Pretoria**

  As employee assistance professional working with personnel at the University of Pretoria, Ms van Zyl (personal communication, March 2004) is confronted with traumatised employees regularly. She defines both a critical incident and a trauma as an unexpected event that poses an immediate threat to a person's well-being and mobilises coping mechanisms immediately. The difference between a critical incident and a traumatic event is that the traumatic event poses the risk of significant loss in terms of safety, self-belief, life-stage, person, expectations or freedom. Critical incidents have short-term effects. Trauma on the other hand has longer-term effects, because of the risk of significant loss. Trauma is determined by the individual's reaction to an event and not by the event itself.

Herman (1992:33) defines psychological trauma as "an affliction of the powerless, where the victim is (at the moment of trauma) rendered helpless by overwhelming force". She differentiates between the force of nature (a disaster) and the force of another human being (an atrocity). These events have the effect of threatening a person's life and/or physical integrity, rendering him/her helpless, terrorised, disconnected and at a loss. In the process the person's ordinary adaptations to life are overwhelmed and the response to catastrophe is evoked.

When working with a traumatised person, the therapist must help the victim to neutralise the event, educate the victim on possible reactions, link the trauma to previous traumas and determine the level of risk the individual is exposed to.

Working with employees, Ms van Zyl (2004) witnessed the ripple effect a traumatic event can have in the workplace. Colleagues and family close to the traumatised person may also be traumatised and experience symptoms of trauma. Traumatisation has an impact on the physical, mental and emotional well-being of a person. Trauma leaves the employee vulnerable and has an effect on the employee's concentration, relationships and ability to work. It often leaves the employee with existential issues and questions about the meaning of life. As a therapist she often uses cognitive restructuring as a method to assist the employee to return to a positive state of mind and to prevent long-term depression.

- **Mr Arthur Neil – Deputy Director, National Defence Force/Psychologist**

  Mr Neil (personal communication, March, 2004) is a psychologist in the National Defence Force and is responsible for the debriefing of employees exposed to traumas in the workplace. He views a critical incident as a threat to a person's well-being when it poses heightened expectations to the person's coping mechanisms. A traumatic experience always indicates the possibility of significant loss in terms of life, safety and freedom.

  He makes use of brief therapy as a model for trauma debriefing and experiences it as being very effective in a person's recovery and long-term functioning. Mr Neil stresses the fact that the traumatised person is very receptive to intervention within two to 24 hours after the incident. Plaggermars (2000:80) agrees and embraces the central principle of the crisis theory, which states that during a crisis: a) people may need additional coping

skills to deal with a traumatic experience; and b) people are unusually open to acquiring new skills. Weeks or months after the incident the person may not see the need for intervention because the person has learned to cope with the trauma. This, however, does not imply that the person is functioning as he/she should and that his/her issues are resolved. A person who did not receive any debriefing after a trauma may react more severely with the next trauma due to the effect of accumulated trauma.

After the war on South Africa's borders, soldiers traumatised by land mines, crossfire and hostage dramas consulted Mr Neil. Some of these soldiers were never debriefed after the incident and became his patient's years after the events because of depression, poor psychosocial functioning, poor work performance, dysfunctional relationships, a tendency to substance abuse and suicidal risk.

Research in the USA, according to Friedman (2003:12), indicates that 60,7% of men and 51,2% of women would be exposed, at least once during their lives, to a catastrophic incident. In South Africa we may infer that the exposure figure in all probability is much higher as a result of the high crime rate, violence and history of political instability.

Mr Neil (2004) stresses the importance of timely intervention to prevent long-term depression, poor work performance and dysfunctional relationships.

- **Mr Craig Higson-Smith – Director of the South African Institute for Traumatic Stress**
  A critical incident, according to Mr Higson-Smith (personal communication, March, 2004), is an event that affects a person's physical safety and results in feelings of fear and helplessness. A trauma is more severe and indicates the threat of significant loss in terms of life, safety, self-belief and freedom. He describes a trauma as an external event, leading to an internal response. He uses different models of intervention for different traumas. Brief therapy has proven to be effective in traumas such as bank robberies or car hijackings because of victims' high receptiveness for intervention and openness to acquire new skills after a crisis (Plaggermars, 2000:80) Long-term therapy (e.g. narrative approach) is effective when working with survivors of sexual abuse. Trauma has a severe effect on a person's psychosocial functioning and work performance and is noticeable in a person's poor concentration, absenteeism, tiredness and irritability. Persons who have received trauma debriefing usually make a full recovery and the risk for developing PTSD

is minimised. On the other hand, people who have not received debriefing are likely to develop post-traumatic symptoms and PTSD at a later stage, according to Mr Higson-Smith.

- **Mrs Yvonne Retief – Trauma counsellor and author of the book *Genesing vir trauma* (translated as: *Healing from trauma*)**

  Mrs Retief (personal communication, March, 2004) is a counsellor who specialises in working with survivors of sexual abuse. She also does trauma debriefing for persons who were hi-jacked, were in bank robberies and car accidents, got divorced and retired. She is of the opinion that any life event can potentially be traumatic. "'n Persoon het 'n trauma beleef indien hy/sy blootgestel was aan gebeure wat te make het met óf sy/haar lewensomstandighede, óf gebeure met sy/haar lewensfase (byvoorbeeld die oorgaan van een lewensfase na die ander of omstandighede as gevolg van 'n nuwe lewensfase wat die person onhanteerbaar vind) en wat tot gevolg het dat daardie persoon se gewone hanterings meganismes lam gelê word" (Retief, 2004:18). "A person suffered a trauma when he/she had been exposed to events that had to do with his or her life circumstances, or events that had to do with his/her phase of life (e.g. moving from one life phase to another or circumstances as a result of a new life phase that the person could not handle) with the result that this person's usual handling mechanisms were paralysed" (Retief, 2004:18) [translated by researcher]. The individual's reaction to the event will determine if it is a traumatic event for that person. Mrs Retief uses traumatic incident reduction (TIR) as model of intervention when debriefing traumatic events with short- and long-term effects. TIR intends to move the client from the chronic stage of victimisation to the previous stage where the client was functioning well. TIR leads to spontaneous client-generated insight, personal growth and empowerment. The model has proven to be successful in long- and short-term therapy, moving clients to the previous level of normal functioning and restoring psychosocial functioning and work performance.

The motivation for this research was to determine how employees' psychosocial functioning and work performance were affected as a direct result of a critical incident. The researcher was further interested to determine if the employee made use of the employee assistance programme, if the level of intervention was appropriate and if the intervention helped in the recovery process. The purpose of appropriate and early intervention is to lessen the effect of the incident on the victim. The researcher is of the opinion that early intervention can prevent

post-traumatic stress symptoms and the development of PTSD. The aim of critical incident debriefing is to minimise the after-effects of trauma and to reduce the likelihood of people involved developing the symptoms of PTSD (Smith, 2001:330). If a victim receives the appropriate counselling after the incident and severe effects are minimised, it can lessen the effect of the incident on the work performance of the victim dramatically. Through this research the researcher hoped to establish whether the intervention after a critical incident was helpful to the victim and if it contributed to the recovery of the work performance of the employee. By establishing how employees are affected by critical incidents and the effectiveness of interventions, existing procedures and protocols can be revised and adapted to improve the work performance of employees and the work performance of the company.

In this chapter, an exposition of the planning, the structure and the strategy of the study are formulated. The motivation for the study, the research problem, the purpose of the study and the research hypothesis are discussed. The research approach, the type of research, the research design and the research procedures also receive attention in this chapter. The pilot study, the description of the research population, ethical aspects and the defining of key concepts are discussed.

1.2 PROBLEM FORMULATION

As a social worker in private practice and an affiliate employee assistance professional for The Careways Group[1], the researcher became increasingly aware of the referrals that were trauma related. In the light of the high crime statistics in South Africa, employees become victims of critical incidents such as hijacking, rape, murder, housebreaking and assault on a daily basis.

The researcher is, however, of the opinion that it is not only crime and violent acts that pose a crisis to an employee. Incidents such as divorce, death of a loved one, suicide, alcohol or drug abuse of a family member and retrenchment can also be critical to an employee.

In defining critical incidents some authors focus on the actual event as being life threatening to the individual. Bohl (1991:27) describes a critical incident as "an incident in which human

[1]The Careways Group is an independent company specialising in employee wellness and delivering employee assistance services to a wide range of employees of different companies.

lives are lost and/or serious injuries are witnessed". Van der Kolk (1991:16) defines critical incidents as "sudden terrifying experiences that explode one's sense of predictability in life". Authors such as Mitchell highlight the individual's reaction to the actual event when defining a critical incident. Mitchell (1986:51) views a critical incident as "any significant emotional event that has the power, because of its own nature and because of the circumstances in which it occurs, to cause unusual psychological distress in healthy normal people". According to Solomon (1986:30), any situation in which a person feels overwhelmed by a sense of vulnerability and/or lack of control over the situation can be defined as a critical incident.

The researcher agrees that when defining a critical incident the focus should be on the reaction of the individual. Different incidents can trigger different reactions from different people. An individual reacts to situations differently from others. It is, however, the reaction that defines if it poses a crisis to the individual or not. A critical incident is determined by the person's reaction and how it affects his/her psychosocial functioning and work performance. A critical incident affects every part of a person's being – his/her thoughts, emotions, behaviour and physical reactions. The effects of a traumatic event only become visible in the workplace when the severity of the incident affects the well-being, performance, work performance and interpersonal relationships of the employee. According to Sonderup (1996:12), even though employees may not disclose that they were traumatised, certain symptoms of their distress might manifest in the workplace, including absenteeism, poor concentration, careless mistakes, hypersensitivity, conflict with co-workers, irritability, aggression, social withdrawal, depression and physical symptoms such as headaches, stomach aches and diarrhoea.

Quick and effective intervention in response to a critical incident can prevent the development of PTSD, which can have serious consequences for both employer and employee in terms of work performance.

The research problem can be formulated as follows:

> The impact of a critical incident on an employee and the reaction of the employee to the critical incident need to be researched in order to assess the effect of such a critical incident on the employee's psychosocial functioning and work performance, the lack of such information, results in the risk of not applying the most appropriate intervention.

1.3 GOAL AND OBJECTIVES OF THE STUDY

The goal of this research study was to explore the impact of critical incidents on the employee.

Goals give a general indication of the direction of the research. Objectives are specific measurable, time limited, achievable and realistic. The achievement of objectives in a study should contribute to the achievement of the goal of the study.

The goal and objectives for this study were as follows:

1.3.1 Goal

The goal of the study is to explore the impact critical incidents have on the psychosocial functioning and work performance of the employee and to explain the appropriateness of interventions.

The goal of the study was, therefore, a combination of exploratory and explanatory research to assess the appropriateness of interventions provided.

Exploratory research

Royse (1995:28) mentions that exploratory research is conducted if information regarding a certain subject is limited. The value of exploratory research is that it produces new questions for future research. Neuman (1994:18) further explains that exploratory research may be the beginning of a new series of studies. The researcher conducts exploratory research to gather information for a second more systematic and more comprehensive study.

Exploratory research was conducted to give the researcher an idea of the critical incidents occurring and affecting the daily lives of the employee. By conducting exploratory research the researcher hoped to form an idea of the impact of critical incidents on the employees of the corporate client in order to serve as foundation for descriptive research where specific details of the situation were further described.

Descriptive research

According to Royse (1995:28), descriptive research elaborates on exploratory research. Descriptive research is usually done on a large scale and the population that is being studied

is well represented. Descriptive research gives exact information about the characteristics of the respondents being studied. Neuman (1994:19) mentions that descriptive research gives a picture of the specific details of a situation, social environment or a relationship. For the descriptive researcher, description of how something happened is more important than why something happened.

The researcher attempted to describe who was affected by the trauma or critical incident and how they were affected by the incident.

Fouché (2002a:107) distinguishes as follows between goals and objectives: "The one goal, purpose, aim is the dream, the other objective, is the steps one has to take, one by one, realistically at grass-root level, within a certain time span, in order to obtain the dream." According to Royse (1995:267), goals are not specific but give a certain direction to research. Objectives are specific, measurable and indicate when a result can be expected. Tripodi (1983:24) is of the opinion that goals are broad generalisations that reflect attitudes and values and give direction for human activity. Objectives are relatively concrete and measurable.

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1.3.2 Objectives

The achievement of the goal was dependent on the realisation of the following specific objectives:

- To provide a broad theoretical framework on critical incidents and their effect on the psychosocial functioning and work performance of the employee and the workforce of an organisation.
- To explore who are affected and how these employees are affected by critical incidents based on the records of referrals managed by the Careways Group call centre.
- To investigate and establish the time period that victims' psychosocial functioning and work performance are affected by a critical incident and whether any of them develop post-traumatic stress symptoms or PTSD.
- To investigate different interventions (e.g. telephone or face-to-face counselling) and different methods of intervention which can effectively be utilised in the intervention of critical incident victims.

- To investigate procedures and protocols in trauma debriefing for the purpose of identifying best practices in trauma debriefing and most effective intervention where clients are traumatised by a critical incident.
- To make conclusions and recommendations regarding the impact of critical incidents on the psychosocial functioning and work performance of the employee and to recommend best practices regarding effective intervention.

1.4 HYPOTHESIS/RESEARCH QUESTIONS

According to De Vos (1998:115–126), a research question is posed to understand the nature of real situations. A hypothesis is a statement about how things can be. Research questions are more relevant in a qualitative study and hypothesis in a quantitative study.

For the purpose of this study the researcher posed a hypothesis as well as research questions.

1.4.1 Hypothesis

If an employee is exposed to a critical incident, the critical incident will have a negative effect on the psychosocial functioning and work performance of the employee – unless such an employee receives proper effective intervention.

1.4.2 Research questions

- What is the impact of critical incidents on the psychosocial functioning and work performance of an employee exposed to a critical incident?
- What is the impact of counselling within the employee assistance programme (EAP) framework on the psychosocial functioning and work performance of such an employee?
- What is the impact of intervention on the well-being and production of the individual employee and business effectiveness of the corporate client?

1.5 RESEARCH APPROACH

In this study the researcher made use of a combination of qualitative and quantitative research. Cresswell (1998:173–190) distinguishes different models in the combination of

qualitative and quantitative research: the two-phase model, dominant less-dominant model and the mixed methodology design model. For the purposes of this study, the dominant less-dominant model was used as a research approach. The one method (quantitative research) would be more prominent and, therefore, the dominant paradigm, alternatively qualitative research, would be a smaller component of the overall study and, therefore, less dominant.

The purpose of qualitative research is to explore a new field of research, situations, phenomena or events (Landman, 1990:50). De Vos, Fouché and Venter (2002:240) agree with Landman that qualitative research is a multi-perspective approach, which describes, interprets and develops social interaction. According to Mark (1996:61), there is no single reality when working with qualitative data. The reality is established by the interaction between the researcher and the phenomena he/she is researching. Methods of qualitative research include observation, in-depth interviews and the studying of material, for example personal documents.

Qualitative research can be challenging because the researcher works with the uniqueness of people and their situations. The researcher is of the opinion that qualitative research is concerned about the characteristics, attributes and qualities of human behaviour in their context. The methods of qualitative research imply intensive involvement and interaction with the individuals or subjects that are studied.

The purpose of quantitative research, according to Schurink (1998:243), is to objectively measure a social phenomenon, to test a hypothesis, and to predict and control human behaviour. Variables are manipulated during quantitative research and standardised methods of data gathering are utilised to describe the relationship between variables.

The researcher made use of quantitative research methods to establish if the psychosocial functioning and work performance of an employee are affected after exposure to a critical incident, hereby testing if the hypothesis is true of false.

After concluding that the hypothesis was either true or false, the researcher used qualitative research methods to establish how and to what extent psychosocial functioning and work performance of the employee was effected.

1.6 TYPE OF RESEARCH

1.6.1 Applied research

Applied research, according to Huysamen (1994:35), is conducted specifically to resolve specific social, psychological or educational problems. De Vos (1998:69) mentions that applied research has a specific intervention mission. Applied research attempts to find solutions to practical problems. Grinnell (1993a:16) argues that applied research is useable. Applied research is also referred to as intervention research, which implies that knowledge obtained from this research should be used to encourage change and development.

For the purpose of this study the researcher made use of applied research. The study purpose was not only to contribute to the knowledge field of social work but, by gaining knowledge, also to attempt solving certain problems and to use the knowledge to the advantage of people. If the study was to confirm that the psychosocial functioning and work performance of clients exposed to critical incidents were affected, this knowledge could be used to motivate the importance and advantages of critical incident stress management (CISM) for the employee and the corporate client.

1.7 RESEARCH DESIGN AND METHODOLOGY

According to Tripodi (in Grinnell, 1981:198), the research design includes the total research process. He states that "the purpose of research designs is to provide a set of systematic procedures for producing data pertaining to the development, modification or expansion of knowledge." The research design is the framework that provides structure and gives specific strategies to conclude research successfully.

As part of the quantitative design the researcher decided to use the randomised one-group post-test-only design. This design, according to Fouché and De Vos (2002:143), is categorised as a quasi-experimental or associative design. Although subjects are randomly assigned, there is no pre-test and, therefore, comparison with a control group is not possible. Members of the group are randomly selected for inclusion in the sample. From the records of the Careways call centre, the researcher drew a random sample of affiliates seeing employees referred to the call centre due to exposure to a critical incident within the last year.

The phenomenological approach was used by the researcher as a qualitative strategy for the proposed study. According to Creswell (1998:56), a phenomenological study is a study that describes the meaning that experiences of a phenomenon, topic or concept has for various individuals. Fouché (2002b:275) mentions that the researcher utilising this approach reduces the experiences of individuals to a central meaning or the essence of the experience. The product of the research is a description of the essence of the experience being studied. Phenomenology tries to understand and interpret the meaning subjects give to their everyday lives. The researcher should understand the "life setting of the subject and place himself in the shoes of the subject". Participant observation and unstructured interviews can be utilised as ways of data collection.

1.7.1 Data collection

Table 1: Methods of data collection

Method of data collection	**Design**		**Number of questionnaires distributed**	**Number of questionnaires returned**	**Response rate**
Questionnaires to clients	Quantitative	One-group post-test design	80	54	67,5%
Questionnaires to therapists			80	54	67,5%
Semi-structured interview – clients	Qualitative	Phenomenological design	**Number of interviews conducted**	**Number of interviews conducted**	**Response rate**
			54	12	22,22%
Semi-structured interview – Managers/ Supervisors			54	3	5,55%
Document analysis			54	54	100%

1.7.1.1 Quantitative data collection

As part of the one-group post-test design, the researcher quantitatively collected data to determine which employees were affected by critical incidents. With the assistance of the

Careways national call centre, clients who experienced a critical incident in the past year were identified. Data were collected by posted questionnaires. The questionnaire explained the purpose of the study and gathered information regarding the impact of the critical incident to establish if their psychosocial functioning and work performance were affected.

1.7.1.2 Qualitative data collection

As part of the phenomenological design, the researcher qualitatively collected data to establish how employees' psychosocial functioning and work performance were affected and the effect of intervention. Employees who responded to the questionnaire were used as a target group. Respondents who participated in the quantitative study were requested to indicate if they would like to take part in the qualitative study. With their permission, records of their assessment and intervention kept by The Careways Group were utilised for document analysis.

Seeing that data were recorded by an affiliate therapist (social worker/psychologist), existing data or case notes regarding the client's intervention were analysed. This data refer to official documents, according to Bailey (1990:294), seeing that they were compiled and maintained on a continuous basis by the Careways call centre. The data, however, were of a personal nature because they contained information regarding employees' personal problems. Document study, as a qualitative data collection method, was used to gather information and to identify main themes. These themes gave direction and formed the basis of an interview schedule constructed by the researcher and used in a semi-structured one-to-one interview as method of data collection. The semi –structured one-to-one interview is not typical for a phenomenological study, but rather unstructured interviews. Due to the fact that it was decided before the study commenced that similar information from the employee and the manager is needed in other to compare, semi-structured interviews was used as data collection method.

Semi-structured interviews, according to Greeff (2002:302) are used "to gain a detailed picture of a participant's beliefs about, or perceptions of, a particular topic." The interview schedule provides the researcher with a set of predetermined questions that may be used as an appropriate instrument to engage the participant and to designate the narrative, according to Holstein and Gubruim (in Greeff, 2002:302). The interview schedule forces the researcher

to think explicitly about what he/she hopes to cover in the interview and what difficulties he/she might encounter.

1.7.2 Data analysis

1.7.2.1 Quantitative data analysis

As part of the one-group post-test-design the researcher analysed data univariatly and bivariatly. The purpose of the one-group post-test-design was to determine in what way employees were affected by critical incidents. The researcher was interested in determining how many employees were the victims of a critical incident (univariate analysis) and the relationship between the critical incident and the employees' work performance and psychosocial functioning (bivariate analysis). According to De Vos, Fouché and Venter (2002:225), univariate analysis is the simplest form of data analysis and means that one variable is analysed, mainly with a view to describe that variable. All the data regarding the specific variable are summarised for easy comprehension and utilisation. The summarised data can be portrayed in different ways, for example tabular or graphical displays.

In bivariate analyses, according to De Vos *et al.* (2002:240), the researcher is interested in the relationship between variables, and the researcher poses the following questions: Does a relationship between the variables exist? If such a relationship exists, what is the direction, positive or negative? How strong is the positive or negative relationship? The bivariate analysis to be used will depend on the type of variables involved. If both the variables are of the categorical type, data will be reflected as a cross-tabulation. In the case of row and column percentages, a clustered bar chart can be drawn to reflect variables.

1.7.2.2 Qualitative data analysis

As part of the phenomenological design, the researcher decided to analyse qualitative data as follow:

1.7.2.2.1 Process of qualitative data analysis

According to De Vos (2002:340–344), data analysis and interpretation can be represented as a spiral image, the data analysis spiral. This means that the researcher moves in annalistic circles rather than using a fixed linear approach. In this process the researcher touches

several facets of analysis, circling around and "upwards" towards the completion of the process.

- **Data collection and recording**

  The first step in qualitative data analysis is to plan to record data in a systematic way, even before data collection starts. A qualitative study involves an inseparable relation between data collection and data analysis. As data are gathered, they are analysed. Data analysis may necessitate revision in data collection procedures and strategies. New data collected after revisions in collecting procedures are subjected to new analysis. The result of this process is the effective collection of rich data that may generate new questions or hypotheses and provide the basis of a shared construction of reality. The researcher uses the same methodological tools in conducting data analysis during data collection to ensure trustworthiness of the study, such as triangulation, development of a working hypothesis and testing of a working hypothesis.

- **Managing data**

  This is the step in data analysis away from the collection site and the first "leap" in the data analysis process. The researcher uses different techniques to code and organise collected data. The purpose of data management is to give the researcher the opportunity to organise data, making data easily retrievable and enhancing their manipulability.

- **Reading and writing memos**

  After the organisation and conversion of data, the researcher continues analysis by getting an overview of the whole database. This is a process of reading the data and re-reading it to become familiar with the data. In this process of exploring the database, the researcher should keep short memorandums in the margin about ideas or concepts that occur to the researcher while reading. This process is important because it helps the researcher to identify data that may be overwhelming and unmanageable.

- **Describing, classifying and interpreting**

  In this loop of the spiral, category formation represents the heart of qualitative data analysis. The researcher starts by working through collected data, trying to identify salient themes, recurring ideas or language and patterns of belief that link people and settings together and to describe them. After describing, the researcher classifies data by taking

the text of qualitative information apart by looking for categories, themes or dimensions of information. After classification, the interpretation of data follows, which means making sense of the data, to look at what "lessons" were learned in the process. The purpose of interpretation is to make meaningful conclusions and recommendations.

- **Representing and visualising**
  This is the final phase of the data analysis spiral. The researcher presents his/her findings and data in text, tabular or graphic form. Visual presentation of data includes a comparison matrix or tables, hypotheses, metaphors and statistical information.

1.8 PILOT STUDY

1.8.1 Feasibility of the study

According to Strydom (2002b:213), apart from studying relevant literature and interviewing experts, it is also necessary to obtain an overview of the actual practical situation where the prospective investigation will be executed. The researcher should at this stage of the pilot study address the goals and objectives, resources, research population, procedures of data collection, the data gathering itself and possible errors that may occur during the study. Preliminary exploratory studies can be of value in the practical planning of the research project, for example the transport, finances and time factors.

As an affiliate social worker for The Careways Group the researcher has some knowledge of the actual, practical situation where the investigation was executed. The researcher did, however, conduct a preliminary exploratory study to familiarise him with the practical situation, the procedures and policies of The Careways Group and the identified corporate client, as well as the feasibility of the prospective project.

According to Huysamen (1994:205), the purpose of a pilot study is to determine the feasibility of the research project and to identify possible problems in the measuring procedures and the operationalisation of variables. A pilot study helps the researcher to identify possible problems in terms of the time frame, the availability of respondents, costs involved and the permission of respondents.

Written approval to continue with the study was given by Dr van Jaarsveld (Director Group Affairs, The Careways Group). The Careways Group agreed to identify a corporate client for the purpose of the study and respondents for the study were available within the workforce of the corporate client. The Careways Group indicated that respondents for the research project would be available for the study after final permission for the research project had been granted. Although the researcher did not foresee major difficulties in the implementation of the project, possible difficulties could have been confidentiality issues regarding respondents, and cost factors. Not using names or identifying companies of clients could assure confidentiality of client information. Possible financial assistance by the Careways Group could help to cut high costs of the research for the researcher.

1.8.2 Pilot test of the data collection instrument

A pilot study implies that the researcher should expose a few cases that are similar to the planned main inquiry to exactly the same procedures as are planned for the main investigation, in order to modify the measuring instrument (Strydom, 2002b:215). Miller (1983:100) suggests that when selecting the cases the correct selection procedures should be used. This contributes to the emergence of meaningful insights that can be helpful in the modification of the final questionnaire and/or interview schedule.

The researcher selected respondents according to the systematic sampling method as a probability sampling procedure from the population for the purposes of the pilot study. It helped the researcher to identify deficiencies in the questionnaire and helped the researcher to plan the contents for the interview schedule.

1.8.2.1 Quantitative study

The researcher used a questionnaire as data collection instrument in the quantitative section of the study. The purpose of the quantitative study was to establish if there was a relation between critical incidents, the work performance and psychosocial functioning of the employee. Research respondents were selected according to probability sampling procedure and specifically using the systematic sampling method that was included in the pilot test. According to Strydom and Venter (2002:205), only the first respondent is selected randomly, thereafter all the other respondents are selected according to a particular interval, for example every fifth or tenth respondent on a list of names. This implies that the first

respondent on the list of affiliates exposed to a critical incident provided by the Careways call centre was selected randomly; thereafter respondents were selected according to a specific interval, namely every tenth respondent on the name list. The researcher included two respondents in the pilot study. Respondents who participated in the pilot study were not included in the main investigation.

1.8.2.2 Qualitative study

Respondents selected for the pilot study were representative of those who were expected to be involved in the research project. The qualitative study was interested in establishing how the work performance and psychosocial functioning of employees exposed to a critical incident were affected and if the intervention of the EAP contributed to their recovery. Only respondents who had indicated in the questionnaire of the first part of the study that they were interested to be further involved in the study were included in the qualitative study. An interview according to a semi-structured interview schedule was used as method of data collection in the qualitative study. The researcher made use of volunteer sampling as a non-probability sampling technique in the qualitative study. Respondents had the opportunity to volunteer for further inclusion in the study by indicating so in the questionnaire. According to Strydom and Delport (2002:332), a statistically correct pilot study plays a less important role in a qualitative study than in a quantitative study. In a qualitative study the pilot study is usually informal and a few respondents possessing the same characteristics as those in the main investigation are involved. The researcher included one respondent as part of the qualitative pilot study. The respondents were subjected to an interview according to a semi-structured interview schedule as planned in the main investigation. The purpose of the pilot study was to establish whether the relevant data could be obtained from the respondents. The pilot study enabled the researcher to test his questions and interviewing schedule in order to make modifications for the data collection in the main investigation. After the pilot study, the interview schedule was modified as it was evident that question 10 in the original interview schedule for both employees and managers was a duplication of question 9. Question 10 was removed from both the semi-structured interview schedule for employees and managers (see Appendix 5 and 6).

1.9 RESEARCH POPULATION, BOUNDARY OF THE SAMPLE AND SAMPLING METHOD

Arkava and Lane (1983:27) distinguish between the terms *universe* and *population*. *Universe* refers to all the potential subjects who have the attributes that the researcher is interested in. The term *population* refers to the boundaries set on a study unit. Neuman (1994:195) refers to *population* as the researcher's demarcation of the sample unit, the geographical location and the temporary boundaries of the population. Babbie (1992:198) refers to a population as "the theoretically specified aggregation of study elements".

For the purpose of this study, the universe included all the employees of all the corporate clients that received EAP services from The Careways Group. The population included all the employees identified by The Careways Group for the purposes of this study who were exposed to a critical incident in the 12-month period, starting from 1 January 2007 to 31 December 2007.

For the **quantitative study** of the research, respondents (affiliate therapists) were selected according to the probability sampling procedure and specifically using the systematic sampling method which was also included in the pilot test. The therapist then used the definition provided for traumatic events to identify any clients in his/her current caseload to be part of the study. According to Strydom and Venter (2002:205), only the first respondent is selected randomly, thereafter all the other respondents are selected according to a particular interval, for example every fifth or tenth respondent on a list of names. This implies that the first respondent on the list of affiliate therapists provided by the Careways call centre was selected randomly, thereafter respondents were selected according to a specific interval, in this case every second affiliate therapist on the name list.

The researcher obtained a list of affiliate therapists working for the Careways Group as a therapist.

In the **qualitative study** of the research project that followed the quantitative study, the researcher made use of volunteer sampling as a non-probability sampling procedure. Volunteer sampling refers to persons who come forward voluntarily, to be part of the research project. Respondents had the opportunity to volunteer for further inclusion in the study by

indicating so in the questionnaire. The researcher planned to include ten to 12 respondents as part of the qualitative study. Certain criteria were set to select respondents who volunteered for further inclusion in the study, for example only employees exposed to violent critical incident such as bank robberies, vehicle accidents or hijacking incidents within a specific timeframe (last 12 months). Grinnell (1993a:162) mentions that, with non-probability sampling, the probability of selection cannot be estimated, so there is little or no support for the claim that the sample is representative of the population of which it was drawn.

1.10 ETHICAL ISSUES

1.10.1 Voluntary participation

According to Babbie (1992:424), participation in research disrupts a person's normal activities and requires that people reveal personal information about themselves. The researcher, therefore, would only include respondents who volunteered to be part of the study and no one was forced to participate in the study.

1.10.2 No harm to respondents

Strydom (2002b:64) mentions that in the social sciences the risk for harm is mainly emotional. It is the researcher's responsibility to protect and to minimise any possible harm respondents may be subjected to. Although harm could not be anticipated, it was decided that respondents who were emotionally harmed in this study would be referred to a therapist for counselling provided by an affiliate counsellor of The Careways Group.

1.10.3 Informed consent

Respondents should be informed about the goal of the investigation, possible advantages, disadvantages and dangers and the credibility of the researcher before participation in the study (Strydom, 2002b:65).

The researcher discussed ethical issues with respondents in order for them to make an informed decision before participating in the research project. Respondents gave consent in writing that they understood the consequences of being part of the study. The researcher contracted with respondents participating in the qualitative study. The signed contract ensured that both the researcher and respondent were obliged to handle all information

regarding the project and participants as confidential. Strydom (2002b:65) emphasises that the researcher must make sure that respondents are legally and psychologically competent to give consent, and they should be at liberty to withdraw from the study at any time.

1.10.4 Deception of respondents

Deception of respondents refers to the misleading of respondents by withholding information or by giving incorrect information. Judd, Smith and Kidder (1991:496–497) mention that there are mainly three reasons why respondents may be deceived:

- To disguise the real goal of the study
- To hide the real function of the actions of the respondents
- To hide the experiences that respondents will go through.

The researcher was open and honest with respondents, and gave them as much information as possible regarding the proposed study.

1.10.5 Anonymity and confidentiality

Babbie (1992:467) states that the greatest concern in research is to protect the identity of respondents. A respondent's identity can be protected by ways of anonymity and confidentiality.

- Anonymity means that the researcher should not be able to identify any respondent after the research project has been completed; in other words, the researcher should not be able to link a given response with a given respondent.
- Confidentiality implies that the researcher is able to identify respondents and their responses, but makes a commitment to handle information confidentially.

For the purposes of the study, the researcher ensured confidentiality to respondents. Owing to the fact that the researcher made use of scheduled interviews as way of qualitative data collection, it was not possible to ensure anonymity. The researcher made use of pseudonyms when discussing individual cases in the research report in order to protect respondents' anonymity.

1.10.6 Actions and competence of researcher

Strydom (2002a:69) mentions that researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake a research project. The researcher ensured that he is theoretically up to date with research methodology by passing an oral examination on research methodology at the University of Pretoria.

1.10.7 Release or publication of findings

It is the responsibility of the researcher to accurately and objectively report the findings of the study. Strydom (2002a:72) states that the "information must be formulated and conveyed clearly and unambiguously to avoid or to minimize misappropriation by subjects, the general public and even colleagues". Researchers should be careful not to manipulate findings to confirm hypotheses or points of views. Babbie (1992:469) stresses the fact that the researcher should be honest and willing to admit shortcomings and failures of the research project.

1.10.8 Debriefing of respondents

The researcher arranged debriefing sessions after completion of the research project in order to assist respondents and to minimise harm. Strydom (2002a:73) mentions that the researcher can help to rectify misperceptions that arise while involved in the project. The researcher should be sensitive to possible emotions respondents may experience when the research project is nearing its end and respondents should be debriefed before termination by an independent therapist who has not been involved in the research process.

1.11 DEFINITION OF KEY CONCEPTS

1.11.1 Crisis

Gilliland and James (1993:3) define a crisis as "a perception of an event or situation as intolerable difficult that exceeds the resources and coping mechanisms of a person. Unless a person obtains relief, the crisis has the potential to cause severe affective, cognitive and behavioural malfunctioning".

According to Plaggermars (2000:80), a crisis represents an acute emotional upset; less of equilibrium and an upset in a steady state, which temporarily hinders one's ability to employ previously, used problem-solving capacities.

Trauma creates a crisis by overwhelming a person's usual coping strategies. A crisis makes it difficult or impossible to conduct one's daily activities (Friedman, 2003:20).

The researcher views a crisis as a state of emotional disorganisation when a person was confronted with an obstacle he/she was not ready to handle, or lacked the capacity to handle at that moment. The inability to handle the obstacle caused emotional and behavioural difficulties for the person.

1.11.2 Critical incident

A critical incident refers to "an event that is extraordinary and produces significant reactions for the intervening person". It may be so unusual that it overwhelms the natural abilities that people have to cope with difficult situations. It may lead to stress, burnout or even PTSD (Lewis, 1996:15).

A critical incident, according to O'Conner and Jeavons (2002:53), is an extraordinary event that has the potential to cause unusually strong emotional reactions.

Solomon (1986:30) sees a critical incident as "any situation in which one feels overwhelmed by a sense of vulnerability and/or lack of control over the situation".

Although the last definition may seem very broad, the researcher agrees that when defining a critical incident the focus should be on the reaction of the individual. The researcher, therefore, defined a critical incident as "any incident that causes emotional distress for a person, and which affects his/her psychosocial functioning temporarily or permanently to some extent".

1.11.3 Trauma

Trauma, according to Sonderup (1996:14), necessitates the presence of a traumatic event. This can be defined as an extraordinary event or series of events which are sudden, overwhelming and often dangerous, either to the individual or significant others.

Any (unpleasant) psychological experience that has a negative influence, usually with long-term effects, on the personality development of a person, for example an accident or death of a loved one, can be described as a trauma (Plug, Louw, Gouws & Meyer, 1997:385).

A traumatic event (Plaggarmars, 2000:80) is more severe than a crisis and has a more unpredictable onset.

The researcher defined trauma as an event or an experience that was threatening to the emotional well-being of a person; it had a negative and usually long-term effect on the psychosocial functioning of the person.

1.11.4 Work performance

Work performance, according to Ivancevich and Matteson (1987:564),"is determined by an interaction of ability and motivation". Personal characteristics of the employee have a detrimental effect on the work performance of the employee (Milkovich & Bourdreau, 1991:91). These characteristics influence the employee's ability to perform his/her duties and the effectiveness to which this duty is carried out. Arnold and Feldman (1998:24–25) refer to five factors which may influence the work performance of the employee, namely motivation, skills, perception, personality and the availability of organisational systems and resources that can support the employee in the execution of his/her duties.

Exposure to a critical incident may seriously affect the perception, motivation and to a certain extent the personality of an employee. This may have a detrimental effect on the work performance of the employee.

The availability of organisational systems and resources, which can support an employee, can further determine the employee's recovery from a critical incident and his/her work performance.

1.11.5 Employee assistance programme

The Standards Committee of EAPA South Africa (2010:1) defines EAP as "the work organizations resource, based on core technologies or functions, to enhance employee and workplace effectiveness through prevention, identification and resolution of personal and productivity issues.

Lombard (1995:423) defines EAPs as "'n reeks beleids- en program procedures deur 'n bedryfsonderneming gesanksioneer om aangewend te word as intervensie by die identifisering van en hulpverlening aan werknemers met probleme wat hulle werksprestasie direk of indirek benadeel of kan benadeel. Dit is dus 'n generiese entiteit in die vorm van 'n bepaalde ondernemingsbeleid en prosedures wat aangewend moet word vir die identifisering van en reaksie op persoonlike en emosionele probleme van werknemers wat inmeng met hulle werksprestasie of dit kan benadeel."
Lombard (1995:423) defines EAP as "a series of policy and programme procedures, sanctioned by an enterprise, to be applied as an intervention for identifying and assisting employees with problems that may impair their job performance, either directly or indirectly. Therefore, it is a generic entity in the form of a particular enterprise policy and procedures that must be used for the identification of and response to employees' personal and emotional problems that interfere with or can impair their job performance" [translated by researcher]

The Careways Group has a holistic approach towards wellness and provides a comprehensive range of wellness and health related services for executives, managers and employees. These include: psycho-social services, trauma, incapacity, HIV/AIDS and disease management, health and safety services, absenteeism, fatigue and lifestyle management, together with legal and financial services. EAP falls within this holistic approach and provide the core values that a more extensive and holistic wellness approach was developed from.

The researcher is of the opinion that the focus of the EAPs is to support employees in an organisation in order to improve their work performance. The support implies help with problems of a personal nature, such as family, marriage, dependence, health, financial, emotional and stress-related problems, which may have a negative influence on the work performance of the employee.

1.12 LIMITATIONS OF THE STUDY

In conclusion after overviewing the evolvement and outcomes of the study it was evident that there were certain limitations in the study. The limitations can be listed as follow:

- Participation.

  In the quantitative study the response rate was 67.5% resulting in only 54 respondents participating in the study. In a quantitative study the ideal is to have a larger number of respondents involved. Due to the specific research population only 80 respondents could be identified for inclusion in the study. The response rate of the research population is therefore satisfactory.

  In the qualitative study the response rate for semi-structured interviews with employees and managers was relatively low. The fact that the researcher requested employees to volunteer to further participate in the qualitative part of the study probably contributed to the diminutive number of participants that participated. The fact that only 3 managers participated in the study was partly because employees might have reservations for the researcher to make contact with the manager despite the fact that confidentiality was guaranteed. Other reasons for poor manager participation were unavailability and contact details that have changed.

- Phenomenological design

  In the phenomenological design unstructured interviews is typically used as data collection method. In the study it was decided to use semi- structured interviews in order to ensure that data gathered from the semi-structured interviews with employees and the semi-structured interviews with managers has the same focus and that results could be compared.

Chapter 2
Literature Review
Critical Incidents

2.1 INTRODUCTION

"It took years to get over it. Years! Long after, when you were working, married, had kids you would be lying in bed and you would see it all before you. Couldn't sleep, couldn't lie still. Many and many times I have got up and tramped the streets till it became daylight. Walking, walking – anything to get away from your thoughts ... that went on for years, that did" McDonald in Tehrani (2004:6) (soldier, after the First World War).

Traumatic events mostly always come as a shock to a person, it is never anticipated and most of the time there were not any opportunity for preparation. What is worse is the outcome of a trauma where people are confronted with almost unbearable pain, either directly or indirectly. This is a truth we cannot negate when facing major losses, the death of someone we love, unexpected and prolonged unemployment, violence or other trauma that painfully tests our ability to cope (Tedeschi & Calhoun, 1995:18).

In the last few years there was a significant expansion in the literature concerning trauma. Literature mainly records the following incidents as catastrophic and the possible causes of a traumatic reaction:

- Rape and sexual violence
- Assault
- Torture
- War situations
- Industrial accidents and fires
- Motor vehicle accidents
- Bomb attacks
- Air craft accidents
- Natural disasters, for example floods, fires, hurricanes, tornados, cyclones and earthquakes

- Child molestation and child abuse
- Incest
- Civil violence
- Riots
- Crime situations and crime scenes
- Armed robberies and hijackings
- Physical violence either as victim or witness
- Shooting incidents and shooting accidents
- Shooting or killing someone or witnessing such an event
- Domestic violence.

Although there is a broad range of incidents that may qualify as a critical incident, the person's reaction to such an event determines if it is a traumatic event or not. According to Solomon (1986:30), any situation in which a person feels overwhelmed by a sense of vulnerability and/or lack of control over the situation can be defined as a critical incident that may lead to traumatic reactions.

The following literature review focuses on the experience of trauma and more significantly how people are affected by critical incidents. It also reviews how the employee's psychosocial functioning is affected.

2.2 DEFINING CRISIS, CRITICAL INCIDENT AND TRAUMA

Trauma, like any other obstruct concept, has fuzzy boundaries and is often used loosely. Terminology such as critical incidents, crisis and trauma is often used to refer to a similar incident. Although this terminology is closely related there are differences. By defining crisis, critical incident and trauma the researcher hopes to clarify the differences between these terms.

2.2.1 Crisis

Gilliland and James (1993:3) defines a crisis as "a perception of an event or situation as intolerable difficult that exceeds the resources and coping mechanisms of a person. Unless the person obtains relief, the crisis has the potential to arouse severe affective, cognitive and

behavioural malfunctioning". A crisis results from stress and tension in a person's life. Stress is the key element in crisis development. As stress mounts to unusual proportions and the individual's coping skills become increasingly ineffective, the potential for a crisis occurs (Greenstone & Leviton, 2002:1)

According to Plaggermars (2000:80), a crisis represents an acute emotional upset, less of equilibrium and an upset in a steady state which temporarily hinders one's ability to employ previously used problem-solving capabilities.

Trauma creates a crisis by overwhelming a person's usual coping strategies. A crisis makes it difficult or impossible to conduct one's daily activities (Friedman, 2003:20)

The researcher views a crisis as a state of emotional disorganisation caused by stress resulting from a trauma the person experienced or when confronted with an event he/she is not ready to handle or lacks the capacity to handle at that moment. The inability to handle or cope with the event results in emotional and behavioural difficulties for the person.

2.2.2 Critical incident

A critical incident refers to "an event that is extraordinary and produces significant reactions for 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).

A critical incident, according to O'Conner and Jeavons (2002:53), is an extraordinary event that has the potential to cause unusually strong emotional reactions.

Solomon (1986:30) views a critical incident as "any situation in which one feels overwhelmed by a sense of vulnerability and/or lack of control over the situation".

Although the last definition may seem very 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 for a

person, and which affects his/her psychosocial functioning temporarily or permanently to some extent.

2.2.3 Trauma

Trauma, according to Sonderup (1996:14), necessitates the presence of a traumatic event. This can be defined as an extraordinary event or series of events which are sudden, overwhelming and often dangerous, either to the individual or significant others.

Trauma occurs when a sudden, extraordinary event overwhelms one's capacity to cope and master the feelings aroused by the event (Terr, 1991:409).

Any unpleasant psychological experience that have a negative influence, usually with long-term effects, on the personal development of a person. For example, an accident or death of a loved one or a physical injury or wound a can be described as trauma (Plug *et al.*, 1997:305).

A traumatic event (Plaggermars, 2000:80) is more severe than a crisis and has a more unpredictable onset.

The researcher defines trauma as an event or an experience that threatened the emotional wellbeing of a person and it has a negative and usually long-term effect on the psychosocial functioning of a person.

The terms critical incident and trauma both refer to an extraordinary event with a sudden unpredictable onset. This event impacts on the person's psychosocial functioning and may have long-term consequences for the person.

According to the literature and definitions for a critical incident and a trauma, there is no significant difference between the terms. Traditionally *trauma* is used more in a medical context, referring to a physical injury or a wound. The term *critical incident* is used more often in a social context, where the incident is more abstract, for example for a retrenchment or a divorce where it is difficult to detect the physical impact, but the emotional and psychosocial

impact is clearer. For the purposes of the study, the researcher made use of the term *critical incident*, which was also inclusive of the term *trauma*.

The term *crisis* can be distinguished from the term *critical incident* in the sense that a crisis is often the result of a critical incident. A critical incident creates a crisis by overwhelming a person's usual coping strategies (Friedman, 2003:20). The crisis results from stress and tension caused by a critical incident (Greenstone & Leviton, 2002:1).

2.3 DIFFERENT TYPES OF CRITICAL INCIDENTS

When a person is involved in an event that takes place in a specific manner, under particular circumstances and at a given point in time, various characteristics of the situation turn the event into an experience of powerlessness, disruption and discomfort. Characteristics of the event and its context, which include the severity of stress, are highly decisive factors in the process of coping with traumatic stress. Most critical incidents are unexpected and the onset of the event is virtually always sudden and not anticipated. Such experiences challenge a person's ability to accurately assimilate and comprehend the experience; as such an event is capable of devastating even the most secured person or family (Kleber & Brom, 1992:40).

The individual may experience a critical incident when he/she is alone, with others or in the context of a community. When a critical incident is experienced while alone, the individual may feel particularly helpless, terrorised, afraid, vulnerable and at the mercy of forces beyond his/her control. When the individual experiences the trauma within a group, the effect of the critical incident might well be different due to the group dynamics and psychological processes that take place. When a critical incident affects an entire community it can produce many secondary stressful experiences if the devastation and destruction is intense enough (Wilson, 1989:53).

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. Typical examples of natural critical incidents are the tsunami disaster which was responsible for the death of thousands of people in Indonesia in December of 2004. A typical example of a man-made incident is the September 11 attack in 2001 on the World Trade Centre and the Pentagon in the USA. Single traumatic incidents are common and typically involve an

accident, which may result in an injury. Most traumatic experiences, however, contain multiple stressors. For example, hijacking typically involves dimensions such as a threat to life, loss of property and personal injury. Critical incidents may be conceived as being relatively complex or simple. Complex traumatic events have many sub-components inherent in the trauma and require the victim to make a number of complex decisions, which may result in ambiguity due to possible alternative actions in the event. A simple critical incident is typically one-dimensional and clear with respect to the nature of the event and the possible behaviours one can enact. Complex traumas might be of such an immensity that ideological perspectives and believes about human nature and life itself may be profoundly altered (Wilson, 1989:56). Whether it is a complex or a simple trauma is to a great extent determined by the victim's reactions to the critical incident. When the critical incident results in traumatisation and severely affects the victim's psychosocial functioning, it can be referred to as a complex traumatic event. A simple traumatic event has no or minimal effect on the psychosocial functioning of the victim.

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. There seems to be consensus in the literature that "man-made" traumas are experienced as more disturbing than natural disasters (Wilson, 1989:72).

Meichenbaum (1994:231) makes a very interesting distinction between different types of critical incidents. He divides critical incidents into type I and type II traumas.

2.3.1 Type I trauma

According to Meichenbaum (1994:231), this type of incidents includes rape, a shocking accident, a car accident or an earthquake. Type I traumas have the following characteristics:

- A single, dangerous and overwhelming event
- Limited duration
- Sudden and surprising

- Quick recovery is more likely
- Likely to lead to typical PTSD with symptoms of re-experiencing, avoidance and hyper-arousal.

2.3.2 Type II trauma

Meichenbaum (1994:232) states that a type II trauma is an incident which most likely has the following characteristics:

- Multiple, chronic and repeated critical incidents
- More likely of intentional human design
- Initially a type I trauma; as the critical incident recurs the victim expects and fears recurrence
- The victim feels helpless to prevent the critical incident
- Dissociation
- May lead to an altered view of the self and the world
- More likely to lead to long-term characteristic and interpersonal problems, for example detachment from others, and a restricted range of affect
- Attempts to protect the self-dissociated responses, by using coping strategies such as denial, numbing, withdrawal and the misuse of addictive substances
- Likely to have poor prognosis (complex PTSD).

Meichenbaum (1994:235) distinguishes between the different types of traumas according to the effect they have on the individual and the anticipation of recurrence of the critical incident the victim may fear. His distinction is not based on the fact that the critical incident is man-made or natural but rather on the individual's reaction to the critical incident.

Friedman (2003:2) explains further by stating that researchers originally believed that trauma may be defined merely and exclusively as a catastrophic event which happened to an individual who was in the wrong place at the wrong time. Thus anyone who was exposed to such an incident would be traumatised. Friedman (2003:3) states that, although exposure to a catastrophic stress event is a prerequisite for the developing of a disorder (acute stress disorder or PTSD), it is insufficient in itself to traumatise the individual. The critical discriminator is the emotional response of a person to such an event.

According to Van der Walt (2001:36) trauma specialists make a further distinction between types of trauma which exist:

- Once-off critical incident. This is a once-off incident which traumatises the victim, for example a hijacking.
- Cumulative or multiple critical incidents. This is where a large number of critical incidents occur at the same time, for example domestic violence and robbery, two hijackings one after the other, a war situation with torture in concentration camps, a motor vehicle accident followed by an earthquake, a hijacking followed by torture and rape.
- Repetitive, re-occurring or continuous critical incidents. This refers to continuous and chronic exposure to critical incidents and being under threat constantly, for example civil unrest and domestic violence.
- Routine critical incidents. This is the regular exposure to critical incidents as a result of the work situation, for example police officers, emergency officers, fireman, ambulance personnel and security guards.
- Secondary or vicarious trauma. Secondary or vicarious trauma refers to where support personnel and professionals, for example psychologists, social workers and debriefing personnel become traumatised by exposure to traumatised clients.

2.4 RISK FACTORS IN TRAUMATISATION AS A RESULT OF A CRITICAL INCIDENT

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 that research indicates that the following pre-trauma risk factors may have an influence on the individual response to a critical incident:

2.4.1 Pre-trauma risk factors

The pre-trauma risk factors include:

- Gender – the possibility of women developing PTSD is twice as likely as in men
- Age –- people under the age of 25 years are more vulnerable
- Education – people without tertiary education are more at risk

- Childhood adversity, for example deprivation and divorce, may have an effect on a person's coping strategies
- Previous exposure to critical incidents in childhood, for example child abuse, rape, war or motor vehicle accidents
- 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, for example divorce, loss of job or financial problems
- Physical health problems, for example asthma, heart disease, cancer or back problems.

O'Brien (1998:93) mentions that post-traumatic illness or the reaction to a critical incident should be short-lived and should only become chronic if there are some pre-existing "maladjustment" or vulnerability factors. Pre-existing mental illness seems to be a very good predictor of PTSD. In studies by Greenwald and Leitenberg (in O' Brien, 1998:05), it was found that the highest rates and also the widest variation of PTSD were with female survivors of sexual abuse, rape and physical abuse O'Brien (1998:95) states that a person's personal view of life and his/her perception of events happening to him/her are of major importance as a predisposing factor in the development of PTSD after exposure to a critical incident. He further mentions that certain personality traits, especially neuroticism, are associated with the development of PTSD following a critical incident. Family instability, academic difficulties, a childhood history of abuse and neglect, a history of mental illness and illicit drug use are pre-trauma risk factors that have to be considered in the development of PTSD, but seemingly have a smaller effect as the exposure to the critical incident itself (O'Brien, 1998:97–98).

2.4.2 Trauma risk factors

Gilliland and James (1993:64) mention that there are a few variables relating to the type of critical incident that seems to influence its impact on the victim:

- Degree of life threat
- Speed of onset
- Degree of displacement in home continuity
- Degree of exposure to death, dying and destruction
- Degree of moral conflict inherent to the situation
- Role of the person in the trauma

- The proportion of the community affected
- Degree of bereavement
- Duration of the trauma
- Potential for re-occurrence.

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 repeated.

2.4.2.1 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. These are:

- **Warning**

  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.

- **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. Often victims of crime go through reactions of self-blame and guilt for not being able to prevent the critical incident. The feelings of blame and responsibility may also be directed at others.

- **Severity of the crisis**

  According to Lewis (1996:53) positive correlations exist between the severity of a critical incident and the reactions of people involved. It is, however, difficult to define severity. 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's people have with the critical incident. 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 a perceived life threat or serious injury.

- **Physical proximity**

  The closer to an incident and the victims, the stronger the reaction (Lewis, 1996:53).When a person is directly affected by a critical incident, the trauma reaction has the potential to be more severe. Where a person know the victims of a critical incident or are closely related to him/her, the risk of secondary or vicarious trauma increases.

- **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).

- **Time**

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

- **Psychological proximity**

  When the critical incident has a personal impact on the victim, the risk of not coping with the event is greater. When a person's child is the victim of a critical incident or a child at similar age to your own child is the victim of a critical incident, there is a tendency of automatic identification with the victim, which improves the possibility of secondary traumatisation (Lewis, 1996:54).

- **Concurrent stressors**

  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, illnesses or other crises and their capacity to resolve this 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 further diminishes the person's ability to cope.

- **Role and conflict or overload**

  If a person is in the position of being a victim of a critical incident, but professionally in the helping professions in dealing 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 coping ability in the present.

- **Age**

  Age also plays a factor in the 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 lack of experience and existing coping skills. An older person usually has more experience in coping with and resolving critical incidents in his/her life (Lewis, 1996: 57).

2.4.3 Post-trauma risk factors

Friedman (2003:27) also refers to the following post-trauma risk factors:

- Poor social support. If a person has a poor or limited support network, the likelihood to be traumatised or to develop PTSD is greater.
- Immediate traumatic reactions such as dissociation or avoidance symptoms. This may be an indication of the severe and sudden impact of a critical incident. Immediate reaction poses a greater risk for the development of PTSD at a later stage.

In terms of post-trauma risk factors, Lewis (1996:11) mentions some factors that can 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 children after a critical incident, they are 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.

2.5 REACTIONS TO A CRITICAL INCIDENT

The experiences of a critical incident vary from person to person and from one event to another, since differences in the individual variables affect 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, which interact in complex ways to co-determine and construct an experience of trauma (Tedeschi & Calhoun, 1995:24).

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.

However, the study also indicates that the response to violent crime can become problematic at any stage. Bisson's (1995:718) research acknowledges that a severe initial response often represents an acute stress disorder. With time, other conditions such as PTSD, anxiety disorders, depressive disorders and substance abuse/dependence may develop. These

conditions can have devastating effects on victims' lives and markedly affect their functioning at personal, social and occupational levels. Across a wide spectrum of traumatic events, however, there is positive evidence that variables other than the dimensions of the trauma itself do influence outcome. Bisson (1995:719) proposes that an acute stress disorder, a psychiatric history, a family psychiatric history, lack of social support and high "neuroticism" are all possible factors associated with exacerbating the experience of trauma as well as increasing the rate of PTSD and PTSD-like symptoms. Individuals exposed to highly stressful events and trauma are likely to experience a constellation of distressing emotions. Although the specific patterns will vary from person to person, it is correct to say that unpleasant emotional states are almost certain to occur. In part, this distress may be due to a sense of hopelessness that is produced when certain events are acknowledged to be irreversible and unchangeable. Also, if a trauma is of human origin, the incidence of PTSD is higher than in cases where the trauma is of natural origin (Tedeschi & Calhoun, 1995:24). It is claimed by Jannof-Bullman (1997:57) that in essence, and contrast to our inherent assumptions, trauma is the abrupt disintegration of the victim's inner world. The survivor's basic elements of trust and confidence are shaken. Consequently, thoughts and images of meanness and meaninglessness may arise.

Findings by Macgregor (1998:41) are in accordance with the aforementioned studies that support the notion that traumatic events can produce negative outcomes. It was found that negatively perceived responses such as telling the victim that he/she was "lucky" had the primary effect of invalidating the traumatic nature of the individual's experience and his/her response to it.

With reference to emotional functioning that is negatively affected after an experience of a critical incident, depression is considered one of the more common reactions. Depression is said to be more likely to develop when circumstances involve significant loss. The study below acknowledges that depression and, significantly, major depression are interconnected with PTSD. Shalev, Freedman, Peri, Brandes, Sahar, Orr and Pitman (1998:638) prospectively evaluated the onset, overlap and course of PTSD and major depression following an experience of trauma. Their results reveal that major depression and PTSD occur early on after a critical incident. Secondly, patients with these diagnoses had similar recovery rates: 63 survivors (29,9%) met criteria for PTSD at one month and 37 (17,5%) had PTSD at four months after the event. Forty subjects (19,0%) met criteria for major depression

at one month and 30 (14,2%) had major depression after four months. Co-morbid depression occurred in 44,5% of PTSD patients at one month and in 43,2% at four months. Co-morbidity was associated with greater symptoms severity and lower levels of functioning. Prior depression was associated with a higher prevalence of major depression after exposure to trauma. Shalev *et al.* (1998:639) conclude that major depression and PTSD are independent consequences of traumatic events, have similar prognoses, and interact to increase distress and dysfunction. The study proposes that both major depression and PTSD should be targeted by early treatment interventions and by neurobiological research.

"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.

Van der Kolk (1987:3) describes a traumatic event as a phasic reliving and denial of the event with altering intrusive and numbing responses. The intrusive responses usually involve hyper-reactivity, explosive aggressive outbursts, startle responses and intrusive recollections in the form of nightmares and flashbacks and enactment of situations reminiscent of the trauma. The numbing response after a critical incident usually consists of emotional constriction, social isolation, retreat from family obligations and a sense of estrangement. Common responses to critical incidents may include various forms of re-experiencing and avoidance (Carlson, 1997:43). These forms of re-experiencing and avoidance may be experienced in different modes or levels. In Table 2, Carlson (1997:44) explains that the cognitive, affective, behavioural and psychological mode of a person who has experienced a critical incident can be affected.

Table 2: Manifestations of re-experiencing and avoidance across modes of experience

Mode	Re-experiencing	Avoidance
Cognitive	Intrusive thoughts Intrusive images	Amnesia for trauma De-realisation/ depersonalisation
Affective	Anxiety Anger	Emotional numbing Isolation of affect
Behavioural	Increased activity Aggression	Avoidance of trauma-related situations
Physiological	Physiological re-activity to trauma reminders	Sensory numbing
Multiple modes	Flashbacks and nightmares	Complete activities in dissociated states

(From Carlson, 1997:44)

According to Schulz, Van Wijk and Jones (2000:29), a person who experiences a critical incident and is traumatised by the event can be recognised when the individual's mind repeatedly replays reminders of an incident, for example re-experiencing a smell or visual sight or a sound that reminds the victim of the incident. According to Schulz *et al.* (2000:30), the replay of such an incident can be so severe in certain cases that the person literally acts as if he/she feels that he/she is experiencing the critical incident. The re-experiencing of such an incident usually involves the cognitive, affective, behavioural and psychological reliving of the incident.

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 has 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 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.

Reaching the stage where the individual can adjust to and accept the critical incident is usually a long and painful process. In this period the individual is subjected to the re-experiencing of the incident on a cognitive, affective, behavioural and physical level. The re-experiencing of the incident can be as painful as the actual critical incident. Owing to the pain and discomfort caused by a critical incident, the earliest response is an overall feeling of numbness. This is a form of avoidance to help the individual adjust to the severity of the incident, which usually threatens the individual's psychological wellbeing. "Avoidance serves the purpose of protecting the individual from exposures to reminders of the traumatic event" (Carlson, 1997:47). Cognitive avoidance can involve putting the critical incident or reminders thereof out of a person's thoughts or it can involve the distortion of a person's perceptions or amnesia. Affective avoidance of a critical incident is commonly experienced as a feeling of emotional numbness. Behavioural avoidance typically involves the avoidance of reminders of the incident. This includes avoiding situations, places or people associated with the critical incident (Carlson, 1997:47).

2.6 SHATTERING OF ASSUMPTIONS

According to Schulz *et al.* (2000:10), a critical incident shatters the life assumptions of the person who is the victim of such an incident. People construct a cognitive and mental frame around reality that forms our assumptions about how the world should operate. Inside this frame our 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:

2.6.1 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 was intruded on and violated (Schulz et al., 2000:11).

2.6.2 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 we live in a rational world is shattered. A critical incident makes a person realise that the world and the people in it are 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 and, when no rational explanation is found, it tends to heighten the traumatic blow (Schulz et al., 2000:12).

2.6.3 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 exist 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 conflict in a person's religious belief systems. When a person suffers injustice, he/she might feel someone is to blame, and somehow 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).

2.6.4 Assumption of self-identity

Every person has a certain picture of who he/she is. This includes an idea of our capabilities and assets and also of our shortcomings. The traumatisation of a critical incident changes a person's self-perception. The person who has had 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 the self, changes how a person approaches life and relationships (Schulz et al., 2000:18–19).

The fact that a person's life assumptions are shattered may be a reaction to what has happened to him/her. The degree to what life assumptions are shattered may differ from person to person and the time it may take to restore these assumptions will also depend on the individual.

2.7 FACTORS MEDIATING THE EXPERIENCE OF A CRITICAL INCIDENT

Although the literature seems to focus on the more dominant predisposing factors that have an intensifying effect on the reactions to a critical incident, attention should also be given to some positive outcomes a critical incident may facilitate in the victim's life.

Acknowledging aspects of renewed self-confidence, looking at what the critical incident has meant to the survivor as well as having to face his/her vulnerability are some of the factors discussed below.

Although a critical incident can lead to the worst of times, struggling with crises in our lives can also lead to the best of times by providing us with the opportunity for psychological growth that would not have been possible without the challenges of a critical incident. Recently, there have been attempts to account for the phenomenon of psychological growth by using contemporary theories as explanations for the process of developing profound and healthy insights into living as a result of surviving trauma (Tedeschi & Calhoun, 1995:38)

One class of benefits cited by individuals who have faced difficult experiences, are positive changes in perception of the self. Figley (1994:67) reports in two separate studies that respondents indicated emotional growth as a positive outcome of dealing with their difficulties. Living through life trauma provides a great deal of information about self-reliance. These experiences affect not only the perception of competence in various situations but the likelihood that one will choose to address difficulties in an assertive fashion.

People coping with a critical incident often draw the conclusion that they are stronger as a result of the event. A psychotherapy client cited in Tedeschi and Calhoun (1995:39) described how her traumatic rape experience had enabled her to become stronger within herself as she had to face her own vulnerability and limitations as a person, something she had never done before. They also state that the experience of overcoming trauma, and the sense of survival, appears to generate a functional pattern of greater strength and confidence that generalises to all kinds of situations in their lives that are less difficult than the trauma they had faced.

The study of Veronen and Kilpatrick (1983:108) is in accordance with Tedeschi and Calhoun's (1995:40) debate, as they also pose that trauma survivors seem to develop a greater awareness of themselves and of others. Their study indicates that a large part of the positive development of social relationships among survivors comes from their increased compassion, greater sensitivity to the needs and feelings of other people, and efforts directed at improving relationships. Therefore, people who suffer from trauma may be more likely to offer support to others in turn. Veronen and Kilpatrick (1983:108) further describe one of the survivors that they had counselled. The woman, who was a rape survivor, learned to discriminate positive from negative relationships after in-depth counselling. This changed approach to relationships subsequently allowed her to be in a position to establish more positive and intimate relationships.

Change in one's philosophy of life is another possible benefit reported by many people coping with life traumas. Tedeschi and Calhoun (1995:40) state that surviving a critical incident may also lead to an enhanced appreciation of one's vulnerability and greater awareness and sensitivity to one's emotional experiences. Survivors who experience extreme stress appear to lose their sense of invulnerability and have to confront their mortality. At first glance, recognition that one is vulnerable may not appear to be a positive outcome. A loss or tragedy challenges one's sense of invulnerability, as does the recognition that it may be impossible to cope without some assistance. However, extreme trauma can create totally new conditions as it may be too much to bear alone. As a result they appear to gain a new appreciation for life. Some people recognise, as never before, that their time and their relationships are precious. They acquire a renewed appreciation for simple moments in everyday life and the relationships previously taken for granted (Tedeschi & Calhoun, 1995:41).

The changed philosophy of life may have a spiritual component. A strengthening of spiritual beliefs may serve a variety of purposes for an individual coping with trauma. Gaining a sense of control and comfort at a spiritual level can facilitate a deeper relationship with a higher and immortal being as well as grow one's spiritual belief system. Attempting to recognise and acknowledge meaning of the trauma is another mediating factor in coping with a critical incident. The debate posed by Tedeschi and Calhoun (1995:38) suggests that when one is in the aftermath of the trauma, searching for meaning allows one to experience emotional release. The attempt to question, search and despair over the experience tends to maintain strong negative emotions, however, finding meaning in a traumatic event results in emotional comfort and release. Perceiving meaning can allow the development of a new philosophy of life that alters the most basic assumptions that the individual holds about how life works its meaning.

White and Epson (1990:33) present another dimension to trauma. They hypothesise that the narrative or storyline of one's life is generated from a variety of incidents or scenes as well as idealised images of the self, which also include the experience of trauma. People confronted with these events must come to terms with how their attempts to cope reflect their narrative– which they have been creating for themselves– or how the way that they have coped with the situation has interrupted their assumed story line. It appears that benefits are derived from such experiences to the extent that these life scenes are incorporated as dramatic devices or plot twists that further one's life narrative. This process of assimilating the critical incident into the life narrative and into the fundamental assumptions about life, or changing the narrative and its assumptions to accommodate what has happened, involves great effort. But despite these efforts and the profound changes that may be wrought in the survivors' fundamental understanding of life and its proper path, there is the possibility that the survivor may perceive beneficial and positive outcomes. The benefits come from the new-found order and purpose that this meaning provides, not only to the event itself but also to other aspects of life which need to become integrated into the survivor's life narrative.

The various findings in the literature presented above indicate that there are factors that can in fact mediate the experience of a critical incident. This process of finding or gaining meaning and initiating personal growth takes a lot of personal effort from the trauma survivor as well as his/her family and support system. Often psychotherapy can be a significant facilitator in this process of finding and making meaning.

2.8 PHASES OF TRAUMA

Most authors agree that there are mainly three phases that a person may go through after the experience of a critical incident. Lewis (1996:57) refers to a fourth phase, namely the pre-impact phase. The four phases consist of the pre-impact phase, the impact phase, the recoil phase and a reintegration phase.

2.8.1 Pre-impact phase

According to Lewis (1996:57) this stage refers to the time the individual becomes aware that a crisis is about to develop. This may only be a moment of warning, a matter of seconds to prepare the person for a flight or fight response.

2.8.2 Impact phase

This phase is the experiencing of the actual critical incident. During this phase survival efforts are initiated. Lewis (1996:15) indicates that the impact phase starts immediately after the critical incident has taken place. This phase can last from a few seconds to a few days. This phase is associated with emotional numbness, disorientation, confusion, being irrational and disorganised. The person usually performs with a sense of detachment and emotional disconnection. Schulz *et al.* (2000:4) indicate that the person who has been exposed to a critical incident experiences temporary helplessness and seeks reassurance and direction in this phase. Retief (2004:31) mentions that the victim may find it difficult to belief what he/she is seeing or hearing; it might feel like witnessing the incident from a distance. Lewis (1996:58) describes this state of shock, depersonalisation or de-realisation as a feeling of being outside of oneself. The victim experiences him-/herself as functioning in a dream-like state similar to having a *déjà vu* experience or may feel that the world around him/her has a sense of unreality. In this phase, where a person experiences helplessness, confusion and shock, a person needs a safe environment with structure and support. Practical assistance such as contacting police or relatives may be of help to give the victim direction in his/her state of confusion (Lewis, 1996:15).

2.8.3 Recoil phase

According to Lewis (1996:16), this phase follows shortly after the impact phase when the reality of the critical incident starts to sink in and the person begins to experience feelings such as anger, sadness and guilt. This phase could start approximately 18 to 24 hours after the incident and could last between three and six weeks until three months. This is the phase where the individual starts to adapt, starts to doubt and experiences feelings of anger, apathy, sadness and guilt. The victim might experience intrusive ideas and may be re-living the critical incident. He/she may also experience fantasies of revenge (Schulz et al., 2000:4). Lewis (1996:16) states that most of the post-traumatic stress symptoms start to develop during this phase.

Lewis (1996:58) refers to this phase as the past impact phase. This phase can be divided into three sub-phases: the honeymoon phase, the disillusionment phase and the reconstruction phase. The reconstruction sub-phase refers to the last phase of the trauma recovery phases and is also referred to as the reorganisation or reintegration phase (see paragraph 2.8.4).

The honeymoon sub-phase is a brief phase in the recoil phase, lasting hours to weeks. During this phase the victim experiences a sense of relief of having survived the critical incident. After the honeymoon sub-phase follows the disillusionment sub-phase.

During this sub-phase the victim of the critical incident realises that a permanent disruption and sense of loss have occurred as a result of the crisis. The person may experience feelings of anger, rejection and frustration. This is often manifested through contradictory blaming of others while concurrently looking to others to fix his/her problems. In this phase people often feel the need to make dramatic changes in their lives. Some leave spouses or jobs or move to another location. During this sub-phase people may become depressed and have difficulty coping.

2.8.4 Reintegration phase

In the final recovery phase the person begins to live with the trauma as a memory that is not overwhelming and begins to re-engage with other people. In this phase the person's trust in others starts to be rebuilt and he/she begins to relate emotionally to others in the same way as before the trauma. According to Schulz *et al.* (2000:4), the person begins to re-establish

former patterns of adaptation to life. This process, according to Lewis (1996:17), starts months after the critical incident and can last for years. The process of recovery is not a linear process; it is likely to involve progress and setbacks. Movement can be backwards and forwards between these last two phases of recovery until a person eventually return to their previous level of functioning, as before the critical incident. Lewis (1996:59) mentions that during this phase the person should take responsibility for the rebuilding of his/her physical and emotional life. It is often a slow and difficult process and requires the support and understanding of others.

2.9 NEUROBIOLOGICAL REACTIONS TO A CRITICAL INCIDENT

A critical incident has an impact on the brain, the nervous system and the immune system of the survivor. A person's response in every phase of the reaction to the critical incident is determined by the body's neurobiological reactions to the critical incident. To understand the effect of a critical incident on the body it is important to understand the function of the brain, the nervous system and the immune system.

According to Tehrani (2004:20), a number of brain structures are closely associated with a trauma response to a critical incident. The most important are the locus cereleus, amygdala, hippocampus, thalamus and the cortex.

The locus cereleus is involved in the access and retrieval of memories through its connections with the hippocampus and amygdala (Tehrani, 2004:21).

According to Schulz *et al.* (2000:71), the thalamus relays the incoming sensory information through its projection fibres to the appropriate region of the cortex. To accommodate the different types of sensory information that must be sorted out, the thalamus is divided into a number of nuclei (groups of nerve cells) that pass the information to the cortex. The thalamic nuclei relay visual, auditory, somatosensory and equilibrium-related information. The thalamus also has a function in controlling sleep and awakening.

The amygdala is involved in the interpretation of the emotional strength and significance of incoming information, which is achieved by the creation of an internal sensory representation of the creation of the external world (Tehrani, 2004:21). When the amygdala is stimulated in a human, a variety of emotions such as fear, anxiety, pleasure and anger are elicited.

The hippocampus is responsible for categorising and sorting incoming stimuli in the short-term memory. The hippocampus processes new stimuli to decide whether the experience was punishing or rewarding. A person's ability to learn from experience depends on the functioning of the hippocampus (Tehrani, 2004:22).

The cortex, according to Schulz *et al.* (2000:73), is divided into various parts. Each part of the cortex is responsible for processing different sensory information. The parietal lobe is responsible for somatosensory processing (sensation in the skin and muscles of the body), in the temporal lobe of the cortex auditory processing takes place and in the occipital lobe the visual processing takes place.

When a person becomes the victim of a critical incident, the body reacts to trauma and the person exhibits certain emotional responses. The schematic representation in Figure 1 illustrates the interactions in the brain that lead to emotional arousal when a person is confronted with a critical incident.

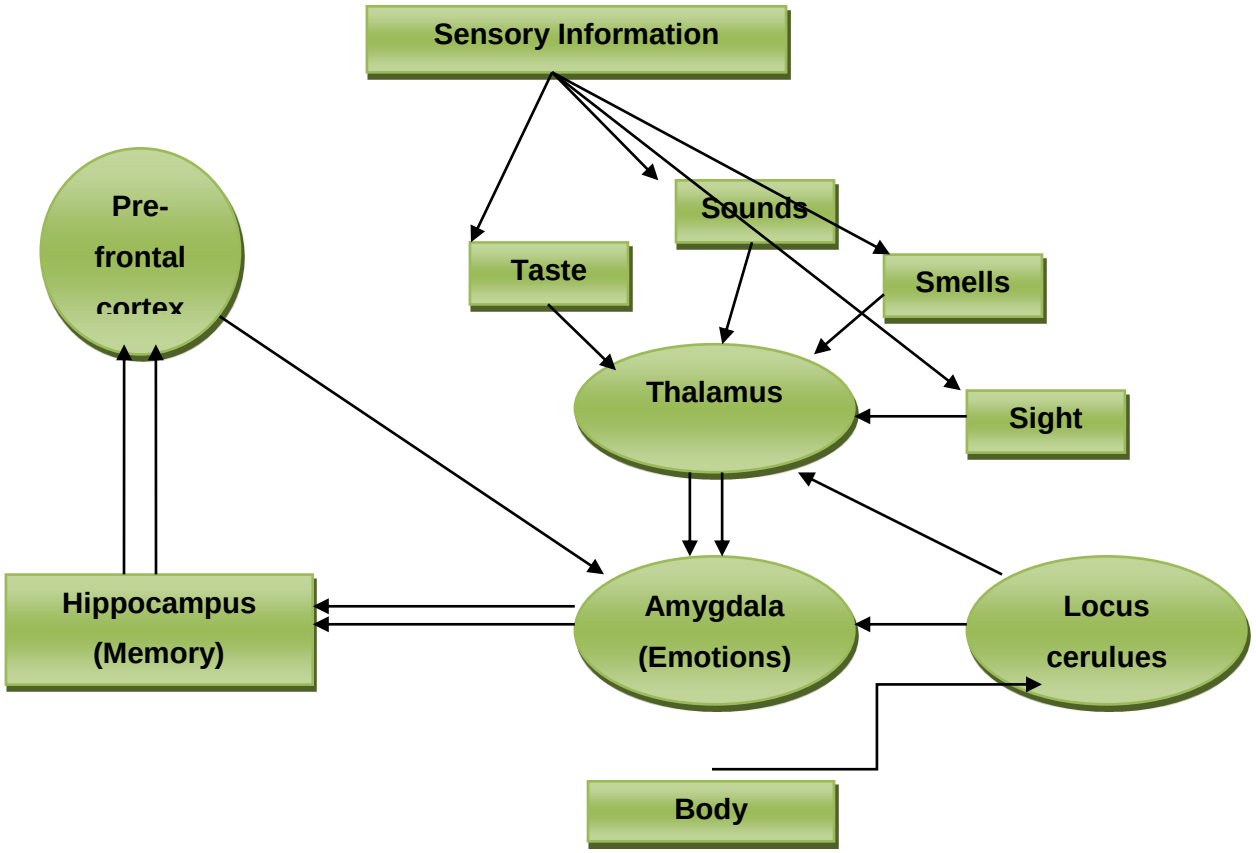


Figure 1: Schematic representation of emotional arousal pathways (adopted from Tehrani, 2004 and Retief, 2004)

When a person becomes involved in a critical incident, the sensory information is transported through the central nervous system directly to the brain. Most of the sensory information is passed to the thalamus where initial processing takes place. From the thalamus, the sensory information goes via the amygdala and the hippocampus to the pre-frontal cortex, and at each stage additional processing of the sensory information takes place (Tehrani, 2004:20). When sensory information reaches the cortex it has been assigned meaning. It is then fed back to the locus cereleus and the amygdala. According to Tehrani (2004:21) connections to and from the locus cereleus and amygdala to the hypothalamus, hippocampus and pre-frontal cortex are then able to affect the behavioural, autonomic and hypothalamic-pituitary-adrenal response systems, which in turn initiate and control the body's responses.

2.9.1 Bio-psychosocial model of stress

A model for the way in which personality factors, stressful circumstances and health interact has been proposed by Folkman and Lazarus (in Schulz *et al*., 2000:78). According to the bio-psychosocial model of stress, a person goes through a two-step appraisal process, which interacts with both the person's unique personality and/or the situation at hand, when he/she is confronted by a potential stressful situation such as a critical incident.

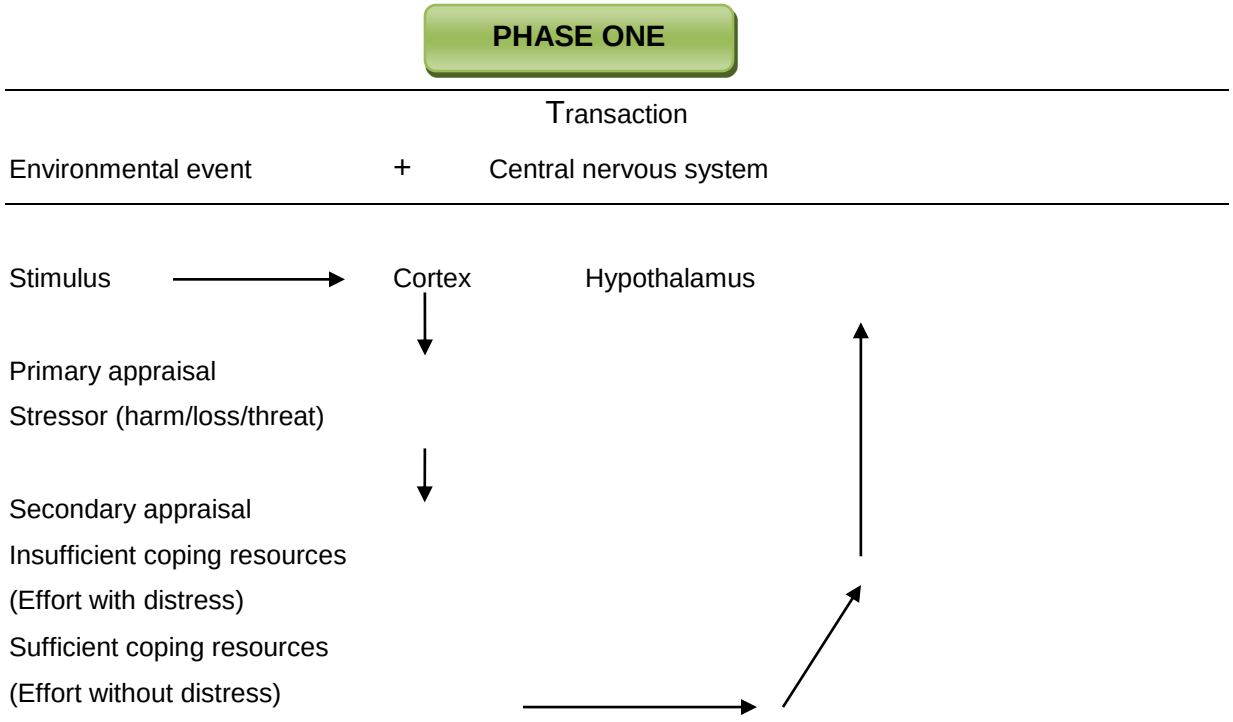
When a person experiences a critical incident, the central nervous system registers that there is danger and the possibility of harm. The interaction between the critical incident and the central nervous system is called a transaction. This transaction, called phase 1 (see Figure 2), activates the brain as follows: a stimulus is registered in the brain by the thalamus, then a message is sent via the amygdala and the hippocampus to the cortex that receives and processes the sensory information, which activates the two-step appraisal process.

The first step in the two-step appraisal process is the primary appraisal. In this step the person analyses how much harm, loss or threat there is in the outcome of a particular situation. If there is potential harm, loss or threat posed by the critical incident, the next step in the appraisal process, namely the secondary appraisal, takes place. In the secondary appraisal step the person assesses what he/she can do to maximise the likelihood of potential beneficial outcomes and to minimise the likelihood of potential harmful outcomes of the situation. This step distinguishes between insufficient coping resources (effort with

distress) and sufficient coping resources (effort without distress). Once the first and second steps have been completed, the person is ready to start coping with the situation, which implies that the person starts managing the internal and external challenges the critical incident poses. This phase is completed by sending the appropriate message to the hypothalamus, which controls the endocrine system, the autonomic nervous system and which regulates behaviour.

Phase two depends on the message sent to the hypothalamus. As soon as the autonomic nervous system and the endocrine system have been activated by the message of the hypothalamus, the second phase, namely arousal, is entered. Arousal is accompanied by the sympathetic response which increases heart rate, respiration and blood pressure, decreases digestion and activates the pituitary glands. The pituitary gland then activates the adrenalin glands, which prepare the body for the fight or flight reaction. The adrenalin glands release catecholamine that consists of norepinephrine (responsible for prolonging the sympathetic response), epinephrine (which arouses the body for action) as well as corticosteroids (which increase metabolism, provide energy and decrease the immune inflammatory response).

The transaction of phase 1, coupled with the arousal of phase 2 is referred to as the general adoption syndrome (GAS) (Figure 2).



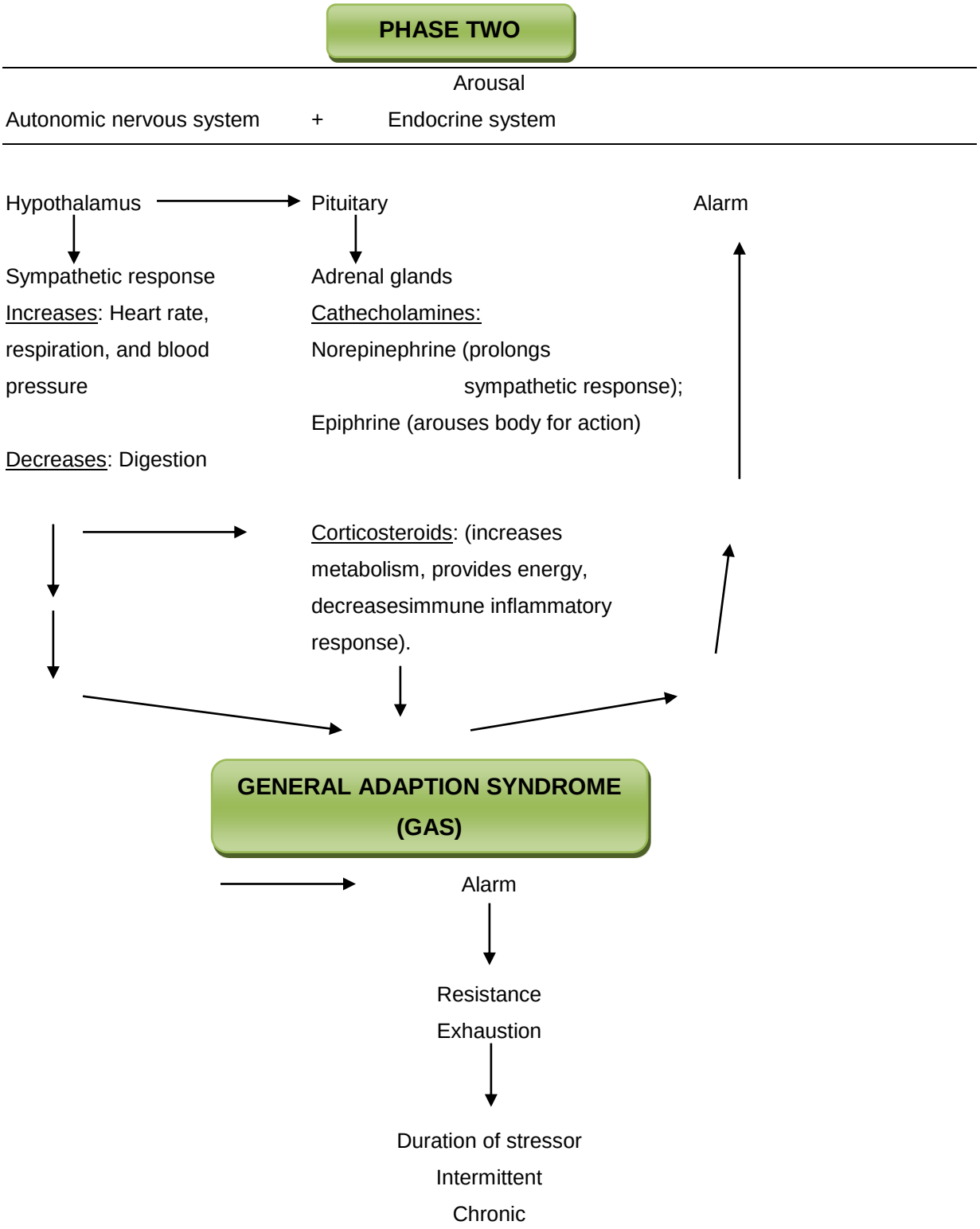


Figure 2: Bio-psychosocial model of stress (Schulz et al., 2000:81–83)

Retief (2004:83) mentions that any critical incident with a high stress impact tends to activate the hypothalamic-pituitary-adrenal pathway. When this occurs, high volumes of stress hormones are released by the adrenalin glands. The stress hormones flood the brain receptors in the hippocampus, of which the primarily function is memory, leading to short-term memory problems. This explains why a person who has been a victim of a critical incident at times finds it difficult to remember what happened and sometimes needs some assistance to remember the details of the incident.

According to Bernard and Krupat (1994:72), the release of catecholamines and corticosteroids after exposure to a critical incident, due to the stress response to the critical incident, can suppress the immune system of the person. The immune system is crucial in dealing with trauma in the long-term. Stressors have different effects on the body and the body reacts to each stressor in a unique way. The body may interpret powerful, inescapable stressors as illness. Kalat (2001:29) mentions that people exposed to a severe critical incident might develop a fever, increase their sleep and experience decreased appetite and sex drive. Prolonged stress can be harmful to the body and lead to an impaired learning ability, memory loss, behavioural problems and an increase in the vulnerability to develop physical illness.

2.9.2 Psychological system

The trauma of a critical incident does not only affect a person's physical well-being, but also his/her psychological functioning.

According to Newman and Newman (1999:83), the psychological approach views human behaviour as a product of the interaction between the individual and society. The way in which these interactions take place is discussed according to the basic concepts of the systems theory, namely balance, feedback and change.

Erikson (in Louw, 1994:62) suggests eight stages in which ego qualities develop. In each stage an individual is challenged to resolve a particular crisis, which always consists of a positive as well as a negative component. If the individual is able to resolve the crisis in a positive manner, the person develops into a well-adjusted person; if the crisis is resolved in a negative way, adjustment problems occur. Each crisis demands the development of a specific

capability. If it is not achieved, some impairment will occur in later development and an unhealthy aspect of personality will prevail. People then tend to withdraw from others, prevent the exploration of interpersonal relationships and resist change and growth, resulting in an ineffective, negative crisis resolution.

In his theory, Erikson (in Louw, 1994:62) proposes that primary adaptive ego qualities develop from the resolution of a trauma or a crisis by active efforts to resolve the stress, and by creating new solutions for the challenge. The creation of individual strategies depends on the talent and motives of the individual and the individual's unique style of coping may be influenced by factors such as gender, resources, interpersonal relationships and life experience (Newman *et al*., 1999:85).

In the following discussion based on findings by Louw (1994:63), Newman *et al* (1999:86) and Roos (1997:24), the focus is on the challenges survivors of critical incidents might experience in coping with traumatic life events, referring to the eight stages of ego development according to Erikson's theory.

- **Trust vs. mistrust**

  The first stage of ego development is trust versus mistrust. According to Erikson's theory, a person who develops mistrust in the course of his/her life will have little hope. Hope is important as it enables a person to handle new challenges successfully. The trauma of a critical incident can disturb the relationship with hope and contribute to the development of social and emotional detachment towards the world and the people in it. The mistrust and hopelessness, which develops as a result of a trauma, may continually recur in a person's life and may affect a person's reactions and sense of coping when confronted with a new crisis.

- **Autonomy vs. doubt**

  People have to learn that they have their own will and that they can enforce it and make choices. A person develops and learns to exercise self-control over his/her body. If a person successfully develops a sense of autonomy, he/she develops pride and feels confident to master new skills. Optional development of autonomy leads to the synthesis of powerfulness and a positive sense of self-confidence. The trauma of a critical incident shatters a person's feeling of autonomy, reinforcing a feeling of doubt, anxiety and

insecurity regarding his/her abilities. A person's response to restore autonomy may include excessive control, over protection and a lack of will power. Emotional vulnerability is related to the experience of powerlessness, exposure, insecurity and instability, which may result in a feeling of purposelessness.

- **Initiative vs. guilt**

  An ego quality that develops in the course of a person's life is either initiative or a feeling of guilt. Initiative is associated with developing the skill of being task orientated. The individual's sense of initiative and task orientation may expose him/her to situations where he/she could be potentially hurt. When a person is traumatised by a critical incident, it may lead to inhibiting his/her sense of initiative and leave him/her with feelings of excessive guilt about acts that are initiated.

- **Industry vs. inferiority**

  A person develops a sense of inquisitiveness and courage to imagine and pursue valued goals in favourable circumstances. Encouraging creative attempts leads to a feeling of self-worth and effectiveness. New social interactions become important to counter the paralysis of action and thoughts that prevents productive work after the trauma of a critical incident. A feeling of inferiority may develop in a context where social support is lacking. This may result in a person withdrawing from challenges. Trauma may emphasise the feelings of incapability and being inadequate, prohibiting the person to meet a challenge with confidence and enthusiasm.

- **Role identity vs. role confusion**

  Role identity leads to a sense of security of the self and establishes a feeling of reliability in the self. The sense of reliability is especially crucial for the survivor of a critical incident; because a person should be able to integrate new roles and to connect with others after a critical incident. A person has to explore new possibilities gradually in order to function more independently and to find common ground with other people. The development of a role identity allows possibilities for more social involvement and for conceptualising the trauma on an abstract level. A well-integrated ego identity is characterised by an inner feeling of uniqueness and the ability to determine clear goals. Without an integrated identity, feelings of confusion, insecurity and unhappiness may be prominent.

- **Intimacy vs. isolation**

  Intimacy is an ego quality that allows a person to share and care for others without the fear of loss. Survivors of a critical incident are particularly challenged to deal with issues of intimacy versus isolation. Critical incidents have the ability to limit the development of intimacy and reinforce a feeling of being lonely, as if no one cares for the survivor.

- **Generatively vs. stagnation**

  People who have been able to integrate the trauma of critical incident in a meaningful way have feelings of creativity and productivity. The opposite is also true, where people have been unable to integrate a critical incident in a meaningful way, and continue to struggle with the negative components of the trauma; they have feelings of being trapped. This can lead to a pre-occupation with the self to such an extent that they exclude others. Trauma and the fear of re-experiencing trauma may limit a person's mobility and prevent them from being socially active and involved with other people.

- **Integrity vs. despair**

  The ego quality of integrity versus despair is prominent in a person's development through trauma. Integrity develops when a person feels satisfied with his/her ability to cope with challenges, has a conscious trust in his/her own ability and gets re-assurance of the meaningfulness of life. Being a victim of a critical incident re-enforces the fact that life can be meaningless and questions a person's ability and trust in the self. This may lead to a feeling of extreme hopelessness and despair.

2.10 SYMPTOMS AND DIAGNOSIS

According to Friedman (2003:2), research on trauma is still in its infancy. The importance of dissociation as the hallmark of acute stress disorder, as a predictor of PTSD, is unclear – based on recent findings. Research shows that 80% of trauma victims with acute stress develop PTSD, but some persons diagnosed with PTSD have never suffered from acute stress disorder. They develop sub-clinical acute stress disorder without dissociative symptoms. Research further indicates that some persons develop PTSD without any acute stress disorder or sub-clinical acute stress disorder symptoms being present.

Friedman (2003:4) states that formal PTSD is a significant health problem affecting millions of people. According to him, 10% of American men and 5% of American women will develop PTSD at some stage of their lives. In South Africa with the country's political unrest and history of violence, current high crime figures for rape, armed robbery and hijacking, and farm murders, the high domestic violence, high road accident figure and high sexual crime figures, it seems likely that the number of people suffering from PTSD is far higher, possibly as high as 25 to 30% (Van der Walt, 2001:151). It is important to mention that if left untreated, people suffering from PTSD do not recover. Researchers working with veterans of the Second World War and victims of the Nazi Holocaust indicate that a PTSD will continue for 50 years or longer. Prevention is, therefore, better than cure. People suffering from PTSD also frequently begin a pattern of violence and thus the saying "the victim today becomes the perpetrator of tomorrow" is appropriate.

Scott and Stradling (1994:178) point out that PTSD was only given official recognition as a general diagnostic category in 1980 when the American Psychiatric Association included the disorder in the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Although PTSD is a new category achieving official designation, it has been in existence for a long time. Gilliland and James (1993:46) describe how Sigmund Freud formulated the concept of hysterical neurosis to describe trauma cases that included symptoms of warded-off ideas, denial, repression and emotional avoidance, compulsive repetition of trauma-related behaviour and recurring attacks of trauma-related emotional sensations.

2.10.1 Definition of post-traumatic stress disorder (PTSD)

Meichenbaum (1994:94) describes traumatic events as events that are so extreme or severe, so powerful, harmful and threatening that they demand extraordinary coping efforts. They represent an unusual event (or series of continuous events) that subjects people to an extreme, intensive, overwhelming threat to themselves or significant others. These events may overwhelm a person's sense of safety and security, and can cause very long-term changes in affect (emotions), stress-related behaviour, physiological functioning and mental health– but not for all victims. For some victims this traumatic event may reactivate unresolved issues from previous traumatisation.

Scott and Stradling (1994:176) point out that from this definition it is clear that it is not necessary for a person to be a victim of a traumatic incident in order to be traumatised. Just witnessing a tragedy may be enough to trigger subsequent PTSD. Armfield (1994:738) emphasises that a traumatic event can be actual or perceived.

What might be severely traumatic to one person might not be to another person. One person may develop PTSD as a result of a critical incident; the other person may only be traumatised. In defining critical incidents some authors focus on the actual event as being life threatening to the individual. Bohl (1991:27) describes a critical incident as "an incident in which human lives are lost and/or serious injuries are witnessed".

Van der Kolk (1999:16) defines critical incidents as "sudden terrifying experiences that explodes one's sense of predictability in life". Other authors highlight the individual's reaction to the actual event when defining a critical incident. Mitchell (1986:51) views a critical incident as "any significant emotional event that has the power, because of its own nature and because of the circumstances in which it occurs, to cause unusual psychological distress in healthy normal people". According to Solomon (1986:30), any situation in which a person feels "overwhelmed by sense of vulnerability and/or lack of control of over the situation" can be defined as a critical incident.

Gilliland and James (1993:48) describe PTSD as a complex and diagnostically difficult disorder to define. They further conclude that the likelihood of PTSD to develop is influenced by several factors: genetic predisposition, personality make-up, past life experiences, state of mind, phase of maturational development at onset, social support system before and after trauma, and content and intensity of the event. This is supported by Armfield (1994:740) who states that "vulnerability to PTSD is enhanced by pre-existing psychological disorder (especially if related to prior trauma), low self-esteem, family problems, and poor coping skills". It is often found that the level of a person's life skills (e.g. conflict management skills, flexibility and stress management skills) and the efficiency of a person's support system are major indicators of how successfully a person will deal with the emotional consequences of a traumatic event.

Besides the formal diagnosis of acute stress disorder and PTSD, the literature also makes a distinct differentiation between acute trauma and complex trauma (Friedman, 2003:10 –15).

Therefore, these are discussed in further detail below, together with acute stress disorder symptoms and PTSD symptoms.

2.10.2 Discussion of Post-Traumatic Stress Disorder (PTSD)

The DSM-IV diagnostic criteria for PTSD 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.

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 feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative 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.

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

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.

E. Duration of the disturbance (symptoms in criteria B, C and D) last longer than one month.

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

Specify:

Acute: If duration of symptoms is less than three months.

Chronic: If duration of symptoms is three months or more.

Specify:

With delayed onset: If onset of symptoms is at least six months after the stressor.

Flashback episode: A dissociative state in which an individual feels as if he/she is reliving a traumatic event.

Physiological reactivity– quickening of the heart rate, blood pressure, and breathing resulting from exposure to internal or external clues that symbolise or resemble an aspect of the traumatic event.

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 on how and why it occurred, and what it means. These results in the individual experiencing a traumatic state 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 symptomological forms, months or years after the event. This is referred to as delayed traumatic stress disorder or PTSD.

Armfield (1994:741) emphasises that symptoms may begin immediately after the trauma, but often they lay dormant for weeks or even years after the trauma.

The American Psychiatric Association, according to Friedman (2003:12),emphasises that the duration of the symptoms (A-F) 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 experience for full month as yet, the person is traumatised, but is not suffering from PTSD as yet.

The DSM-IV-TR (2000:209) also distinguishes between (a) acute; (b) chronic and (c) delayed PTSD, based on the duration and onset of the symptoms. PTSD is defined as:

Acute: When the victim has experienced symptoms for less than three months.
Chronic: When the victim has endured symptoms for three months or more.
Delayed: When the victim did not develop symptoms until at least six months after the trauma.

The disturbance should cause clinically significant distress or impairment in social, occupational, or other important areas of functioning before it can be classified as full-blown PTSD.

According to the American Psychiatric Association(in Friedman, 2003:14), Scott and Stradling (1994:128) and the DSM-IV-TR (2000:209), in order to be identified as suffering from full-blown PTSD, a person must experience the following characteristic symptoms.

- **Re-experiencing symptoms**
  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 experienced during the actual event.

Gradually intrusive, repetitive thoughts about the traumatic event begin to dominate the individual's existence (Gilliland & James, 1993:49). These intrusive thoughts generally take the form of visual images that are sparked by sights, sounds, smells, or tactile reminders that bring the repressed images to awareness.

- **Avoidance numbing of general responsiveness**

  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 or people associated with the trauma. Trauma victims display a tendency not to feel, because exposure to feelings invariably makes them vulnerable to further pain. Instead they often become passive and emotionally paralysed. They may wander around aimlessly in a daze of shock. It is also common for victims of severe trauma not to remember certain aspects of the trauma. In this way they detach themselves from overwhelming fear, pain and helplessness.

  Gilliland and James (1993:50) explain that, as individuals attempt to cope with catastrophe, they become passive (immobile and paralysed) or active (able to cope with the situation).

  Individual reactions tend to fall into three major groupings:

  - Momentarily freezing
  - Flight reaction
  - Denial or numbing.

Denial or numbing is the most common response. Desensitising one to totally unacceptable events and then trying to return to normality in a peaceful world is a very common characteristic pattern of traumatisation. This allows the victim to get through the trauma and cope with it without losing complete control. Typically, survivors of trauma will let down their defence barriers and will have acute stress disorder immediately after the trauma, but will recover. For those who do not, continued emotional numbing and repression can have severe consequences.

- **Hyper-arousal symptoms**

  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, 1993:52). 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 explains 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 critical incident.

  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.

2.10.3 Complex post-traumatic stress disorder (PTSD)

Friedman (2003:19) indicates that many clinicians who have worked with victims of longstanding trauma such as torture or hostage victims believe that the victims present with complex PTSDs. These include the following symptoms together with those of PTSD:

- Behavioural problems, for example impulsiveness, aggression, sexual acting out, eating disorders, alcohol/drug abuse and self-mutilation
- Emotional problems, for example emotional instability, anger outbursts, panic attacks 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 fulfill the criteria for PTSD and an additional diagnosis is unnecessary.

Pearlman (in Wilson, Friedman & Lindy, 2004:205) mentions that, in addition to the symptoms of PTSD that include intrusive experiences, avoidance and arousal, complex PTSD includes dissociation, relationship difficulties, revictimisation, 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 or "frozen" appearance, dissociation, problems with concentration or memory, anger, self-mutilated behaviour, depression, anxiety and rational problems.

2.10.4 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.

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 viewed as "a mechanism involving the segregation of any group of mental or behavioural 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 (2003:16), three of the following five dissociative symptoms must be present in order to diagnosed acute stress disorder:

- Numbing. It is the subjective experience of numbing, detachment or absence of emotional reactions.
- Dissociative amnesia. This is the inability to remember important aspects of the trauma.
- Reduction in awareness. This is a 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".
- Derealisation. The world that the individual has always known is dramatically changed and he/she feels estranged or detached from the environment and has a sense that the environment is unreal.
- Depersonalisation. In the individual this may manifest as a distorted perception of his/her body, identify or him-/herself as a coherent entity. The person for example, feels that his/her body has been divided into sections.

In addition to the dissociative symptoms, one of the following also has to be present to make a diagnosis of acute stress disorder (Friedman, 2003:17):

- Re-experiencing
- Avoidance
- Anxiety
- Arousal symptoms.

In conclusion it can be stated that people's basic assumptions about their belief in the world as a meaningful and comprehensible place, their own personal invulnerability and their view of themselves in a positive light account for their individual manifestations of traumatisation and PTSD. Even in the most well-integrated person, who has excellent coping abilities, good rational and cognitive behaviour patterns and positive social support system, residual effects of traumatising events linger (Gilliland & James, 1993:56).

2.11 EFFECT OF A CRITICAL INCIDENT ON FAMILYAND RELATIONSHIPS

Research on trauma and the effects of trauma often focuses on the victim's experience of a critical incident and how he/she is affected. Engelbrecht (1997:109) states that studies have clearly shown that the symptoms of PTSD can have psychological repercussions on other family members as well. His study further states that the marital dyad, nucleus family and

even extended family are also possibly affected by the victimisation of one of its members. Figley (1994:23) suggests that traumatic events have a much wider systematic impact than only affecting 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.

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 wives, partners or children. Relationships can become strained and difficult with a lack of ability to communicate.
- If a person is suffering, they might find it difficult to talk to their partners and retreat behind a wall of silence and suppressed anger.
- Inability to stop talking about the event. This can become frustrating and 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 an inability to cope affect the victim's self-esteem and the way he/she interacts with family members and friends.

Brende and Goldsmith (1991:121) propose a post-traumatic family victimisation cycle. According to their findings, there is a cycle of post-traumatic victimisation, which can fragment a family's functioning. The phases of the process include the original traumatic event, which often leads to alienation and isolation of family members with anger becoming the predominantly expressed emotion. Family shame, as well as fragmentation of the family system, seems to develop as the result of a sudden, shattering tragedy, with few couples able to survive the impact. Finally, triggering events can provoke responses that may cause repetition of symptomology.

It appears that trauma has the capacity to seriously affect the levels of functioning within the family. Child-parent relationships also seem to be directly influenced by the experience of trauma. Sack, Clarke and Seeley (1995:1160) considered the rates of psychological distress in two generations of Cambodian refugees living in the Western United States. PTSD was found to be significantly related across parent-child generations, where parents were more likely to report an earlier onset of PTSD symptoms. This study suggests that PTSD may cluster in families. Whether this phenomenon is caused by a genetic susceptibility to trauma awaits further research, according to their study.

De Vries, Kassam-Adams, Cnaan, Sherman-Slate, Gallagher and Winston (1999:1294) support the notion that trauma is a family experience, with the members' reactions to the trauma being closely interwoven and interrelated. Their study estimated the prevalence of PTSD in traffic-injured children and their parents and identified risk factors for PTSD development. Twenty-five percent of the children and 15% of the parents suffered diagnostic PTSD, but only 46% of the parents of affected children sought help of any form (including from friends) for their child and only 20% of affected parents sought help for themselves. The results reveal that PTSD in children and their parents is a common, yet overlooked consequences of pediatric traffic-related injury with prevalence rates similar to those found in children exposed to violence. De Vries *et al*. (1999:1295) suggest that pediatric trauma patients, as well as their significant others, should be screened for PTSD and referred for treatment where appropriate. This indicates that the experience of trauma may very well be maintained within the family context. It appears then that the family may act as a double edged sword in post-traumatic reactions; on the one hand the family provides a valuable resource and source of social support to traumatised individuals but, on the other hand, the family may support and maintain pathological reactions to traumatic experiences.

According to Smith (2005:1), family members who experience a shared trauma often become closer and appreciate each other more. Examples of traumatic events include life threatening car accidents, bush fires, floods, sudden illness or traumatic death in the family, crime or violence. A critical incident can change a person's attitudes, beliefs, feelings and behaviour.

Critical incidents have an effect on the family's functioning and dynamics even years after the incident. According to Smith (2005:1–3), family dynamics can be effected in the short, medium and long term.

2.11.1 Family dynamics – immediately following the event

Every family is different but, generally speaking, common changes to family dynamics soon after the event include the following (Smith, 2005:1–3):

- The parents may fear for each other's safety and the safety of their children outside the home.
- Family members may have nightmares about the event.
- Family members may be fearful of another trauma happening to them.
- Family members may be angry at whoever they believe was responsible for the critical incident. Sometimes this includes feeling angry with the affected loved one or angry with the family in general.
- Family members may feel overwhelmed by feelings of insecurity and lack of control.
- Family members may not know how to talk to each other, because each person is struggling to understand what has happened and how they feel about it, leading to constant arguments.

2.11.2 Family dynamics – weeks or months later

Family dynamics may change weeks or even months after the event. Because time has passed, family members sometimes do not realise that these changes are directly linked to the traumatic event. Every family is different but, generally speaking, common changes in the weeks or months after the event include the following (Smith, 2005:1–3):

- Family members may be short-tempered or irritable with each other, which leads to arguments and friction.
- Family members may lose interest in activities and perform less well at work or school.
- Children may be clingy, grizzly, demanding or naughty.

- Teenagers may become argumentative, demanding or rebellious.
- Some family members may work so hard to help their loved ones that they neglect to look after themselves.
- Family members may feel less attached or involved with one another.
- The parents may experience sexual problems.

2.11.3 Family dynamics–years later

An individual's response to trauma may take a long time to present itself. In some cases, it may take years for problems to surface. Every family is different but, generally speaking, changes to family dynamics can include the following (Smith, 2005:1–3):

- Family members may relive the trauma when faced with a fresh crisis.
- Fresh crises may be more difficult to handle.
- Changes to family dynamics that occurred in the days, weeks or months after the traumatic event could become permanent habits.
- Family members may cope differently with reminders of the event. For example, some may want to commemorate the anniversary or revisit the scene of the traumatic event, while others may want to forget about it. A conflict in coping styles can lead to arguments and misunderstandings if the family members are not sensitive to each other's needs.

It is important to remember that a family is a unit– what affects one member affects all members of the family. A critical incident primarily affects the victim, but the secondary victims of a critical incident are the family members of the survivor of the critical incident.

2.12 CONCLUSION

Chapter 2 explores the concept of a critical incident on various levels. The introduction of this chapter gives an indication of typical critical incidents and how they affect an individual's life and cause trauma. This is followed by defining the terms, crises, critical incident and trauma and discussing the difference between these terms. Different types of critical incidents are discussed in detail. The focus is on certain risk factors that play a role in the extent to which an individual is traumatised by a critical incident. The reactions following a critical incident and the shattering of assumptions as a result of a critical incident are reflected on in detail. Factors mediating the experience of a critical incident are presented.

The different phases of trauma are presented, followed by the neurobiological reactions an individual may exhibit as a result of the critical incident. The different symptoms and diagnosis, resulting from a critical incident, are critically discussed according to the DSM (IV) model. Lastly the researcher reflects on the effect of a critical incident on family and relationships.

The following chapter evaluates different intervention models in critical incident debriefing.

Chapter 3
Critical Incident Stress Management

3.1 INTRODUCTION

Critical incident stress debriefing (CISD) is a unique intervention process developed by Jeffrey T. Mitchell to mitigate post-traumatic stress, thus preventing PTSD. Initially it was used to lessen or prevent post-traumatic stress in emergency services such as police, fireman and emergency medical personnel to reduce the risk of post-traumatic stress associated with these professions. Owing to the success of CISD as an intervention, it was later used in disasters to intervene with both primary and secondary victims. Traumatic events where CISD has been effectively used are natural disasters such as earthquakes, tornados and hurricanes as well as "man-made" disasters such as the New York city fire bombing in 1990, the Los Angeles riots in 1992 and crime (Everly, 1995:279).

3.2 DEFINITION OF CRITICAL INCIDENT STRESS DEBRIEFING (CISD)

Feuer (1999:497) describes debriefing as the "cornerstone" of the trauma response, "a psycho-educational group meeting that although not group therapy is by its very nature naturally therapeutic". She states that it gives the victims the opportunity to share their experiences without being judged. CISD gives them a choice of beginning the road to recovery from what had happened by using a safe secure environment and involving all victims in this helping process.

Harbert (2000:400)defines CISD as "a group process, employing both crisis intervention and an educational process, focussing on mitigating or resolving psychological distress associated with a critical incident or traumatic event". Debriefing is an established multi-phase crisis intervention process that helps individuals to work through their thoughts, reactions and symptoms, followed by training in coping techniques. It involves a structured, time-limited discussion and explanation of the incident and its effects on individuals (Spiers, 2001:8). Debriefing gives the traumatised person the opportunity to ventilate and verbalise his or her feelings within a controlled environment. The National Trauma Committee of the South

African Police Services defines debriefing as an "emotional ventilation of feelings in a controlled and safe environment. The symptoms and feelings the person experiences are normal reactions to an abnormal situation" (1998:2). Trauma debriefing can be conducted with individuals as well as in groups. Spiers (2001:27) indicates that debriefing can include one or more persons with the purpose to review the impressions and reactions of survivors to learn about common reactions and to explore existing coping strategies. Everly and Mitchell (in Harbert, 2000:396) as well as Feuer (1999:497) are of the opinion that CISD is part of the crisis intervention model and not the model itself.

According to the researcher, debriefing is a group process (including one or more individuals) where victims have the opportunity to re-experience the traumatic event through expressing their own feelings, thoughts and reactions to fellow victims, and to get a better understanding of the whole incident by listening to others, thus finding peace in the safety of the environment and the confirmation that their feelings are normal and that others do not judge, but want to comfort and support.

3.3 GOALS OF 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 have suffered a critical incident and is done 24 to 72 hours after the incident or after they have left the scene. This time frame is essential for decreasing 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).

Feuer (1999:497) and Schulz et al. (2000:147)point out at the following goals for CISD:

- Creation of a safe harbour – to create a safe environment in which the individual or group can be supported and guided by trained debriefers and feel free to ventilate their feelings.
- To establish the principle of normality – to create a setting in which the traumatised person can realise that he/she is still "normal". The abnormality of a critical incident is often confused with the feeling of abnormality within the victim.

- Regaining control – critical incidents often makes one feel powerless and helpless and disturb a person's functioning. Debriefing provides opportunities for the traumatised person to gain control over certain aspects of his/her life and give a feeling of hope.
- Cognitive redefinition – debriefing gives the experience a cognitive structure and emotional release when reviewing it, enabling the person to distance him-/herself from the incident and redefining what has happened.
- Prevention of PTSD–debriefing is pro-active and helps to counter the development 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.

3.4 EFFECTIVENESS OF DEBRIEFING

Everly (1995:282)and Parkinson (1993:202) discuss some reasons why CISD is effective and beneficial to the traumatised client:

- It gives opportunity for early intervention and assessment of post-traumatic stress.
- It reduces any short-term or long-term distressing after-effects.
- It gives opportunity to victims to express and ventilate their emotions without fear, which is very important for the recovery from psychological trauma.

- It gives the opportunity to verbalise the trauma. It is not just ventilating emotions, but also gives the opportunity to verbally reconstruct and describe the event, thus having therapeutic value.
- It gives the victim a behavioural structure in which he/she can fit all the bits and pieces into the structure, thus helping him/her to regain equilibrium and reducing stress and despair.
- The cognitive-affective structure has a tremendous advantage to the victim, because he/she moves from the less-emotional thoughts to the emotional and then back to the less emotional. This helps the victim to relax and feel safe again after the strain of showing emotions.
- It is a group intervention and so the CISD therapist can take advantage of all the group support and the group process in helping him/her to assist in the healing process of individuals.
- Peer groups can be of tremendous help in supporting each other and is also more cost effective than seeing individuals and, therefore, beneficial to the employer.
- It gives opportunity regaining feelings of hope and control.
- It reduces the incidence of sickness and absenteeism.
- It reduces personal marital and relationship problems.
- It reduces work-related problems.
- It reduces anxieties for anyone who may feel threatened or embarrassed if he/she had to ask for help.
- It reduces anxieties about stress and traumatic reactions being thought of as a sign of weakness.

The CISD therapist has to acknowledge the needs of the trauma victim. Harbert (2000:390) stresses that trauma victims have the need to talk about what happened, how they reacted and how they left. They need to "express their fear, panic and loss within a safe environment" (Harbert 2000:400). They need to realise what has happened to them and come to terms with that. They also need to pick up where they left off and restart their lives with the social, physical and emotional resources available. Most off all, they need to be listened to with empathy. Sometimes they need an individual ear and sometimes they feel safe in their peer group and want to talk to others about the incident. According to Harbert (2000:400), emotional recovery requires that traumatised individuals be able to incorporate events into their lives and to maintain at least some perception of control.

3.5 PRINCIPLES OF TRAUMA DEBRIEFING

To maximise the effectiveness of debriefing, it is necessary that implementation of the debriefing process is structured according certain principles. The principles can be explained according to the SPIE and IMPRESS A RAVEN models, as discussed by Schulz et al. (2000:148–149).

3.5.1 SPIE

The abbreviation SPIE refers to the following principles that are important in the debriefing process:

S:Simplicity– treatment should be practical and simple.
P:Proximity – traumatised individuals should be treated in the proximity of the place where the critical incident occurred, for example if the incident occurred in the workplace, the debriefing should also take place at the workplace.
I:Immediacy– treatment takes place as soon after the critical incident as possible, preferably between 24 and 72 hours after the incident.
E: Expectancy – debriefing should encourage the expectation of resuming normal duties as soon as possible.

3.5.2 IMPRESS A RAVEN

The principles of trauma management below are especially used by emergency services. The principles are abbreviated as "impress a raven".

IMPRESS

I:Immediacy– physical and psychological needs should be identified and dealt with as soon as possible after the incident in order to prevent the traumatic incident to get worse.
M:Maintain milieu – people involved in the critical incident should remain in their normal environment and not be handled as patients. The defusing process should take place as close as possible to the traumatic scene. The person must continue with his/her normal activities as soon as possible.
P: **Proximity** – the traumatised person should be given support as close as possible to the scene and within the reach of his/her support system.

R: **Rest and replenishment** – a period of rest and opportunity to replenish the internal resources (psychological and physical) must be given. The traumatised person can be offered food, something to drink; clothes (if necessary) and a place to rest.

E: **Expectancy** – the expectation that a person must resume his/her normal functioning as soon as possible should be emphasised. The fact that the traumatised person is a survivor and not a patient should also be emphasised.

S: Simplicity – treatment must be practical and simple and must be accompanied by extensive diagnostic and remedial techniques. Intervention where the traumatised person gets the opportunity to ventilate and talk about the incident and his/her actions should be available.

S: Supervision – the individual's condition and adaptation must constantly be monitored by professional health workers and management. Family and friends should also receive the necessary information on symptoms and behaviour in order to be aware of the person's adaptation.

A

A: Activity – the person should be mobilised to continue with normal functioning and activities. The person should also remain involved in therapeutic activities. The emphasis on the continuation of normal activities shows that the traumatised person is not a "sick" person.

RAVEN

The following principles should be applied during the debriefing process.

R: Reaction – the traumatised person must realise that he/she can expect certain symptoms as a reaction to the critical incident. These symptoms are normal under abnormal circumstances. The experiencing of symptoms is not a permanent mental dysfunction.

A: Awareness – the traumatised person must constantly be made aware of his/her feelings, actions and thoughts regarding the critical incident.

V: Ventilation – the traumatised person must be encouraged to talk about his/her emotions and thoughts concerning the incident to a professional person, friends and family.

E: Encouragement – the traumatised person should be encouraged to unload emotionally towards friends and family members and during the debriefing process. He/she must also be encouraged to work as soon as possible.

N: Normal behaviour – the normality concept should be emphasised. The traumatised person should be reminded that the symptoms he/she experiences are normal under abnormal circumstances.

Applying these principles before and during the debriefing process helps the debriefer to maximise the effectiveness of the debriefing process so that the individual can benefit as much as possible and return to his/her normal functioning as soon as possible.

3.6 TRAUMA DEFUSING

Defusing is a short version of the debriefing process and is usually performed within a few hours of the critical incident. The goal of defusing is to defuse 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, du Toit & du Toit., 2003:108), there is a vast 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 focus of trauma defusing differs from trauma debriefing, and requires different skills and techniques.

The process of defusing creates support mechanism 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).

3.6.1 Aims of defusing

Roos *et al.* (2003:109–111) and Schulz et al. (2000:151) discuss the aims of defusing as follows:

- **To ensure the safety of the victims of the trauma**
  The first priority is to ensure that victims are safe and to minimise the risk of further traumatisation. This may necessitate those victims to be removed from the specific scene but not the general scene. The assistance of the emergency services may be called in to help secure safety.

- **Gaining the confidence of the victims**

  The trauma diffuser only has a few moments to gain the confidence of the trauma victim. The moment the trauma diffuser arrives at the scene, he/she enters the personal lives and privacy of the victims. The way in which the trauma diffuser approaches the victim already establishes a relationship and the attitude of the trauma diffuser should reflect calmness, confidence, empathy and respect. Before the trauma diffuser approaches the victim/victims, he/she should try to get the names and as much information regarding the victims from the emergency services or other relevant people.

- **Calm the victims**

  Trauma scenes are usually characterised by extreme emotions. The trauma diffuser has to be prepared for reactions ranging from fierce and uncontrolled anger, hysteria, apathy or total denial. These reactions are normal and can be expected under the circumstances. The diffuser should feel comfortable with these emotions and should not panic. He/she should stay calm and reassuring and should not take anger or refusal to talk personally.

- **Establish what happened**

  After the trauma diffuser introduced him-/herself and calmed the victims to the extent that they can talk, the diffuser can request the victim to tell what happened. Usually at this stage the victims are eager to tell their story. This gives the trauma diffuser the opportunity to gather information in order to make a decision on how to handle the situation. The sharing of information also provides the trauma victim with the opportunity to ventilate his/her feelings.

- **Provide emotional support**

  The trauma diffuser should not only provide emotional support to victims, but also to family members, friends or colleagues who came to the trauma scene to support the victim. It is important to assist victims to establish contact with their support systems. Family members, friends and colleagues may become concerned if they see the reactions of the victims. The trauma diffuser should comfort them and inform them about the possible reactions and further intervention.

- **Provide practical assistance for physical needs**

  The trauma diffuser can help to provide practical assistance for physical needs, for example make phone calls, arrange for tea, offering a blanket/jacket to regulate temperature while their bodies are in shock and alert doctors/medical personnel if a victim needs assistance. When members of the victim's support system arrive, they normally take over the function of practical assistance.

- **Assist victims in regaining control and routine**

  Trauma victims normally feel that they are helpless bystanders while their lives fall apart as a result of the critical incident. The trauma diffuser should assist them to regain same control. This is achieved by giving the victim practical things to do. They can be given small tasks to do, for example request an emotional upset wife to pack a bag for her husband who has to be transported to hospital, or a person to hold the drip while the trauma team is helping his/her loved one. This makes the victims feel less helpless as they feel that at least they are of some assistance.

- **Protect victims against secondary traumatisation**

  The trauma diffuser often has to deal with bystanders at the scene who fulfil absolutely no function but who can be the cause of secondary trauma for the victim. The diffuser can assist to ensure the victim's privacy and make way for emergency workers, family and close friends.

- **Provide clear information about the process**

  An important function of the trauma diffuser is to provide clear information to victims about the process that will follow. Victims of a critical incident experience severe emotional confusion and rarely absorb information given to them. It is, therefore, a sensible idea to identify a family member or a friend who seems to be calm enough to absorb the information given to him/her and to explain everything in detail. The trauma diffuser should provide victims with telephone numbers and details of the trauma debriefing session.

3.6.2 Format of the defusing session

Schulz *et al.* (2000:154) provide a format as a guideline in which the defusing session can be conducted. This format gives more structure to the process and achieves the aims as discussed.

Step 1: Establish common ground

The trauma defuser should get the victim on his/her own, start by introducing him/herself, win the victim's confidence and show that he/she cares.

Step 2: Establish the facts

Ask victims what happened, focus on the facts and not the emotional responses to what happened.

Step 3: Talk about the feelings

Allow victims to express their feelings. The trauma diffuser should use his/her listening skills and show empathy. Focus on how the victim is feeling and nod after hearing the story.

Step 4: Give the victim a future

The trauma diffuser must assist the victim to secure his/her immediate future by establishing what immediate plans he/she has from here onwards. It is important to establish if there is someone that the victim can talk to and confide in when necessary.

Step 5: Checking and closing

Determine what methods the victim intends using to handle his/her situation, mobilise the victim to make contact if he/she feels the need for it and provide him/her with contact details.

The function of trauma defusing is to stabilise the person shortly after the critical incident and to prevent the victim from "bleeding emotionally to death" until the time that a proper debriefing session can be conducted. According to Meichenbaum (1994:183), trauma defusing is a shorter version of trauma debriefing. A trauma defusing session usually lasts less than an hour, compared to the two to three hours of a debriefing session. This implies that to a certain extent the phases of trauma defusing may overlap with those of trauma debriefing.

3.7 CONCLUSION

Chapter 3 explores the concept of a critical incident stress management. The introduction of this chapter gives some background on CISD. This is followed by defining the terms CISD.

The goals and effectiveness of CISD is discussed and the principles of CISD are explained. Trauma defusing as a critical incident stress management intervention is discussed. Some attention is given to the aims of trauma defusing and the format of a defusing session.

Chapter 4
Models in Critical Incident Stress Debriefing

4.1 INTRODUCTION

Different models in critical incident stress debriefing exist and it is evident that therapist uses different models in treating clients exposed to critical incidents. In this chapter different models in critical stress debriefing is discussed in order to provide some insight on the different models, how they work and what are their similarities and differences.

At the Careways group, therapists are encouraged to work according to the Solution Focussed Brief Therapy model in order to ensure that therapeutic goals are reached within a short space of time. Most of these models however have similarities and stem from the original model developed by Jeffrey T. Mitchell.

4.2 MITCHELL'S DEBRIEFING PROCESS

CISD is a specific model of group debriefing which can be used to accelerate recovery from traumatic workplace events. This specific model of psychological group debriefing was developed by Dr Jefferey T Mitchell in the late 1970s. It is a standardised 7-stage model that can be divided into a four-phase debriefing process (Sacks, Clements & Fay-Hillier, 2001:134). According to Roos *et al.* (2003:97), Mitchell divides the debriefing process into four phases:

- Phases 1 – On or near the trauma scene debriefing (defusing)
- Phases 2 – Initial debriefing
- Phases 3 – Formal CISD model
- Phases 4 – Follow up CISD

4.2.1 Phase 1: Defusing

Plaggemars (2000:85) mentions that the process and application of the defusing process are more immediate (often immediately or within the first 24 hours) and less intense due to a

shorter reaction in the reaction phase. The focus of this phase is to give informal debriefing to the people involved in a critical incident or those who witnessed the critical incident. People are given the opportunity to ventilate their emotions and the trauma diffuser should be aware of any acute stress reactions. The main objective of the defusing process is to give support on the scene and to protect survivors from secondary trauma (media, inquisitive people, etc) (Roos *et al.,* 2003:97).

4.2.2 Phase 2: Initial debriefing

According to Roos *et al.* (2003:97), this phase usually starts a few hours after the critical incident and refers to the ventilation of emotions in a natural way. This is a process where survivors discuss the critical incident and emotions resulting from the incident within their support systems.

4.2.3 Phase 3: Formal CISD

The formal CISD process, according to Plaggemars (2000:82), is a group process that which employs early intervention, brief treatment, task-centred and problem-solving techniques, which allow for catharsis around having experienced a critical incident. Additionally debriefing provides:

- Education about stress reactions
- Emotional ventilation
- The promotion of cognitive organisation through a 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 process
- Preparation for experiences such as symptoms or reactions that may arise
- Screening for people who need additional support
- Maintenance of employee health and welfare.

Roos *et al.* (2003:97) indicate that the debriefing session is conducted by a trained debriefer and sometimes also with the help of a co-trauma worker. The session preferably takes place

between 24 and 72 hours after the critical incident. In using CISD as a technique, the trauma debriefer goes through seven stages with the victims. The stages consist of an introduction, followed by the fact phase; the thought stage, the reaction stage, the symptom stage, the teaching stage and lastly the re-entry stage.

4.2.3.1 Introductory stage

According to Everly (1995:280),Feuer (1999:500) and Harbert (2000:400), this stage is the starting point of the CISD and begins with an introduction of the CISD team, explanation of the purpose, process and rules, motivation of participants to participate, establishment of confidentiality and selection of leaders. It is important to give feedback on the condition of hospitalised employees as soon possible in the session. Then it is important to establish ground rules such as:

- Everyone should turn off their pagers, cell phones, radios and distracting devices.
- Group members are reassured that they do not have to say anything but are encouraged to state their name and connection with the incident.
- Strict confidentiality is emphasised; generally speaking, whatever is stated in the room should stay in the room. If information is to be taken from the meeting, then participants need to be reassured that it will be handled sensitively and not attributable to individual group members.
- Group members should speak only for themselves.
- The debriefing is not a critique or a tribunal; nor is it a procedural debriefing.
- Group members are warned that they may feel worse during the session and for a while afterwards, as they may be getting in touch with painful thoughts and feelings.
- Participants are advised that the group may proceed without breaks, so they should use ablution facilities if needed. However, a five-minute break may be called by the debriefing team.
- Group members are reminded that they can leave the group if they become too distressed but are encouraged to come back if possible.
- Participants are then given a brief outline of the structure of the meeting and given the opportunity to ask questions.
- Participants are told that one-to-one sessions will be available for everyone after the group session. The sessions will not last more than half an hour. Attendance is not compulsory.

Furthermore Plaggermars (2000:84) emphasises that participants should be informed that debriefing is not a logistical analysis of the event. A supportive non-judgemental tone should be established to reduce resistance and anxiety, and to encourage mutuality among participants.

4.2.3.2 Fact stage

During this phase the participants are encouraged to describe the event from their point of view–what they were doing when it happened, where they were and what they think happened. When giving facts, they talk about things outside themselves and, therefore, it is impersonal. It is important for the debriefer to encourage everyone to talk, but to ensure them that if they do not want to talk, it is in order. Some will benefit just by listening to their peers. In the conversations, the debriefer needs to look at body language and other signs of distress such as squirming, eyes down, tears welling up, crying, clenched hands or increased agitation. If a participant starts to express emotions while stating the facts, it is a sign of distress (Evenly, 1995:280; Feuer, 1999:501; Harbert, 2000:401–402). Schulz *et al*., (2000:161) state that the debriefer should ask brief factual cross questions with the aim of establishing an accurate picture of the sequence of the events. Debriefers are interested in eliciting as much contextual information as possible, including sensory information regarding the incident such as what individuals saw, heard, smelled, touched and tasted. Getting people to identify the above can help them to become aware of possible triggers that might precipitate flashbacks. This can reduce anxiety that accompanies "reliving" episodes. According to Plaggemars (2000:84), through the discussion of facts, a collective realistic picture of the event is erected. Since facts are objective by nature, they are the easiest to discuss. This ideally facilitates a subsequent transmission to a more emotional response.

4.2.3.3 Thought stage

After everybody has had a chance to "paint the picture" from his/her angle or experience, the debriefer can ask a question concerning their thoughts once they have realised what is happening to them. This is a transition phase from the factual world outside themselves to a closer look at their own experiences, but still without the necessity of showing their emotions. The debriefer must be very alert for participants' reactions during this stage. They may show anger towards themselves or other group members. (Everly, 1995:280;Feuer, 1999:501; Harbert, 2000:402)

During this stage, the debriefing focuses on the thought processes and decision making. Participants are asked to describe their first or most prominent thought during the incident. The thought stage represents a transition from the cognitive domain to the affective domain, thus preparing the participants for a more personalised response (Plaggemars, 2000:84).

4.2.3.4 Reaction stage

This can be the most difficult and longest part of the debriefing process as individuals identify the most traumatic aspect of the event. Plaggemars (2000:84) describes this stage as the most powerful, seeing that participants are asked to recall the worst or most difficult part of the incident.

This stage is the most important stage for it gives opportunity to open their deepest emotions and ventilate. It is important to give those who feel the need to speak the opportunity to speak freely. Questions that can be asked are the following: "What was the worst thing about the incident for you personally?" and "If you could erase one part of the event, what would it be?" This stage is also the longest (it can last up to 40 minutes), because emotions will flow freely and the debriefer will use his/her therapeutic skills to listen, give empathy and let them feel safe in having these feelings (Everly, 1995:280; Feuer, 1999:502;Harbert, 2000:402)

As emotional responses can be strong, the debriefer's approach is to contain emotions sensitively and quickly and not to use the group format for therapeutic and cathartic purposes. Some emotional release is helpful at this stage, as is the sharing of feelings between other group members. According to Plaggemars (2000:84), the thought and reaction phase bind together. By gradually putting words to what was most difficult to them, individuals begin to expose content that, if not dealt with, in all likelihood can be problematic in the future.

Schulz et al. (2000:156) mention that an individual's emotions shown in this stage should only be explored in a one-to-one session following the group process. It is during this process that debriefers are likely to recognise those who by their reactions, or lack of them, need to be invited to have a one-to-one follow-up session.

4.2.3.5 Symptom stage

When the participants become quiet, it is time to move on to the symptom stage which is yet another transitional stage – this time back to cognitive discussion. This stage redirects

participants to consider the physical, emotional and behavioural symptoms they have experienced (Plaggemars, 2000:85). The thoughts of the participants must be restored to a level where they can relax and resume their normal responsibilities and life. The debriefer focuses the participants' thoughts on their cognitive, physical, emotional and behavioural experiences that may have occurred since the incident. Sometimes participants are unwilling to share these experiences because they think they would be the only ones "thinking crazy thoughts or experiencing a physical reaction". In this stage any signs of suffering and pain that may be early signs of post-traumatic stress are identified (Everly, 1995:281;Feuer, 1999:502; Harbert, 2000:403). Spiers (2001:38) mentions that at this stage many of the symptoms of the PTSD (intrusion, avoidance and increased arousal) may be elicited. Plaggemars (2000:84–85) mentions that the debriefer may stimulate the process by mentioning common stress-related symptoms which participants may have experienced after the critical incident. By discussing these symptoms they may be normalised, which may serve to reduce their frequency and intensity.

4.2.3.6 Teaching stage

This stage puts the participants at ease by normalising and demystifying the incident. It focuses on stress management, coping skills and education that can be used to minimise possible future stress. It is very important for the participants to know that their reactions are normal in the circumstances. Furthermore, the debriefer informs them of symptoms of distress. It is essential to educate the group regarding diet, exercise, rest, talking to important people and each other, supporting each other and avoiding alcohol and caffeine. The reason for giving so much information is to help the individual who is prone to post-traumatic stress realise it and to affirm assistance when help is needed. It is also recommended to let them now share something less painful and acknowledge them for the way they handled themselves during the impact of the incident (Everly, 1995:281; Feuer, 1999:503;Harbert, 2000:404).

Spiers (2001:43)mentions that it is important to highlight the fact that people can cope with a great deal of adversity. Most reactions are normal or typical following such an incident but usually decrease with time.

Plaggemars (2000:85) mentions that information given in the teaching stage engenders a sense of self-control and encourages on going self-awareness and self-assessment during recovery.

Schulz et al. (2000:193) mention that it is helpful to give participants guidelines to assess themselves. Useful guidelines might be to monitor behaviour in terms of:

- If symptoms do not decrease after six weeks
- If symptoms increase over time
- If functioning at home or at work is significantly impaired.

If any of the abovementioned becomes apparent, the participant should seek professional assistance.

4.2.3.7 Re-entry stage

This is the final stage in the CISD process where a summary is made by the debriefer who discusses everything that happened, giving his/her thoughts on how they experienced and observed the CISD process. This is the time of showing respect, encouragement, appreciation, support and final direction. Suggestions of simple tasks to help participants to feel in control again and encourage them to reach out for help from family, friends, co-workers and the EAP. The debriefer should guide them to think about something positive that has come out of the incident and let them know that treatment resources are available (Everly,1995:281; Feuer, 1999:503;Harbert,2000:404).

This last stage provides the opportunity for the group to ask questions or review material presented during the debriefing. It is also the last opportunity within the group setting for participants to bring up new information they would like to discuss before the group adjourns. The debriefer should try to summarise, encourage the use of techniques and strategies, and offer further assistance where appropriate and, to round up the discussion and to tie up loose ends.

Plaggemars (2000:85) suggests that at this point issues for further assistance should be identified. He further mentions that follow-up activities must be identified by the debriefer. This usually entails post-debriefing feedback. Post-debriefing feedback should be solicited

from those who requested the debriefing, usually managers or supervisors. Specific recommendations, for example individual consultation or referrals for counselling, can be made as part of the post-debriefing feedback. Finally, post-debriefing meetings are held. This is referred to as debriefing the debriefers. Debriefers usually benefit from revisiting their responses in the meeting and learning from feedback and suggestions.

4.2.4 Phase 4: Follow-up CISD/ Trauma aftercare model

Debriefing contains elements of normalisation, promotion of support, encouragement of normal processing of the event as well as exposure through recounting facts and exploiting feelings. The trauma aftercare model is a model for intervention after the CISD for those individuals who need further assistance.

The debriefer needs to have knowledge of the normal responses to critical incidents. McWhirter and Linzer (1994:405) list a few symptoms: tearfulness, shakiness, nightmares, insomnia, irritability, isolation, panic, headaches and gastrointestinal upset. Emotional reactions such as depression, anger, apathy and extreme fear often arise within victims and need to be acknowledged by the debriefer.

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, 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.

Spiers (2001:101) discusses a trauma aftercare model that is an integrative model in that it is not based solely on one theoretical approach. The model involves searching for therapeutic explanation, but will not necessarily involve retelling of the story of what has happened to the client. The trauma aftercare model owes a great deal to Herman's three stage model. Although this model was designed to work with complex PTSD, the stages are crucial to all trauma counselling. The stages Herman outlines are safety, remembrance, mourning and reconnection. Recovery can only take place within a context of an empowering relationship that enables the necessary work to take place. The task of establishing safety (both mental and physical) is primary and must be achieved before any therapeutic work can be done. Telling the story is seen as essential for integration of the experience, although the need to balance this with safety is stressed. Mourning the losses resulting from the trauma, whatever they may be, is seen as a essential part of reconstruction. The final stage is reconnecting with other people and with the world (Herman, 1992:104–109).

The trauma aftercare model takes into account people's different reactions to trauma and offers ways of working with all of them within the same framework. The framework for the model is outlined within four sessions; however it acknowledges that, depending on the individual’s needs, more or less sessions may be required.

4.2.4.1 Session 1: Making contact

In the first session of the trauma-aftercare model it is important to create a working alliance with client, wherein the client feels safe. It is important that the therapist lays down boundaries and clarifies what happens during the session, stresses confidentiality, sets rules and discusses future options. The therapist's attitude should be holistic, positive, mindful, empathic, congruent, supportive and respectful.

An early task of the session is to normalise the client's reaction to the critical incident and the symptoms he/she is experiencing. Clients get anxious about the fact that they are experiencing symptoms that are distressing and that they do not understand, thus exacerbating the problem. Usually clients are reassured that their experience is entirely normal. Although giving advice is something therapists should be cautious about, it is essential in trauma counselling. As early as in the first session, clients should be advised on how to manage their symptoms effectively, for example on stress reduction techniques.

It is also important to start exposing the client to the traumatic event in the first session, if the client feels ready. The client should be encouraged to express his/her feelings and the client's strengths should be emphasised.

After the first session it might be helpful consolidating the initial assessment and to analyse the process. It is important for the therapist to reflect on his/her sense of what is going on with the client, the therapist's understanding of the symptoms and the therapist's own reaction to the client. The therapist should consolidate relevant history in terms of previous traumas, repeating patterns, coping strategies and shattered beliefs (Herman, 1992:104–109).

It is important not to make any assumptions about any of the above but to be curious about the possibilities and bear them in mind as the therapist proceeds.

4.2.4.2 Session 2: Assessment and the way forward

The second time the therapist and the client meet, the therapist will probably find that he/she has developed a real sense of the nature and the severity of the client's reaction. The therapist may also begin to get a sense of the client's character style and coping strategies, and how effective these are. During this session the therapist assesses the client's progress in terms of the symptoms and decides together with the client on a way forward. The following scenario may be present:

- The client has made a dramatic recovery, symptoms are greatly reduced and there has been a cognitive shift.
- The client has moved forward a bit, but more help is needed. A short-term stress reaction seems likely.
- A strong reaction is evident, intensive support is required.
- Trauma is not an issue.

The therapist should work within a person-centred framework in this session and be guided by the client. If the client is comfortable with talking about what happened, the therapist should explore the thoughts and feelings the client has experienced since the previous session. When the client tells the story, the therapist should observe the client's tone of voice, body language, level of arousal when he/she talks, physical reactions and emotionality.

The therapist may become more aware of coping strategies used subconsciously by the client to deal with the difficult and painful reality. Some clients may withdraw from the world around them, others may suppress their emotions, and others may throw themselves into an all-consuming activity. Clients who appear to be experiencing strong post-traumatic reactions may separate or dissociate from their experience. The opposite of dissociation is hyper-arousal where the client is unable to modulate, let alone "cut-off" from his/her feelings. Clients are overwhelmed by grief, anxiety, fear or terror. Many clients may be confused at this stage, trying to make sense of what has happened to them. The therapist should use continuing normalisation and education as a technique to help the client in a state of confusion. The therapist must identify coping strategies and explain them to the client in order to develop insight. Effective coping strategies in dealing with trauma usually involve strategies facing rather than avoiding pain, for example dealing with emotions and fears, and ventilating emotions. The therapist can help the client to identify more effective coping strategies. If it seems that trauma is not an issue, the therapist can prepare the client for termination in the following session. When the client is still distressed in any way, the next session is used for resourcing and moving forward (Herman, 1992:104–109).

4.2.4.3 Session 3: Resourcing and moving forward

In this session it might be useful to reflect on the client's experience of the counselling process and whether there has been any change since it started. In this session, the therapist should detect which way the process is going. There are three possible ways forward, emerging from the previous session:

- Client is moving forward very rapidly. A client whose symptoms have largely disappeared will be working towards ending the process. The client may be reflecting on his/her learning from the experience, together with finding ways of integrating it and moving forward.
- Client is still working through his/her reaction but still need more help. Therapy can be focused on helping the client to find meaning in what has happened, and to build his/her beliefs about him-/herself and the world.
- Client appears to be developing PTSD. This is a point where the client and the therapist should consider how the client's needs can best be met in the longer term. Factors such as single or multiple trauma, psychiatric history, substance abuse history, fragility, ego strength and co-morbidity should be considered.

A decision based on the abovementioned information should be made in terms of long-term therapy or short-term focused work. If the decision is made that an appropriate referral should be made to best meet the needs of the client, the client should be prepared for this. If it is likely that the client is at risk of developing PTSD, the process should continue and the client should be prepared for it. If the risk is low, the client can be prepared for closure in the next session (Herman, 1992:104–109).

4.2.4.4 Session 4: Ending or preparation for PTSD intervention

If the client experienced a short-term reaction that has eased, the therapeutic process can end. The client and the therapist can review learning from the incident and the reaction. Ongoing support and re-sourcing for the client can be explored.

A client still experiencing post-traumatic stress symptoms more than a month after the incident will probably need additional intervention to resolve them. It is useful to continue to reassure your client that PTSD is a normal response and help is available. The therapist can give more information about PTSD and can explore if another issue is preventing recovery. The client's perception of what is happening and his/her thoughts on progress need to be explored. The client and the therapist should discuss ongoing intervention. If PTSD symptoms subside, intervention can be terminated in the following sessions. If the client continues to be distressed and PTSD symptoms prevail, the client should be referred for alternative therapy, for example, trauma incident reduction (TIR).

The trauma aftercare model presented by Spiers (2001:101–120) is a model of ongoing care after the CISD. This model focuses on clients who are distressed after the CISD or indicate that they need further support. It is a short-term model focused on the needs of the client, and the process can be terminated as soon as the client's symptoms have eased. The process is focused on supporting the client and helping the client to understand and to integrate what has happened to him/her (Herman, 1992:104–109).

4.3 BRIEF THERAPY

Both among professionals and clients there is a vast amount of confusion about exactly what the term "brief therapy" refers to. The term suggests that it is distinguished from other types of therapy which is not brief, for example long-term therapy. For some, brief therapy refers to

a maximum of 10 sessions for others it is up to 25 sessions. In a study by Weakland at the Brief Family Therapy Centre (De Shazer, 1985:4), it is reported that 72% of the cases either met their goal for treatment or made significant improvement within an average of seven sessions.

Brief therapy (Logan, 1996:30) is defined by its time limited nature, from as few as five sessions to as many as ten sessions: "Brief therapy uses active therapist and client cooperation to define and carry out goals, monitor progress and praise accomplishments. Its techniques emphasize solutions rather than symptoms, strengths over pathology and behavioural or action-orientated goals rather than insight into problems". Logan (1996:30) conducted a study to measure client satisfaction with brief therapy offered through an EAP. Results from this study indicate that clients experience brief therapy quite favourably. Based on an analysis of client satisfaction questionnaires, clients indicate their satisfaction with brief therapy at 28,92 out of a possible 32. Ryan (1994:5) defines brief therapy as a group of therapeutic interventions aimed at solving a client's problem in the shortest possible period of time.

In the Careways group where the research was conducted, the preferred model for intervention is the brief therapy model, as this model is focused on reaching identified therapeutic goals within a limited amount of sessions. These characteristics make this model cost and time effective, benefitting both the employee and the company.

4.3.1 Brief therapy and the characteristics of brief therapy

Owing to the need for cost containment, time constraints and the growing need for psychotherapeutic services, short-term therapies have been among the most rapidly expanding areas of growth within psychotherapy and counselling. According to Franklin (2003:198), there are different approaches that use a variety of theoretical orientations none of which automatically lead to a reduction in the number of sessions.

Brief therapy acquires skills to work with clients on a time-limited basis. According to Franklin (2003:199) this will require the therapist to contract very clearly with the client, to use focal techniques that will help the client to stay with central issues and to be realistic about what can actually be achieved in the given time.

According to Franklin (2003:200), there is a misconception that there is one particular theoretical approach to brief therapy. She suggests that there are three main differences that distinguish brief therapies from other therapies, namely:

- They have a limited aim which the patient is made to understand from the beginning
- The number of sessions is limited
- The techniques used are "focal".

Loar (1999:513) supports this view and states that brief therapy has three primary factors that make it unique. "The first is the setting: therapy is intended to be short and in some cases the termination date may also be precisely defined. The two other aspects have to do with the therapeutic stance: therapeutic focus and the professional's activity in maintaining the focus." This implies that the therapist is responsible for keeping in mind the aim and focus, and bringing the focus back to the presenting problem.

Brief therapy aims to stimulate, guide and strengthen the client's problem-solving efforts; the task-centred model requires that the targeted problems are alleviated through the client's own actions (Reid, 1989:72). Although there is no set rule to the time frame in which brief therapy should be concluded, Gingerich and Eisengart (2000:478) are of the opinion that brief therapy normally lasts less than six sessions.

Butcherana and Koss (in Franklin, 2003:199) report that structured time-limited interventions can be as effective as less structured, open-ended interventions. They outline common characteristics across brief therapy approaches:

- Limitation of therapeutic goals
- Directive management of session by the therapist – therapist is active
- Centering the therapeutic content in the present
- Rapid early assessment
- Promptness of intervention
- Flexibility on the part of the therapist
- Ventilation or catharsis as an important element of the process
- A quickly established interpersonal relationship to obtain therapeutic leverage
- Appropriate selection of clients, since not all clients can profit from a brief therapeutic contact

- Therapeutic management of limitations.

4.3.2 Solution focused brief therapy (SFBT)

Solution focused brief therapy (SFBT) is an approach that lends itself perfectly to time-limited therapy. It incorporates the techniques based on the principles of systemic family therapy. The key characteristic of SFBT is that the primary focus is on the development of solutions rather than the exploration of problems (Franklin, 2003:201). According to Gingerich and Eisengart (2000:478), this therapeutic intervention is primarily focused on creating solutions instead of resolving problems. The main therapeutic task for the therapist is to help the client imagine how he/she would like things to be differently and what it will take to make it happen. Miller (1997:21) states that SFBT enables clients to "assume that their lives will get better and provides them with interpretive 'lenses' for seeing their lives in new ways".

In SFBT, contracting is freer and less formalised, and there is less emphasis on exploration, history taking and understanding. In the solution focused interview there is minimal focus on problems and problem-free and solution talk is encourage where possible. The therapist uses techniques such as the "miracle question", "problem-free talk" and exception finding to describe systematic goal setting and action planning, which are normally used in cognitive and behavioural therapy (Franklin, 2003:201).

According to De Shazer (1991:54), SFBT assumes that the solution lies in the changing interactions in the context of the unique constraints of the situation. It is believed that new meanings can be created for at least some aspect of the presenting problem. The SFBT approach, according to Stalker, Levene and Coady (1999:469), focuses on the symptom or problem and aims to help the client to set up some conditions that allow for the spontaneous achievement of the stated goal. Setting a concrete goal elicits the expectation of change, and provides criteria for success. Seeing that a lot of emphasis is placed on goal setting, specific techniques for identifying concrete goals and to de-emphasise the problem have been developed. These questions (called miracle questions) may include: "How will you know that the problem is solved?", "What will be different when the problem is solved?", "How will others know that the problem has been solved?" Behaviourally, specified answers to these forms of the "miracle questions" become the goal of SFBT. Stalker *et al.* (1999:469***)*** mention

that in SFBT gathering information about the past is seen as problem talk and is limited in order to minimise pre-set ideas.

SFBT assumes further that clients have the necessary resources to change. "Every client carries the key to the solution: The therapist needs to know where to look" (De Shazer, 1986:95).

In SFBT the therapist develops compliments or "clues". Stalker *et al.* (1999:470) mention that those compliments are statements based on what the client is already doing well and has achieved. The compliments are aimed at encouraging the client to strengthen positive behaviour, and to normalise personal difficulties. Clients are encouraged to perceive that the therapist is on "their side", improving the client's willingness to accept "clues" about possible solutions. Dryden (1995:3) states that the client undergoing SFBT should be able and willing to present his/her problems in a specific form and set goals that are concrete and achievable. He further highlights the inter-active role of the client in the therapeutic process; through empowerment in the therapeutic process the clients takes responsibility for resolving his/her own problem. De Shazer (1991:57) mentions that SFBT is seen as a "mutual endeavour involving therapist and client together constructing a mutually agreed upon goal".

4.3.2.1 SFBT versus long-term therapies

Neff, Lambert, Lunnen, Budman and Levenson (1996:71) distinguish between the ideologies of long-term and short-term therapeutic approaches.

Table 3: SFBT versus long-term therapy

Long-term ideology	Short-term ideology
1.Seeks change in basic character.	1.Prefers pragmatism and does not belief in the notion of "cure"
2. Believes that significant psychological change is unlikely in everyday life.	2. Maintains perspective from which psycho-logical change is viewed as inevitable.
3. Sees presenting problem as reflecting more basic pathology.	3. Emphasises patients' strengths and resources; presenting problems are taken seriously.
4. Wants to be there when client makes significant changes.	4. Accepts that many changes occur after therapy.
5. Sees therapy as having "timeless" quality.	5. Does not accept the timelessness of some models of therapy.
6. Unconsciously recognizes the fiscal convenience of maintaining long term client.	6. Fiscal issues often muted either by the nature of the organisation of the therapist practice or by the organisational structure of reimbursement.
7.Views psychotherapy as almost always benign and useful.	7. Views psychotherapy as being sometimes useful and sometimes harmful.
8.Seeing clients being in therapy as the most important part of their lives.	8. Sees being in the world as more important than being in therapy.

Whether planned short-term interventions offer a more effective practice strategy than less structured, open-ended approaches to intervention in part depends on the nature of the problems and objectives of the intervention. Ideally the appropriate method will depend on the nature of the client's particular problem and the therapist's assessment. There are, however, external influences (e.g. time, money, resources) that in reality mean that the therapist has less choice than he/she wishes.

According to Franklin (2003:202), SFBT should not be seen as an expedient counselling approach but used skilfully where and when appropriate. It is not suitable for all situations. If the approach is inappropriate, a client's mental state can be further "damaged". Sensitivity is required to determine if a client's problem would be more appropriately addressed in a long-

term approach intervention. The importance of skilled assessment in the first session is emphasised. If the case material is not suitable for SFBT, then the therapist should be clear from the start why he/she may not be able to take the case.

4.3.2.2 Strengths and weaknesses of SFBT

According to Wells and Phelps (1989:21), one of the strengths of SFBT is that it can be applied to a broad range of problems over a large range of the workforce. It effectively deals with problems such as depression, anxiety, low self-esteem, difficulties in relations and sexual problems. Gingerich and Eisengart (2000:477–492) refers to well controlled studies where SFBT proved to be effective in the management of depression, the teaching of parental skills, emotional assistance in the rehabilitation of orthopaedic patients, reducing recidivism in a prison population, anti-social behaviour in adolescents and couples therapy.

Anderson-Klontz, Dayton and Anderson-Klontz (1999:114) mention that SFBT is a model that can be effective in many different contexts with diverse populations and can be integrated with other therapeutic traditions such as experiential family therapy. The SFBT model is time limited and focused; the client is helped by the therapist to achieve maximum benefit from the therapeutic session in the minimum time. Gingerich and Eisengart (2000:477) mention that more companies and government sectors started to embrace SFBT because it is short term and relatively inexpensive with successful outcomes and a high client satisfaction rate. Anderson-Klontz *et al.* (1999:115) state that SFBT provides a solid framework in which the client can reach achievable goals within a limited time period. They further state that SFBT focuses on the positives, solutions and goals. Change is facilitated in the right direction if the client is focused on the positive, the solution and the future. Franklin (2003:200) mentions that there can be several advantages using a time-limited counselling approach. Some clients may find the conscious understanding that therapy will be short term reduces their anxieties in terms of potential dependency, thus enabling them to enter the therapeutic process. Clients may also feel more in control because they know exactly how long the counselling will last and this can assist them to focus on their chosen goals. Where the client's motivation or ability for change is minimal, it becomes apparent to the therapist quite quickly and it can be helpful in managing case loads and appropriating time constructively. Stalker *et al*. (1999:473) mention that SFBT puts more emphasis on the strengths of the client and the importance of collaboration. These authors, however, mention that although SFBT can be very effective and make therapeutic services more accessible, the SFBT model cannot take

all the credit. The SFBT is based on a variety of models and uses the strengths of a variety of therapeutic models, for example cognitive therapy, psycho-dynamic therapy and strategic therapy.

This model has successfully identified techniques and strategies that are affective in a time-limited space. Although there are many advantages of SFBT there are also some disadvantages. The SFBT model is not effective in treating all kinds of problems. Stalker *et al.* (1999:473) mention that studies have shown that SFBT is less effective than longer-term therapies with regard to clients with severe problems.

This challenges SFBT precepts that the therapist does not need to know anything about how the problem developed, that the client story does not need to be heard and that the most difficult problem, for example trauma or abuse, can be overcame quickly. A major concern about SFBT is the neglect of client history and broader assessment (Stalker *et al*.,1999:474).

SFBT does not allow opportunity for a therapeutic relationship between the therapist and the client due to time limitations. The fact that time is limited, as well as the lack of emphasis on a therapeutic relationship, limits the opportunity of the client telling his/her painful story. The limited client catharsis can be viewed as one of the major weaknesses of the SFBT model. Moreover, Falker (2003:200) mentions that some clients may experience time-limited counselling as frustrating and disappointing. Having had access to a therapeutic process, the client becomes more aware of related connections to their presenting situation, only to find that opportunities to work through and to resolve those issues are limited. The client may also experience referral for long-term therapy as negative due to the fact that he/she started to trust and open up towards the therapist.

In the field of EAP and the constantly increased demands for therapeutic intervention, the SFBT, in spite of the criticism, plays a valuable role. The SFBT model, with general emphasis on collaboration and client strength as well as the many techniques to facilitate the development of solutions, has clear utility in the field of therapy.

4.4 TRAUMA INCIDENT REDUCTION (TIR)

The therapeutic goal for a victim of a critical incident who developed PTSD is to move from the chronic stage of victimisation back into the previously unsuccessful acute stage since that

is the stage where assimilation and accommodation were present. Gerbode (1995:436) states that what must be assimilated and accommodated from a traumatic event are one's reactions to the incident, including one's thoughts, sensations, feelings and perceptions. He further states that a trauma only remains emotionally charged or unresolved if the victim has perceived the critical incident incompletely and has not made sense of it. French and Harris (2000:8) mention that TIR is based on the assumption that there is a primary traumatic root incident in a person's experiences that other subsequent traumatic incidents, or sequences, are dependent on. In other words, trauma is inextricably linked to and conditioned by the root incident. Trauma symptoms, therefore, are "powered by" the emotional charge associated with the root incident, one which may be far removed in time from the most recent experience of the symptom. He further suggests that the greater the number of sequences, the less likely it is that the victim will necessarily consciously associate them with the primary traumatic root incident. That is, the root can be far enough removed that a particular trauma response appears to be more directly affiliated with one or more recent sequents. Moore (1993:119) states that is why PTSD is so difficult to treat. In the absence of addressing the root directly, there is always an emotional charge present to be triggered. The theory behind TIR is that, where past traumas have never been fully faced, they retain an emotional charge and can be triggered by later incidents. Spiers (2001:122) mentions that TIR is a method of enabling people to confront their past traumas by exploring the recent incident and linking back. This is achieved by going through a critical incident repetitively, enabling the client to engage with it and to work out links with previous repressed but re-stimulated incidents.

TIR is a procedure intended to render benign the consequences of past traumatic events. If this procedure is used correctly and in suitable circumstances, it eliminates virtually all of the symptoms of PTSD as listed in the DSM (IV) and is capable of resolving a host of painful and unwanted feelings and emotions that have not surrendered to other interventions (French & Harris, 2000:14). TIR usually leads to spontaneously client-generated insight, personal growth and empowerment. According to French and Harris (2000:14), the therapist's role in TIR consists of keeping the session and client's attention tightly focussed. The therapist always consults the client in deciding what to address in a given session. Once started, the session continues until the presenting incident or target symptom (called "theme"), which the client and the therapist have agreed to address in the session, has been concluded or brought to an "end point". At this point the client typically experiences at least a sense of peace, respite or relief. The therapist creates a safe environment in which the client can

confront and explore his/her trauma, and manages the session by guiding the client through the procedure. Sessions have no fixed length and can continue until the appropriate theme reached an end point (Spiers, 2001:122).

The first step in TIR is to identify the issue or "item" that is going to be addressed. According to French and Harris (2000:15), this may be the client's description of a "presented incident" – a specific incident identified as troublesome by the client – or a description of some content or theme that is common to a sequence of incidents experienced, that is, a "thematic" item. These two types of items – themes and presented incidents – are treated somewhat differently with TIR. Spiers (2001:123) mentions that clients are encouraged to imagine the incident happening as if they were watching a video, that talk through what they have seen, repeating this procedure until some resolution occurs. Resolution may take the form of a cognitive shift, a distinct relaxation, or a sudden return to the present. The therapist does not interpret what the client says, but listens intently, enabling the client to feel held and accompanied on his/her journey. The client connects with his/her feelings as he/she moves through the process, enabling him/her to be discharged. Additionally, he/she is usually able to make a cognitive shift, achieving a different, more constructive perspective of the incident.

4.4.1 Basic TIR

French and Harris (2000:15) mention that if a severely traumatic incident or a presented incident is readily accessible, it is a good idea to address it first, with a procedure called basic TIR, before trying to address thematic themes. In the process it may or may not turn out that this is a sequence of earlier incidents underlying a presented incident, but the presented incident can often be handled by itself, without reference to earlier related material. Having selected a specific incident in which the client is interested, the therapist may lead the client to go through the incident a number of times in his/her mind, reporting after the run-through what happened in the incident and any thoughts or reaction the client may have while reviewing the incident. French and Harris (2000:15) report that the client "will generally experience great relief".

4.4.2 Thematic TIR

French and Harris (2000:15) say it is safe to assume that a high percentage of all negative feelings, attitudes, or undesirable impulses clients have and wish to be freed from will be

found to be themes, for example "fear of men" or "woman are not to be trusted". These themes, feelings (i.e. fears), emotions, sensations, attitudes, beliefs and even some physical pains in turn will be found to be contained in a sequence of separate incidents linked by a common theme(s) triggered or re-stimulated in the client. Many of the incidents in such sequences will be secondary trauma, because in themselves they are not a trauma that causes primary pain but they are linked to the trigger/primary pain that causes traumatisation. Such sequences will be found to originate in root incidents that typically do contain primary pain – a real, or untriggered independent source of trauma. By thoroughly working through the root incidents, the emotional charge that hold the theme which is linked to later incidents will be released.

The therapist works through a theme by asking the client to identify an incident, any specific incident in which the specific theme is present. If a client is affected by, for example, a fear of men, the therapist can ask her to identify a specific incident that she can recall that contains a fear of men. The therapist then takes her through the incident several times until no further emotional charge is released from the incident and the client reaches an end point, or her attention moves and can be redirected to an earlier incident containing the same theme (fear). The same process is then used to work through that incident until there is no charge. The therapist eventually encounters the root incident, and at the review of that incident the client, at the minimum, experiences a feeling of relief, usually coupled with one or more realisations or insights regarding her own behaviour or functioning. After this the therapist usually moves to a next theme.

French and Harris (2000:17) mention that it is very important to understand the concept of an end point. At the end point of an incident certain characteristic "indicators" appear. When TIR reaches an end point, the following indicators in the client are observed:

- The client feels and manifests a sense of relief from what was problematic
- The therapist sees the client relax and "lighten up" visibly
- The client's attention redirects from the past to the present
- The client often has some kind of significant insight.

It is important that the therapist is aware of these indicators and that the TIR process is not terminated while the client is feeling miserable or if there still is an emotional charge. Flexible session times are important to allow for the process to reach an end point. It is important for

the therapist to be able to continue a session until a client has reached an end point, at which he/she feels relieved because something has been resolved. It is equally important for a therapist to be able to stop when an end point is reached. When the client feels confident that the therapist will allow for anything to be resolved that is encountered in the session, the client willingly moves into highly charged areas. The time to work through an incident or a thematic sequence is highly variable and it may take anything from five minutes to three hours to reach an end point. French and Harris (2000:18) mention that clients may need more than a single session to reach an end point. It then may happen that some of the work that goes into the attainment of the true end points may take place between sessions. It is, therefore, important that the therapist starts a session by asking the client about particular thoughts, feelings or insights he/she has had since the last session. This gives the therapist the opportunity to asses if a client has reached an end point between sessions. It is important that the therapist assesses the emotional charge of the critical incident and not terminate TIR therapy while the client is still feeling miserable or "locked into" the incident. On reaching an end point, the client reclaims the personal power that was tied up in maintaining the incident or sequence as part of the present.

In the session, as a client approaches an end point, the therapist generally witnesses the client's indicators improving and that the incident that are being worked through will be getting "lighter" or less painful. Gerbode and Moore (1994:30) refer to an emotional scale (see Figure 3). The client moves upward on this emotional scale when reaching an end point. The therapist should wait until the client has full positive indicators, involving expressions of relief and a feeling of peace with the issue that has been addressed. The client ideally expresses a realisation, or mentions a decision at the time of the incident. This shows that the client has come into contact with an aberrant belief or intention – one made or adopted at the time of the incident that since then became inappropriate – and is now coming into contact with that realisation. An expression of such a realisation is a good indicator of an end point. If these signs are not present it may be necessary to review the incident again until an end point is reached. It is important not to interrupt a client while there is still emotional charge. If the client is still looking inward, it is likely that the client has not reached the insights needed to come to an end point.

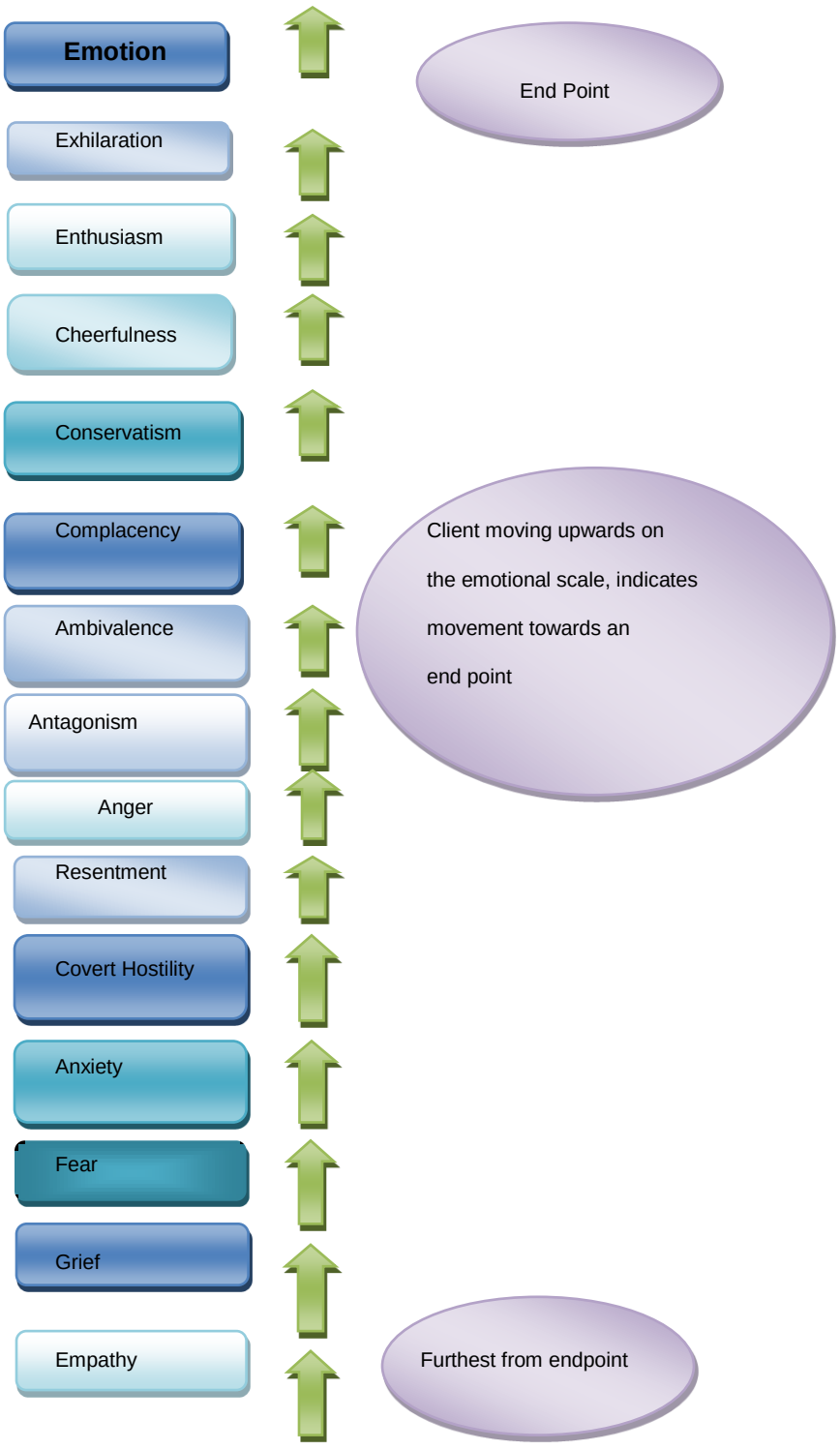


Figure 3: Emotional scale (Gerbode & Moore, 1994:3)

4.4.3 Change in emotional scale

According to French and Harris (2000:21), the various emotions we experienced in life can be arranged to form a scale (Figure 3). The higher emotions on the scale tend to relate to success while the lower emotions on the scale indicate failure. In any given moment a person can occupy two or more emotions on the scale, referred to as chronic and acute emotions. If a person is by nature anxious and anxious most of the time and only cheerful when, for example playing golf, the chronic emotional is anxiety and cheerfulness is the acute emotion. An emotion, depending on its nature, acts to provoke or inhibit certain reactions from us, for example:

- Promote the happiness and well-being of ourselves and those around us
- Impair or frustrate the happiness and well-being of ourselves and those around us.

When the emotion is chronic, it actually structures or dictates the world we live in, acting as a self-fulfilling prophesy. The TIR therapist is interested in both the client's acute and chronic emotions. The chronic emotion dictates the overall case plan and the strategy, and the acute emotion dictates the therapist's immediate actions and the tactics at any given moment in the session. The chronic emotion indicates how the client experiences his/her world and how he/she views life. The chronic emotion of a person suffering from PTSD typically is on the bottom half of the emotional scale. The goal of the therapist is to allow that to change and, to the degree that the therapy is successful, it does. Three things happen, according to French and Harris (2000:22) that are visible by the therapist and the client:

- The chronic emotion gradually moves up on the emotional scale
- The client experiences a feeling of well-being
- The client responses to reactions from the world are experienced as positive.

4.4.4 Steps in TIR

According to French and Harris (2000:23), basic TIR consists of certain steps. Before these steps are followed the therapist should have determined if TIR is an appropriate tool to use for the specific client.

The steps in basic TIR, according to French and Harris (2000:23–24), are as follows:

Step 1 "Consulting your client's interest and selecting an incident to address."

This assessment is essential and done before the therapeutic process begins. The presenting incident is the one the therapist will start with.

Step 2 "Find out where the incident happened."

Responses such as "it happened at home", "when we were living in Cape Town", or "when we were on vacation" are common. Any indication of a place is acceptable.

Step 3 "Determine how long the incident lasted."

Any responses indicating the time are acceptable, for example "it lasted for 20 minutes", "only for a few seconds" or "it was just long enough for me to smoke a cigarette".

Step 4 "Have the client focus on the moment the incident occurred."

This is preparing the client for the TIR process by focusing the attention on the beginning of the incident.

Step 5 "Have your client close his/her eyes (if he/she is comfortable to do so)."

Closing the eyes helps the client to "see" the incident more clearly in his/her imagination, eliminating distractions from the environment.

Step 6 "Ask your client to describe the scene at the moment the incident begun."

This begins the description of the incident, but is only the beginning moment (to set the stage).

Step 7 "Have your client silently review the incident from beginning to end."

This is a silent reviewing process that helps the client to put the incident in perspective before he/she begins to tell what happened.

Step 8 "Have the client tell you what happened."

The client's response to this request may be a broad outline of what happened or a very detailed description.

Step 9 "Repeat steps 4, 7 and 8".

From this point the therapist facilitates the viewing by letting the client repeat the cycle of going to the start of the incident, reviewing it silently to the end and then telling what happened (steps 4,7 and 8) until the client reaches an end point. The steps for basic and thematic TIR are basically the same and have little to do with the principle differences between basic and thematic TIR. The questions and instructions given to the client remain the same.

4.4.5 Rules for facilitating TIR

According to French and Harris (2000:59), the therapists are bound by certain rules. Although these rules may seem simple, the importance cannot be overstressed and the adherence to these rules is important and essential to attain consistently successful results in the TIR process.

There are 12 rules of facilitation (French & Harris, 2000:60–64):

4.4.5.1 Do not interpret

The therapist should resist all temptations to interpret what the client is seeing or experiencing. Interpretation is the client's job, and the therapist should regard the client as the only valid authority on matters he/she experienced and should only accept and acknowledge the client's data. The therapist does not have to agree or disagree with the client's statement or view point. The possibility exists that this statement, if neither reinforced nor disputed but only acknowledged by the therapist, will change in the course of the session.

4.4.5.2 Do not evaluate

Negative or positive feedback is evaluative. Validation draws attention to a specific observation or response of a client; if one of them is validated all of them should be validated. The absence of validation may be perceived as disapproval by the client. Successfully avoiding evaluation can be very demanding as even the finest gesture or smile at the wrong moment can capture the client's attention and thereby take the client "out" of the session.

4.4.5.3 Maintain complete confidentiality of session data

No real therapy can occur without confidentiality. The therapist must, therefore, make ethical decisions on how to protect his/her clients and information shared in the session.

4.4.5.4 Maintain control of the session at all times, but do not overwhelm the client

TIR work in a relatively fixed and predictable framework, by which it enables the client to discover his/her own answers and insights and enhancing the degree of "safety" for the therapist.

4.4.5.5 Ensure understanding of what the client is saying

The therapist should never imply that he/she understands something the client has told him/her, when he/she in fact does not understand it. People tend to feel misunderstood when they are. When seeking clarification, always assume responsibility for not having understood, never imply that the client was at fault.

4.4.5.6 Be interested, not interesting

This might be the single most important rule. The therapist's interest, if genuine, is felt clearly and valued highly by the client. The perception that the therapist shows genuine interest makes it possible for the client to confront issues he/she needs to work through in order to attain his/her goals. The therapist who is interesting to the client significantly impedes progress at its best and undermines successful TIR results.

4.4.5.7 Therapist's primary intention must be to help the client

The therapist intention must be to help. In the TIR session the client must be the therapist's primary motivation.

4.4.5.8 Ensure that the client is well fed and rested and not under the influence of any psychoactive drug

When the client is experiencing any physical phenomenon (e.g. hunger, exhaustion or physical pain) or under the influence of a psychoactive drug that might dull or attract attention, the TIR process is disturbed.

4.4.5.9 Ensure that the session is being given a suitable space and with appropriate time available

The therapist should create an environment that is comfortable and free of distractions. As a TIR session can be long, it is important that the client is seated comfortably. Neither the therapist nor the client should be under time pressure that could force the session to be interrupted prematurely. The traditional 50-minute session may be unsuitable for TIR seeing that the session is terminated only when an issue has no emotional loading left.

4.4.5.10 Act predictably

The client needs to trust the therapist and be confident that the therapist would not cut him/her off when the client needs a longer-than-expected session. If the therapist finds it necessary, the next client may be kept waiting because a current session is taking longer than anticipated. When the client knows what the therapist's action would be, there is more trust and he/she finds it easier to open up.

4.4.5.11 Never attempt a session with a client who is unwilling or protesting

The aim of therapy is to reduce stress. Forcing a client increases stress. If a client is forced by the court, a spouse or parents to attend sessions, the therapist first has to convince the client to willingly engage in therapy. The client has to be motivated before there can be any hope for success in the sessions. It is important that the therapist never takes up an issue because the therapist, and not the client, has decided to address the issue.

4.4.5.12 Take each issue in any session to a positive end point

The therapist should make every effort never to leave a client "triggered" or "locked into" any significant degree of re-stimulation. Clients arrive at valid end points within a single session of TIR if they are permitted to and sessions are kept open ended within wide limits to facilitate this. It is the therapist's responsibility, and not the client's, to end the session at an appropriate time.

TIR is a long-term therapeutic process aimed at resolving not only the current trauma, but also previous sequences of trauma until the root trauma is reached. It may be necessary to re-visit incidents several times until there is no emotional load left. TIR is a process that is not restricted by time. The client needs to know that he/she will be able to finish a specific issue, even though it may take longer than the traditional 50-minute session. TIR is an effective intervention where a client has been diagnosed with PTSD and symptoms continue to affect functioning long after the critical incident.

4.5 CONCLUSION

A client who becomes victim to a critical incident, specifically in the workplace, can be exposed to a range of interventions in order to assist or debrief him/her. Usually the first intervention is defusing, where the focus of the intervention is to contain and protect the client

from further emotional and physical harm and then to link up or to refer to further interventions such as CISD. CISD is the next step in crisis intervention. This is a formal debriefing process consisting of certain stages according to Mitchell's model. This phase follows 24 to 72 hours after the critical incident and aims at debriefing the client by ventilating emotions, educating regarding possible reactions, normalisation and focusing on problem-solving techniques. This process is usually a group intervention where the debriefer uses the group interaction as a tool to ventilate emotions and focus on reactions. If a client indicates the need for further help, or if the client is significantly distressed or if symptoms related to the critical incident increase or do not decrease after six weeks, the client needs to be referred for individual therapy. The trauma aftercare model is aimed at assisting the client after being debriefed but who is still affected by the critical incident. In therapy as part of the aftercare model, the client can be assisted by a therapist on an individual basis. Aftercare is usually necessary where there is a risk that the client might develop PTSD.

SFBT fits well into the aftercare model because of the model's tendency to focus on resolving the symptoms and moving on. The SFBT model is a short-term model focusing on early assessment, intervention and referral for long-term therapy if needed. The SFBT model is focused on developing solutions; it is a short-term model which is goal orientated and time limited. This model is aimed at empowering the client and strengthening the client's natural coping abilities through the therapeutic process. If a client is still affected and symptoms do not decrease, it is important that the therapist using the SFBT model should identify early on that there is no progress and refer the client for longer-term therapy. A longer-term therapeutic model that is effective in the intervention of victims of critical incidents is the TIR model. This model is effective in treating victims who have developed PTSD by moving them back from the chronic stage of victimisation to the previous acute stages where assimilation and accommodation was present. This model is helpful where the client is still affected by previous traumas and previous traumas still have an emotional load. TIR is a method that enables the client to contact past traumas by exploring the recent critical incident and linking back. TIR is a long-term model focusing on the client's emotional catharsis and it is not restricted by time. The process of TIR is terminated when the root incident has been worked through and an end point was reached – resulting in the client developing significant insight in his/her emotional functioning and experiencing a feeling of well-being.

Schematically the researcher summarized the process by illustrating the process as follows.

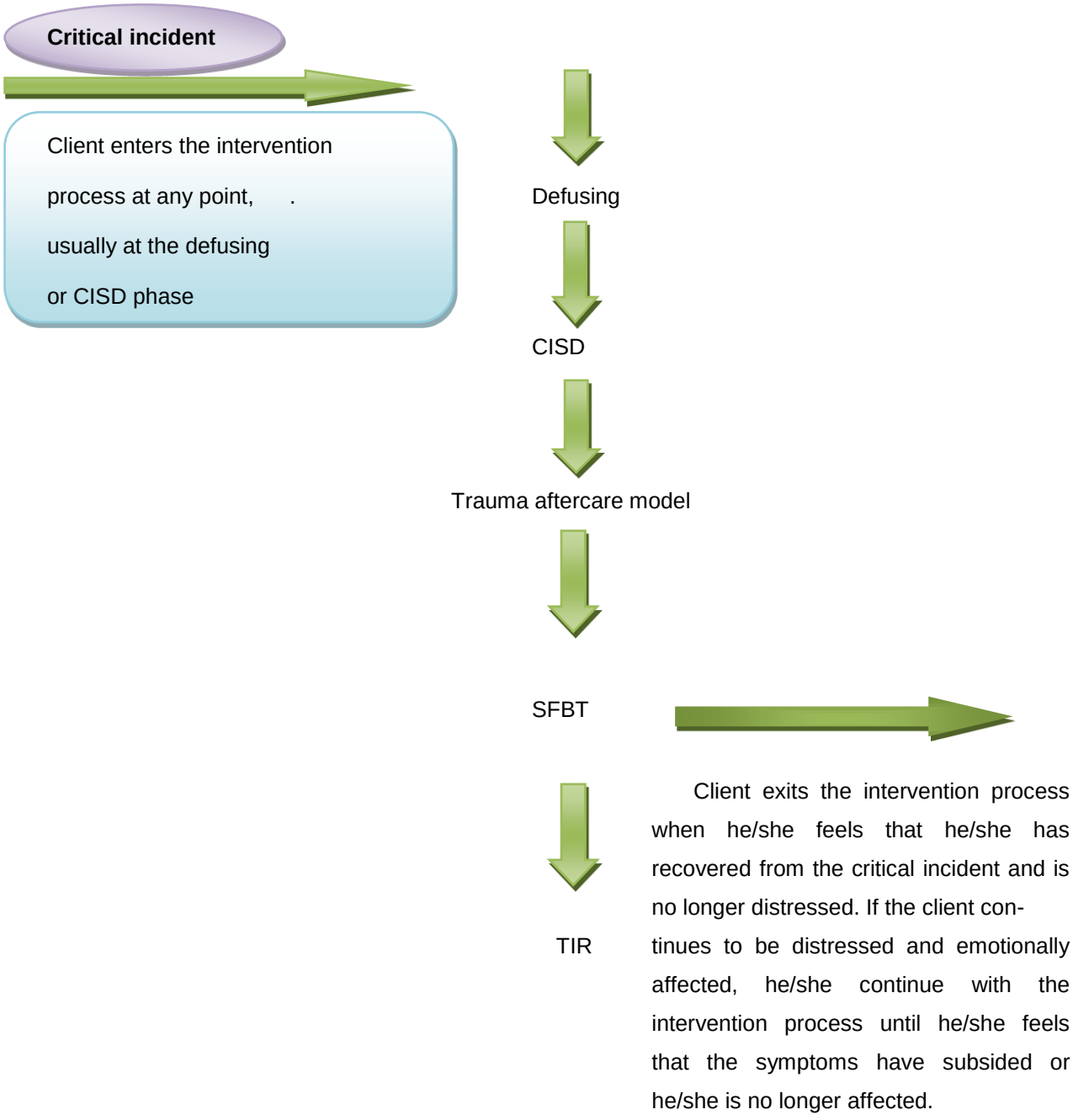


Figure 4: Trauma intervention process (illustrated by researcher)

After being traumatised by a critical incident, the client enters the trauma intervention process either by a defusing session or CISD session or by seeking help as a result of being distressed. The client remains in this process until the symptoms resulting from the critical incident are cleared or he/she is no longer distressed. If the client continues to be distressed, he/she moves forward into the trauma intervention process until trauma is appropriately

addressed and the client no longer feels distressed and feels ready to exit the trauma intervention process.

Chapter 5
Employee Assistance Programmes

5.1 INTRODUCTION

In a society where the scramble for employment has become a way of life and where companies are facing financial and economic challenges and constrains, some form of specialised service is required within the setting to deal with concerns before they escalate or deteriorate. Furthermore, spending most of our working hours and thus most of our lives at work means that we should be happy and satisfied in the workplace. Akabas (in McKendrick, 1990:201) describes work as "the natural life space for adults". Personal problems will inevitably enter the world of work, just as work-related problems are taken home (Googins & Godfrey, 1992:39) – be it an emotional experience or a specific task that requires completion. These issues seem to transcend any boundaries that may subconsciously or consciously be implied.

The workplace takes the form of a community or society and serves those members who form part of that community with its own rules, values, organisational climate and organisational culture. Here workers also engage in relationships with others, adopt roles and routines and complete specific tasks. What makes this community different from the larger community is its task-oriented focus (Googins & Godfrey, 1992:66). The successful completion of tasks is aimed at the fulfilment of the organisation's objectives and is a strategic issue from management's point of view. If there are impending forces that prevent this from happening, it is management's duty to use all means at its disposal to get to the bottom of things. Work and human beings are inevitably connected and an individual's psychosocial functioning determines his/her work performance. Companies have a responsibility towards managing problems that employees experience for the benefit of the employee, that is to resolve his/her problems, and to enhance productivity in the company.

Critical incidents are sudden, unexpected, often life-threatening time-limited events that can inhibit an individual's capacity to respond adaptively. The impact of critical incidents may be debilitating and stems from recurrent intrusive images, persistent fear, displaced anger, guilt and isolation. 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).While addressing various technological, operational and logistical issues in the aftermath of a tragedy, it is also advisable to pay special attention to the human needs of affected employees during and after a crisis.

5.2 WORK

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".

Work has different purposes and meaning for different people. Work plays an important role in the fulfilment of people's needs and therefore a variety of reasons exist why people work. Baily (1990:2–4) mentions the following reasons why people work:

- **The opportunity to earn money**

  One of the most important reasons for people to work is to earn a living. Money is a necessity to feed, clothe and provide accommodation to a person and his/her family. Money not only enables a person to provide for his/her basic needs and those of their families but also enables a person to provide security, comfort and enjoyment.

- **Social contentment**

  The workplace provides opportunity to meet other people and to develop friendships. "In fact many employees spend more time interacting with their co-workers than they do with their own families" (Steers & Porter, 1991:574). In the work environment people can give and receive understanding and acceptance.

- **Positive emotions**

  People get satisfaction from the work they do. Work provides people with a feeling of reparation and self-worth. The fact that a person's skills are needed contribute to the feeling of self-worth.

- **Source of status**

  Work provides a certain sense of status and position. People choose a certain work/position because of the respect the community has for it.

- **Personal development**

  Most people have an inherent need to develop themselves. The work milieu provides the perfect setting for them to learn, grow and develop.

- **Health**

  To work is important for a person's mental and physical health. The satisfaction people feel as a result of achievements at work help them to feel better. People who are happy in their work feel better and are more positive.

- **Self-actualisation**

  Work can be the place where the individual can find the opportunity to live out his/herinterests, skills and talents.

Furthermore, Akabas and Kurzman (1982:41) mention that "work is the cornerstone of life, which helps individuals and families to live both as private and social beings".

Googins and Godfrey (1992:75) introduce the notion that work has four roles which need to be considered in order to prove its value for intervention purposes:

1. As a social microcosm of larger society
2. As a means of personal/collective identification
3. As a vehicle for intervention in or maintenance of human behaviour systems
4. As a diagnostic tool.

5.2.1 Work as a microcosm of society

This role allows for consideration of the fact that the workplace is part of a much bigger picture – society at large and the world. This means that all macro issues that impact on society in general also inevitably impact on conditions in the workplace.

5.2.2 Work as a means for personal and collective identity

This role allows people the opportunity to develop a positive self-identity. This implies that work allows for the development of its own norms, values, culture and climate that impact on individual and group functioning within the workplace, as stated earlier.

5.2.3 Work as a means of intervention/maintenance of human behaviour systems

This role refers to the skill of supervisors to assist subordinates to develop themselves and grow within the organisation. Often a break or change from a monotonous routine/existence for further development is called for in order to re-inspire employees to reach greater heights.

5.2.4 Work as a diagnostic tool

This role implies that, in planning interventions, each individual's bigger picture must be carefully assessed. This is due to the fact that individual behaviour patterns expressed in the work situation are part of the individual and, therefore, a person is not considered to be one way at work and another way at home. Personal characteristics are an integral part of who we are.

Googins and Godfrey (1992:39–41) make some further assumptions about the workplace.

- The workplace is a community where human needs and problems exist. It is part of a larger community/social system (political, social and economic) that impacts on what happens within the workplace.
- The current structure, culture and design of present-day organisations cannot meet social needs; although issues and problems are not new, effective intervention, as well as recognition and definition of problems, is necessary.
- Professionals (employee assistance practitioners) are in a position to meet some of the needs by virtue of their professional mandate and unique training and skills.

In the workplace, where the employee spends most of his/her time, the employee should experience some work satisfaction in order to be productive and to perform well. 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 adopts better after disruption (at work or at home).

Berker (2003:467) defines work satisfaction as "the degree to which an employee has a positive attitude about the employer, the working conditions, relationships with other workers and those served and future opportunities".

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

Although there are different opinions about the relationship between job performance and work satisfaction, the researcher holds the view that the higher the work satisfaction the higher the job performance. Berker (2003:467) mentions that the relation between increased job satisfaction and better work performance has not been proved. McCarth (2000:35) mentions however that there is no clear evidence supported by research findings; the conventional wisdom holds that worker attitudes and behaviour are related, meaning that increased job satisfaction is perceived to be a factor that contributes to improved work performance.

Organisations providing EAPs for their employees can contribute to increased work satisfaction by improving work conditions and helping employees work through personal and work-related problems, thereby hoping to have a positive impact on the work performance of the employee by making conditions to perform more favourable.

5.3 INFLUENCE OF SOCIAL PROBLEMS IN THE WORKPLACE

Ribner (1993:333) mentions that "because of the critical importance of work. Any disruption in the homeostasis of the workplace may have a profound impact on the worker". The emotional impact of an incident can be critical "when dreams and way of life are threatened with extinction" (Ribner, 1993:333).

Most systems are constantly in a state of change, which allows for growth and development. At the same time, the system requires structure and stability. Compton and Galaway (1984:123) state that "at the same time that a system is constantly in a state of change, it must maintain a dynamic equilibrium". Problems occur within the system owing to its inability to cope with the stress and tension created by the change. As a result, the system is unable to maintain order and functions in a state of chaos. Problems seem to be the system's way of responding to the overwhelming chaos.

Because the boundaries of the system are semi-permeable, they sustain change within the system. It is this same boundary characteristic, however, that allows one system to influence another. We therefore presume that changes in the work social system influence the family social system, and problems within the family social system influence the work social system. The same holds true for all of the other systems of which individuals form a part. An employee, as part of the work system, therefore cannot be adequately understood in isolation of his/her roles within the other social systems to which he/she subscribes.

It is important to acknowledge that changes may be positive or negative. For this reason the employee's general life-satisfaction and happiness have a positive impact on his/her work; similarly an employee's general discontentment with life and his/her resentment influence his/her work performance negatively. Good working conditions, therefore, simply cannot guarantee a problem-free production environment. It would be impractical to expect employees to leave their personal problems at home, and it would be naive to believe that the problems resulting from the workplace will remain separate from the employee's personal life.

Bruce (1990:37) mentions that "no employee stands alone, unchanged by the events and actions around him or her. Employees have lives outside the world of work. In those lives family and friends make demands on time and energy". The influence –of social problems experienced by employees within their other social systems– on the workplace is further explored below. According to Kessler and Stang (2006:20), "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 our individual responses to stress and our own uniqueness. The resulting impact on the workplace however, can be narrowed down to five broad categories:

5.3.1 Poor work attendance

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 (Remanathan, 1992:235–236)

- **Lateness**

  Employees such as single parents are often late. Perpetual lateness may be a sign that they are not coping with the pressure of being the sole responsible adult. Single parents usually require visible support by means of flexi-time policies. This is often enough to significantly improve work attendance.

- **Excessive use of sick leave**

  Sick leave benefits have a direct financial cost to any company, as the company pays salaries to employees who are productive for certain times. Excessive use of sick leave, owing to vague ailments such as flu and diarrhoea, may be indicative of the employee experiencing some kind of crisis. Women in domestic violence relationships often conceal the real reason why they are off sick, due to the physical injury sustained being at the hands of their own partners. They fear the employer's and their co-workers' reaction to the truth.

- **Long-weekend syndrome**

  Often employees take sick leave on a Monday or Friday to create "long-weekends". Doing this on a regular basis is usually indicative of a substance abuse problem.

- **Temporary absence from the workstation**

  This type of absence is often also linked to substance abuse. Addicts usually require a "quick fix" to remain functional. Sleeping on duty may also be viewed as being absent from the workstation. Depending on the person's job description, this could cause the company considerable loss of income, both in production and in other areas such as theft and loss of clientele.

5.3.2 Drop in productivity

When people find themselves in a crisis, they often become preoccupied with their situation. The employee is, therefore, unable to focus on the task at hand. His/her productivity declines correspondingly. A drop in the employee's productivity may manifest itself in a variety of ways (Carson & Butcher, 1992:280; Kessler & Stang, 2006:21–22):

- **Inability to concentrate**

  Preoccupation with personal problems makes it difficult for the employee to concentrate on his/her work, which then takes much longer than before to complete. As a result, his/her productivity may decrease and the employer's production costs increase.

- **Erratic job performance**

  This is often related to substance abuse. Quick visits to the bathroom, being absent from the worksite for extended periods and long coffee breaks, together with highs and lows in production, are often indicative of substance abuse problems.

- **Complaints from co-workers**

  When an employee's personal problems affect his/her ability to work, his/her co-workers inevitably picks up the slack, to ensure that the task is completed. They usually do not want to be associated with collective poor job performance. This results in a "Catch 22" situation for the co-workers. The troubled employee is then not confronted with the consequences of his/her poor performance, which perpetuates the cycle. It also makes it difficult for early intervention because the initial symptoms are hard to detect. Eventually, colleagues and co-workers become resentful about the extra workload, which they carry, and begin to complain to their supervisor. Complaints from co-workers should be taken seriously, especially when the complaints are from different sources, and the matter should be dealt with in a highly sensitive manner.

- **Complaints from clients**

  Poor turnover and quality of work are of concern to clients. Often this is when management first becomes aware or suspicious of problems with the employee. Because the troubled employee is often forgetful, unable to meet deadlines and sometimes negligent, clients often become angry and frustrated in their dealing with him/her. In most

cases, the cost of early detection is far less to the organisation. Waiting for a crisis to occur within the workplace is usually extremely costly.

5.3.3 Deteriorating interpersonal relationships

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.

- **Overreaction to real or perceived criticism**

  Employees in crises are usually hypersensitive and believe that they are constantly being judged. Because one is acutely aware of one's shortcomings during a period of crisis, reactions to criticism are usually out of context. For this reason it is extremely difficult to associate this response alone with underlying social problems. It is, therefore, imperative that this response be viewed within the context of the employee's overall behaviour and job performance. The impact of this behaviour on co-workers and supervisors, who constantly have to deal with an over-sensitive person who is not working according his/her full potential, should not be underestimated. Frequently, co-workers and supervisors suppress their frustration until the problem reaches a level where they are unable to sustain the additional pressure any longer, and they begin voicing their anger and resentment.

- **Unwarranted grievances**

  The hypersensitivity of people in a crisis is apparent in their moodiness, irritability and resentfulness towards co-workers and management. Often this manifests itself through the instituting of petty grievances against others. This results in a complete waste of resources. The problems experienced by one member in a section have the potential to lower the morale of the entire group, should the problem behaviour not be confronted.

5.3.4 Health issues

Issues related to personal and family health also often impact and the employee's work performance:

- **Depression**

  Depression typically occurs when the employee is completely overwhelmed by a whole range of social problems. People who suffer from depression usually have a loss of interest in life in general, and are unable to function due to chronic fatigue and psychomotor retardation. This impaired functioning impacts the workplace and co-workers significantly, and is exacerbated by the human response to alleviate the person's responsibilities. If this situation goes unattended, eventually co-workers will become frustrated and intolerant of the employee.

- **Physical illness**

  The prolonged illness of a spouse or child requires considerable emotional investment by the employee, as he/she is expected to over-function in maintaining family relationships. This has the potential to be both emotionally and physically draining for the employee. The concern and worry felt by the employee often results in him/her being preoccupied with things outside of work, such as increased medical bills, or he/she may be too exhausted to focus on the task at hand. In a technical environment, the consequences can be significant. In power generation plants and factories, for example, accident rates are often linked to the company's insurance premiums. Increased accidents, therefore, result in increased premiums, which are then added to the cost of production.

5.3.5 Societal issues

Organisations can only exist with society's sanction. Therefore, society demands that its organisations fulfil a responsible role as a member of that society. Within society there exist many social problems and human rights issues that require comprehensive and integrated solutions. This implies that, although organisations are not solely responsible for the solutions, they are required to form partnerships with other societal systems, such as non-government organisations, educational institutions and community groups. Their response to these issues will be a direct reflection of their commitment to broader social values and business ethics:

- **HIV/Aids**

Employees, unions and management alike feel the impact of the HIV virus on the workplace. According to Harris (1990:25), "the workplace has become a public arena where the facts and fictions of Aids were publicly debated". The reason for this debate, however, is the result of an emotional or a fear response that individuals may infect each other within the workplace. To counteract the impact of Aids, on the workplace and society, a more humane approach needs to be developed. Masi (2000:321) states that "by the year 2009, 17% of the workforce will be showing symptoms of Aids and at present 27% of the workforce is infected with the HIV virus, with 3–4% actually being ill with Aids". In South Africa it is indicated that the prevalence of HIV in 2008 among young adults (age 15 to 24) was 8,7% and for adults (age 25 to 49) the prevalence was16,8% of the population. Although there is no specific workforce statistics available, this indicates that a significant number of adults who play a leading role in the workforce are infected. These statistics reveal a gloomy picture. Company policies need to address not only individuals' fears, but also their grief when co-workers and colleagues succumb to the disease. It has also become the responsibility of the workplace to promote safe sex practices and monogamy. Organisations should also address long-term issues such as the impact of losing trained staff to the disease. Cost-saving practices to the employer, in terms of financial gain, would be difficult to measure. Profitability at this point could probably be calculated in terms of the cost of having an HIV/Aids infected workforce versus the cost of prevention. It must be noted that every system within society has to take some responsibility for combating the HIV/Aids epidemic. Employers would be well served to explore partnerships for effective interventions and policies.

- **Retrenchment**

  With the downswing in the South African economy, many companies are looking at streamlining their workforce to increase their efficiency and cost effectiveness. Companies need to be aware, however, that retrenchment has a direct impact on societal problems, such as increased unemployment, substance abuse, suicides and family murders. They owe it to the person being retrenched and his/her families to implement retrenchment in the most considerate way possible. It is the responsibility of the organisation to assist the employee with career counselling and skills retraining to facilitate his/her reintegration in the workforce.

- **Discrimination**

  The *Employer Equity Act* no. 55 of 1998 prohibits that any worker be discriminated against by virtue of ethnicity, race, gender or disability. Unfortunately, we are not as yet living in Utopia, and incidents of discrimination are bound to occur, despite legislation, as the workforce becomes more and more diversified. It is up to the organisation to ensure that it complies with the regulations specified in the Act. Inappropriate responses could result in grievance procedures being brought before the Commission for Conciliation, Mediation and Arbitration (CCMA). These hearings are costly and a waste of valuable resources, however, this is nothing compared to the cost of the negative publicity a company receive should it be found to be guilty of discriminatory practices. The damage to the company's reputation would be far more harming.

- **Sexual harassment**

  According to Prinsloo (2006:74), sexual harassment can be defined in three different categories based on conduct:

  1. Physical conduct ranging from touching to sexual assault and rape, and including a strip search by or in the presence of the opposite sex
  2. Verbal conduct, including innuendoes, suggestions, sexual advances, comments with sexual overtones, sex-related jokes or insults
  3. Non-verbal conduct, including gestures, indecent exposure or the display of sexually explicit material.

  The *Domestic Violence Act* no.16 of 1988 classifies sexual harassment of a worker as prohibited. As a result, employers have a legal responsibility to respond to this issue, in a proactive way. Failing to do so could result in costly legal battles, as employees will seek restitution through the CCMA.

- **Crime**

  With the high incidence of crime in South Africa, many employees become victims of crime. Female employees and security guards are especially vulnerable. Victims of crime often suffer traumatic stress, resulting in anxiety and paranoia, which hampers job performance and effective interpersonal relationships with co-workers. Owing to the high frequency of crime, failure to provide accessible counselling for victims ultimately results

in a complete breakdown of employee morale, and reduces productivity and company performance irreparably.

There is a host of problems that affect the employee and his/her work performance. These problems may be personal in nature, brought about by outside societal factors, or they may be a result of the work environment itself. Much of the concern of the employer is their effect on the cost of production, service delivery and efficiency.

5.4 EAP AND EMPLOYEE WELL-BEING

EAPs are "job-based programs operating within a work organization for the purpose of identifying troubled employees, motivating them to resolve their troubles, and providing access to counselling or treatment for those who need those services" (Sonnenstuhl & Trice, 1990:18).The EAP, according to PPC International (PPC Clinical Practice, 2004:2),is a management tool paid for by the employer with the expectation that the utilisation of the programme will decrease absenteeism, accidents, tardiness and mistakes and will increase productivity. The purpose of the EAP is to prevent, identify and treat personal problems that often adversely affect job performance. The purpose and the expectations of the EAP are accomplished through an integrated system of policy and procedures, management consultation and personal, confidential counselling that is easily accessible to all employees and members of their households.

EAPs have evolved and are still evolving, in response to influences within and outside the workplace, into a diverse service group with distinctive structures and services.

An EAP is an instrument used to improve the quality of life of employees, by giving them the necessary support to resolve personal and work-related problems. The purpose of EAPs is to improve the well-being of employees and to improve the effectiveness and productivity of the company.

According to the standards committee of EAPA South Africa (1999:4), EAP is a worksite-based counselling service programme, designed to assist in the identification and resolution of productivity problems of employees impaired by personal problems or concerns including health, alcohol and drug abuse, family, marital, financial, legal, emotional and stress-related

or personal problems that adversely affect the employees' job performance. The Standards Committee of EAPA South Africa (2010:1) defines EAP as "the work organizations resource, based on core technologies or functions, to enhance employee and workplace effectiveness through prevention, identification and resolution of personal and productivity issues." EAPA South Africa's definition for EAP changed from a more reactive approach in 1999 to a more preventative and proactive approach in 2010.

According to Oss and Clary (1998:5), an EAP is "a confidential and professional service provided as an employee benefit which complements and extends in-company resources in the constructive and supportive management of people impacted by concerns in their personal and work lives".

The intended beneficiaries of an EAP are both the employees working for the employing organisation and the company as the employing organisation. The focus of counselling is not personal restructuring (e.g. psychotherapy) but rather helping the individual to cope and adjust to work and non-work issues that are affecting his/her performance.

EAPs evolved over the years to provide a better and a more effective service for the individual and the employing organisation. According to Hartwell, Steele, French, Potter, Rodman and Zarking (1996:804), EAPs evolved from industrial alcoholism programmes to the EAP of today with a broadened scope of employer involvement. The EAP evolved into a multi-service programme aimed at addressing all kinds of personal problems including illicit drug use, and family and mental health problems that affect job performance and the general personal welfare of workers. Tirbutt's (2005:47) definition of an EAP illustrates the broader scope of employer involvement and multi-level programmes: "A 24-hour helpline backed up with the ability to access face to face counselling service, with a heavy emphasis on stress management but also extending to legal, financial and other personal and work related matters. EAPs normally offer management referral and provide employers with management consultancy data on accurate utilisation statistics."

There is a growing trend to engage with an EAP in the pro-active prevention of absence and to link it with occupational health. Employers are increasingly demanding that EAPs be integrated with health/life balance issues and the promotion of a healthy workplace. The position of the EAP is changing from that of an out dated service to forming part of a bigger

more extensive service, focusing on employee well-being. A further trend in EAP, according to Tirbutt (2005:48), is that management is more pro-active in making referrals to EAPs rather than simply waiting for employees to refer themselves. Such formal referrals lead to an increased usage of programme services and increased knowledge on the diversity, purpose and function of the programme.

5.4.1 Models in EAP

The intense competition among external EAP service providers has raised the availability and quality of services in the market. According to Oss and Clary (1998:7), the EAP is likely to develop in several directions. EAP services are expanding and compete for the coverage of the largest proportion of the labour force. This competition forces EAP service providers to develop programmes and services that fit the needs of the company at a competitive price. The demands of the workplace effect the growth and development of EAPs, changing the characteristics to fit the need of the workplace. Stress and cultural influences, the use of alcohol and illicit drugs and behavioural health problems could impact on the need for EAP services in the workplace. Originally the EAPs focused on the individual troubled employee, his/her supervisor and how to manage the problem and restore performance in a reactive way. EAPs have recently started to take a more preventative focus, participating in work-place risk management activities and attempting to mitigate the workplace risk factors.

Society in general also has an influence on the development of EAP services (Burke *et al.,* 2006:290) Not only in America but also in South Africa, people are becoming aware of EAP services. A big proportion of the workforce has access to EAP services and this proportion grows annually. Owing to the employee's awareness and usage of the service, adaptations are made to fulfil the needs of the individual employee using the EAP service. The workforce is aware of the existence of EAP service and demands a quality service.

PPC International (PPC Clinical Practice, 2004:3) provides two models for EAPs:

- Assessment and referral model
- Brief counselling model.

Both EAP models include comprehensive, customised programming that integrates policy and procedure development, benefits administration, management training and consultation,

employee communications and programme implementation customised to best meet the needs of the client organisation. The assessment and referral model provides one to three sessions to clarify, define and assess the problem, after which the employee is referred to a provider in the resource network when appropriate. This model relies heavily on the use of employer group health benefits, private medical insurance or governmental resources.

The brief counselling model provides one to eight sessions within a solution-focused brief therapy model. With this model 75% of problems can successfully be resolved within the EAP an only 25% need to be referred for treatment outside the EAP.

The external EAP service providers are in a position, and compete, to deliver services for the needs of the company and they, therefore, offer a variety of programmes. According to Burke, Carruth and Pichard (2006:291), the most commonly used programme is delivered by an external service provider in the full service programme. EAPs, according to Tirbutt (2005:47), "unlike mere help lines", offer face-to-face counselling in addition to telephone advice. The more sophisticated versions also offer services such as career guidance, retirement preparation, management consultancy advice, stress management, bereavement counselling, relationship counselling, training in various areas and absence management. They also interpret data in order to identify trends and problem areas in the market and plan strategies and interventions to address these issues. "The focus is thus on delivering a range of services."

Full service contracts delivered by an external service provider in terms of an EAP usually includes up to eight emotional counselling session per employee and direct family members per problem. This is usually a more expensive programme. External services providers usually give companies the option of a cheaper programme. This programme is called a fee-for-service or pay-as-you-go programme (*Careways Procedures Manual*, 2005). According to Tirbutt (2005:46), the pay-as-you-go option is appealing to small and medium businesses that cannot afford the full service programme. This programme entails that the company pays a retainer fee and thereafter is billed for the services delivered. By giving these options companies can choose a programme "tailor made" for the company's workforce needs and budget.

5.5 EFFECTIVE EAPS

5.5.1 Goals of an EAP

Thompson (1990:164) mentions the following goals of EAPs:

- *Identifying* employees whose personal problems negatively impact on their work performance. Supervisors should identify employees whose work performance deteriorates.
- The *motivation* of employees to seek help and to accept help for their problems. Sonnenstuhl and Trice (1990:2) mention that supervisors should confront employees with evidence of poor performance, to guide them on how to improve work performance and motivate them to make use of the EAP.
- The *assessment* of the employee's problems, personal resources and the development of an action plan to support the employees. Bruce (1990:137) is of the opinion that referral to the EAP should not be considered a punishment. It must be seen as a natural consequence if an employee consistently fails to follow through with plans that are part of performance monitoring.
- The *support* of the employee to make use of services that he/she needs to live a healthy and productive life.

5.5.1.1 Essential elements of an EAP

According to Arthur(2000:550–551) and Quick and Tetrick (2007:293–294), there are certain essential elements that distinguish an effective EAP from other EAPs. Such an EAP is distinguished by its integrated approach and its systematic design that mesh the administrative and social systems of the organisation and its environment.

The essential elements consist of:

- A systematic survey of the organisation to determine the nature, causes and extent of problems perceived by individuals, taking the viewpoints of all stakeholders and functional specialists in the organisation into account
- Continuing commitment and support from top management to provide counselling, advisory and assistance services to troubled employees on a non-judgmental, non-cost, confidential basis
- A clear written set of policies and procedures that outline the purpose of the EAP and how it functions in the organisation

- Close co-operation with local unions
- An effective programme of production and publicity of the EAP to all employees as potential clients, emphasising in particular its confidentiality, access and scope of issues covered
- Training of supervisors on the role of problem identification
- A linked programme of education and training on the goals and methods of EAP for all staff members focusing on the identification of the "troubled employee", and for the individuals responsibility for wellbeing on the roles of managers, supervisors and shop stewards within the design and implementation of the EAP and the duties and capabilities of counsellors, including any limitations on their activities
- A procedure for contact with the EAP and referral to counselling, details of procedures for self-referral and (if appropriate) managerial referral(in cases of managerial referral, employee consent for referral needs to be obtained)
- An explicit policy of confidentiality of employee information
- Maintenance of records for programme evaluation purposes
- A definition of problem assessment procedures, including diagnosis routes, unlimited confidentiality guarantees, scope of counsellors' training and their accreditation, competencies and organisational knowledge
- A protocol outlining the extent of short-term counselling and longer-term treatment and assistance
- A statement of macro and micro linkages with other services in the community or with specialist resources or support mechanisms
- A procedure for follow-up and monitoring of employees
- An administrative channel for the feedback of aggregated statistics on the age and short- and longer-term outcomes of EAP, generated by the providers of the programme
- An evaluation procedure of individual and corporate benefits of the EAP on the most impartial basis practical.

These elements are essential ingredients for an effective EAP whether it is an internal or external programme.

Other than these essential elements that an effective EAP should consist of, there are certain core technologies distinctive to EAP services. Roman and Blum (1988:22) and EAPA SA

(1999:15) discuss these core technologies and mention that they are pertinent to effective employee assistance:

- Consultation, training and assistance services for managers, supervisors and union stewards, who seek to manage the troubled employee, enhance the work environment and improve employee job performance, outreach and education for employees and their family members about the availability of EAP services
- Confidential and timely problem identification/assessment services for employee clients with personal concerns that may affect job performance
- Use of constructive confrontation, motivation and short-term intervention with clients to address problems that affect their work performance
- Referral of clients for diagnosis, treatment and assistance, as well as case monitoring and follow-up services
- Consultation to the employer organisation to encourage the availability of employee access to health benefits covering medical and behavioural problems, including but not limited to alcoholism, drug abuse, mental and emotional disorders
- Consultation to the employer organisation in establishing and maintaining effective relations with treatment and other service providers and in managing provider contracts.
- Identification of the effects of EAP services on the employer organisation and individual job performance.

More recently EAPA SA (2010:1–16) mentions certain core technologies that are fundamental to a successful EAP. The core technologies entail the following:

- **Training and development**

  Organisation stakeholders (managers, supervisors and unions) should be trained, developed and assisted to effectively manage the employee who is experiencing problems, enhancing the work environment and improving job performance.

- **Marketing**

  EAP services should be promoted to management, supervisors, employees, unions and family members.

- **Case management**

Timeous risk identification, assessment, motivation, short-term intervention, referral, monitoring, follow up, reintegration and aftercare service should be offered in a confidential manner to employees with personal and work-related issues in order to improve work performance.

- **Consultation with work organisation**
  After identifying trends from personal and organisational issues, the work organisation should be addressed to proactively address the issues

- **Networking**
  Through networking effective relations can be established and maintained with service providers and internal and external role-players.

- **Monitoring and evaluation**
  Consistent monitoring and evaluation of EAP services in terms of value or success or impact for the work organisation and the individual job performance are crucial.

The elements of an effective EAP and the core technologies of an EAP are closely linked and overlap in some ways, but both indicate guidelines that are necessary for an effective EAP. The elements and core technologies can be used to evaluate if an EAP is effective and consists of the important fundamental aspects that enable it to deliver effective services.

According to Hartwell *et al.* (1996:804), EAPs can be administratively affiliated with the human resources, medical or other department of the company, functioning either as an internal administrative unit or as an external contractor, depending on the needs and resources of the company. Essentially there are two models in EAP service delivery. Services according to the in-house model are delivered by personnel employed by the company. Often there is direct control by the occupational health or human resource management departments. The external model makes use of an external service provider company specialising in EAP services. It has a network of counsellors to provide services for a variety of large and smaller employer clients alike.

Developments in EAP are affected by stringent economic climate and confidentiality issues have predisposed delivery methods to be increasingly performed by external contractor providers.

5.6 EAP'S ROLE IN MANAGING CRITICAL INCIDENTS IN THE WORKPLACE

Traditionally, EAPs will be the first port of call if an employer has a crisis in the workplace. The majority of EAP service providers have a programme in place to address workplace trauma. Stephenson and Schneider (2006:35) mention that the demand on EAPs has increased dramatically in terms of addressing emotional and mental health demands of the customer organisations and their employees in response to large scale natural or man-made disasters. This response is often a generic response and usually includes critical incident stress debriefing.

Vineburgh, Ursano, Gifford, Benedek and Fullerton (2006:14) mention that, with events such as9/11 (the terrorist attack on 11 September 2001), Hurricane Katrina and the avian flu pandemic, it was realised that trauma response was not sufficient and could be improved. They ask the question how employers and their employees can be better served before, during and after a disaster and acts of terrorism. They conclude that the focus should be more on managing the overall event rather just than reacting to the impact of the event. The focus, therefore, moves more towards CISM.

CISM is stated to be "a comprehensive, integrative, multi-component crisis intervention system. CISM is considered comprehensive because it consists of multiple crisis intervention components, which functionally span the entire temporal spectrum of a crisis. CISM interventions range from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. CISM is also considered comprehensive in that it consists of interventions which may be applied to individuals, small functional groups, large groups, families, organizations, and even communities" (MedicineNet.com).

CISM is the comprehensive approach to managing critical incident stress (CIS). PPC International (PPC clinical practice 2004:41) mentions that the comprehensive management of traumatic stress includes the following components:

- Critical incident education

- On-scene support
- Defusing
- Demobilisation
- Debriefing
- Individual consultation
- Follow-up debriefing
- Post-trauma counselling

Robinson (2004:29) mentions that it is a multi-component approach to staff support that incorporates education, individual support, group meetings (including CISD), organisational consultation, family support, referral and follow up.

The EAPA SA Standards document (2010:11) indicates that one of the standards to consider in designing, implementing and evaluating an EAP is clinical services. As part of an effective EAPs clinical service, trauma management should be offered. The goal of trauma management should be to respond to traumatic situations timeously in agreement with organisational policies and procedures. The objective of trauma management should be to provide trauma defusing services for the immediately affected employees, to provide debriefing for traumatised employees and to influence policies and procedures relating to trauma management. The motivation for trauma management is to lessen or prevent long-term difficulties or dysfunction for both individual employees and the organisation.

The researcher is of the opinion that EAPs play a pivotal role in the managing of trauma in the workplace. The fact that EAPA SA indicates that trauma management should form part of an EAPs scope of clinical services signifies that trauma management forms part of an effective EAP service offering to clients. Trauma management integrates with other services provided by EAPs and assists the company to address problems experienced by individuals and the organisation on various levels. Owing to the expertise of an EAP, the company can ensure that the trauma employees are exposed to and that impacts on their psychosocial functioning and work performance is correctly assessed and managed:

- **Organisational screening**

  Stephenson and Schneider (2006:44) suggest that prior to a critical incident the organisation should be assessed in terms of group resilience, adaptive functioning,

mutual social support of the group, management support, resources in terms of providing shelter and physical care as well as emotional care, existing structure of dealing with critical incidents and internal role players.

The organisational screening should also include a surveillance of potential risk factors. This includes a clinical and organisational assessment of mental health issues, substance abuse issues and skills of employees, and identifying all potential medical, organisational and mental health resources to address possible reactions after an incident.

Vineburgh *et al.* (2006:14) mention that the organisational screening should include the assessment of possible threats to an organisation, the level of employee preparedness, the overall health, performance and leadership functions necessary to sustain organisational resilience in the face of disasters or terrorism attacks.

EAPs can translate knowledge about appropriate disaster behaviour into workplace health interventions to foster human continuity and organisational resilience.

- **Consultation with management**

  After the organisational screening, management should be informed about the outcome of the organisational screening, and possible risks should be highlighted. This gives an idea of the employee population in terms of physical and mental health issues, possible reactions, resources and concerns in the event of a critical incident (Stephenson & Schneider, 2006:45).

  According to Vineburgh *et al.* (2006:15), this information can assist the EAP to provide a contingency plan for possible critical incidents and disasters. It will further assist management in developing a policy on conduct in such an event, integrating certain professionals (e.g. security) as change agent partners, mobilising a task team and communicating strategy to employees.

- **Psychological first aid (PFA)**

  The role of the EAP will also be to explore the efficiency of debriefing and alternative approaches to organisational crises intervention. Current literature agrees that PFA is a favoured alternative approach to CISD and forms an integral part of CISM.

"Psychological first aid (PFA) consists of a systematic set of helping actions aimed at reducing initial post-trauma distress and supporting short- and long-term adaptive functions" (Ruzek, Brymer, Jacobs, Layne, Vernberg & Watson: 2007:17). According to VandePol, Gist, Braverman and Labardee (2006:123), PFA "is by intent a more flexible approach to assessing impacts, determining viablepoints of productive assistance, and generating helping strategies specifically geared toward the express needs and expectations of the organisation being served and the employees affected. As such it is consultative rather than clinical and advocates assistance rather than intervention."

PFA is constructed around eight core actions (Ruzak *et al*., 2007:17):

- Contact and engagement

  The PFA providers are challenged to rapidly establish contact with traumatised employees and to develop a positive relationship.
- Safety and comfort

  Practical help must start by ensuring immediate physical safety, providing physical and emotional comfort and promoting a psychological sense of safety.
- Stabilisation

  When traumatised employees are emotionally overwhelmed, it may be important to attempt to calm them down and to reduce their distress.
- Information gathering

  Because the focus is on immediate assistance for the traumatised employee, information gathering in the context of PFA focuses mainly on the identification of immediate needs and concerns, for example immediate post-trauma circumstances, on-going threat, physical illness, need for medication, severity of experiences during the disaster.
- Practical assistance

  Assisting traumatised employees with current or anticipated problems is crucial. On-going adversities and continuing problems resulting from the disaster can add significantly to the stress levels of survivors, distract them from self-care and maintain distress reactions.

- Connection with social supports

  Assistance with re-establishing contacts with primary support persons or other sources of support (e.g. family, friends and community helping resources) is an important PFA action.
- Information on coping support

  Although PFA is not focused on treatment of psychological problems, the PFA contact provides an important opportunity to influence coping behaviour of affected employees by providing brief education about the incident, stress reactions and coping.
- Linkage with collaborative services.

  It is likely that affected employees might need additional assistance following a PFA contact, the contact is used to link survivors with appropriate services.

  The objectives of PFA are practical and palliative rather than therapeutic (VandePol *et al*., 2006:124), focused on the initial intervention after trauma and referring for more specialised care if needed.
- Specialisation or speciality partnerships

  Universal approaches such as defusing and debriefing are widely accepted as a standard way of care and can be adapted by any provider to suit the needs of the client. It has become evident that ordinary approaches to crisis response are not fully addressing the needs and issues of employees. Specialisation or speciality partners focusing only on providing CISM help organisations to plan, assess, respond and react to critical incidents in the best way, and provide constant access to the best information available and the best practices, no matter what the circumstances or situation.

The role of the EAP is to provide a specialised service or to establish a working relationship with a specialised partner in the field of CISM in order to be in a position to provide the best possible service to the clients. According to VandePol *et al.* (2006:126–128), an EAP with a specialised CISM service or a specialised partner should be able to deliver the following:

- Training, information and preparation to inform best practice
- Consultation and assistance with contingency planning
- Access to tools, techniques and instruments
- Rapid access to trained and capable response staff

- Access to evidence-based tools and techniques for responding beyond the crises situation
- Evaluation, follow up and impact analysis.

Effective CISM is focused on normalising the abnormal in the quickest possible time to prevent any unnecessary discomfort to the employee, the company and family members and to restore functioning and productivity.

5.7 VALUE OF AN EAP

The value of an EAP is mostly determined in terms of normalising the reactions employees display after a critical incident and improved psychosocial functioning of the individual, meaning that the focus is on showing less symptomatic discomfort. Effectiveness is also measured in terms of restoring and stabilising the organisation, that is, being fully functional and productive in the quickest possible time. It is usually difficult to measure these factors and to determine the direct impact of an incident and the result of an intervention in the process of restoring the individual's and organisation's functioning.

There is, however, evidence from the literature that EAP intervention in terms of critical incidents is effective.

Critical incident stress response(CIR) refers to an integrated, comprehensive, multi-component crisis intervention approach for addressing the psychological consequences of critical incidents. CIR usually forms part of a EAPs CISM strategy that focuses on the appropriate intervention for a specific critical incident. Over the past 25 years, a general model of CIR group debriefing has been developed that can be used to accelerate recovery from traumatic workplace events (VandePol *et al.,* 2006:119).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.

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".

What is not a debate anymore, however, is that the use of CISM or other kinds of psychological early interventions cannot successfully *prevent* the experience of PTSD, according to research reported by Bryant (2007:22) and Feldner, Monson and Friedman (2007:86). But once someone has developed PTSD or acute stress disorder, there are treatments with empirical evidence of their clinical efficacy.

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 as well. The business value for employers of 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, and reduced worker turnover because an increasing number of employees can successfully return to work after being on disability due to experiencing a traumatic event (Smith & Rooney, 1999:341). Some businesses provide access to CIR services as a form of risk management and to reduce their legal exposure to workplace-related traumatic incidents (Tehrani, 2002:474).

EAPs strive to improve employee productivity and organisational performance. According to Holtyn (2006:8) and the results of the exclusive return on investment study conducted among wellness managers in America, workplace wellness programmes improve employee morale, reduce company healthcare costs and increase productivity on many levels.

The employee assistance workgroup (EAP workgroup) was established in 2007 to develop recommendations for improving the coordination and integration of EAPs, as well as examining best practices and evidence-based approaches to design and deliver effective and efficient EAPs (Rothermel, Slavit, Marlo & Dan, 2008:2).

According to Mercer (2007:201), EAPs aligned with an overall health and productivity strategy can perform a critical role in identifying individual and organisational risk factors that may decrease performance. A report by Wyatt (2007:19)suggests that organisational response to health and productivity challenges will increase revenue, market value and shareholder returns.

Rothermal *et al.* (2007:8) mention that an EAP that is aligned with organisational values and vision measurably enhances business operations, the overall employee experience and the community's perception of the company.

EAPs add value in the following three ways McCleod and McCleod, 2001:187; Rothermel *et al*., 2007:8–9):

- EAPs leverage the value of the organisation's investment in its workforce by:
  - Encouraging employee engagement
  - Improving employees and their dependents' abilities to successfully respond to life challenges
  - Offering employees and dependents short-term problem resolution services or referring them to mental health treatment services
  - Developing manager and employee competencies in dealing with workplace stress and improving team performance.
- EAPs address the cost of doing business by:
  - Reducing workplace absenteeism and unplanned absence
  - Decreasing workplace accidents
  - Lowering employee turnover and related replacement costs
  - Facilitating safe, timely and effective return-to-work for employees after short-term and extended absence
  - Reducing healthcare costs
  - Increasing efficient use of health care through early identification, care management and recovery efforts.
- EAPs mitigate business risk by:
  - Reducing the likelihood of workplace violence or other safety risks
  - Managing the effect of disruptive incidents in the workplace, such as violence, injury or other crises, and facilitate a swift return-to-work after adverse workplace events
  - Supporting disaster and emergency preparedness and minimising disruption after such an event
  - Smoothing the adjustment to mergers, acquisitions, site closures or other workforce change events
  - Reducing the likelihood of legal action or liability

- Promoting and supporting drug-and alcohol-free workplace policies and programmes.

According to the American Psychological Association, successful organisations more and more realise that taking care of employees is not only the right thing to do, it also makes good business sense as some of the employers demonstrate that investing in employee health and wellbeing leads to business success (Newman, 2007:17).

5.8 CONCLUSION

Trauma and critical incidents area part of everyday life and affects employees and organisations on a daily basis. EAPs play a pivotal role in the world of work and providing an appropriate intervention for trauma. Both employers and employees benefit from EAPs as they provide easy access to intervention for a range of problems and traumas that effect employees and organisational performance.

Although it is at times difficult to prove the impact of an EAP, it is clear, according to the literature, that it has a positive effect on employees affected by critical incidents. Companies also benefit as EAPs help to reduce absenteeism and presenteeism, health care costs, staff turnover and accidents at work. This leads to a decrease in the time employees and companies are affected and leads to increased productivity.

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.

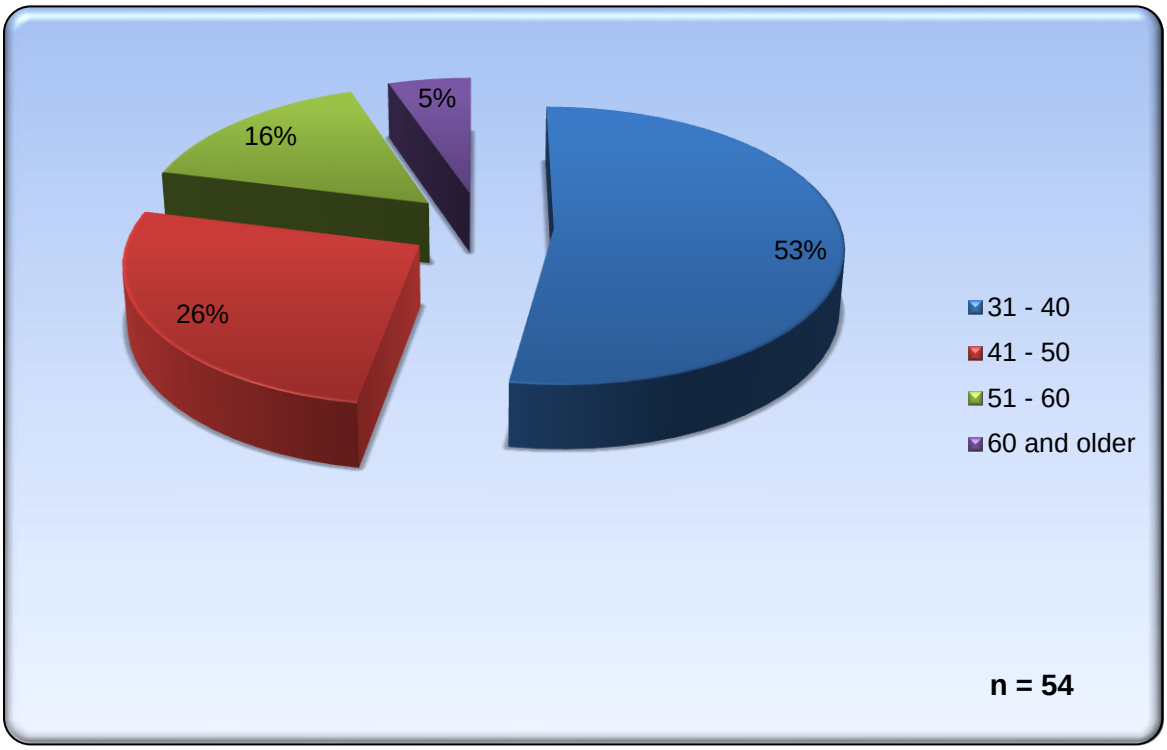


Figure 5: Age of respondents

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.

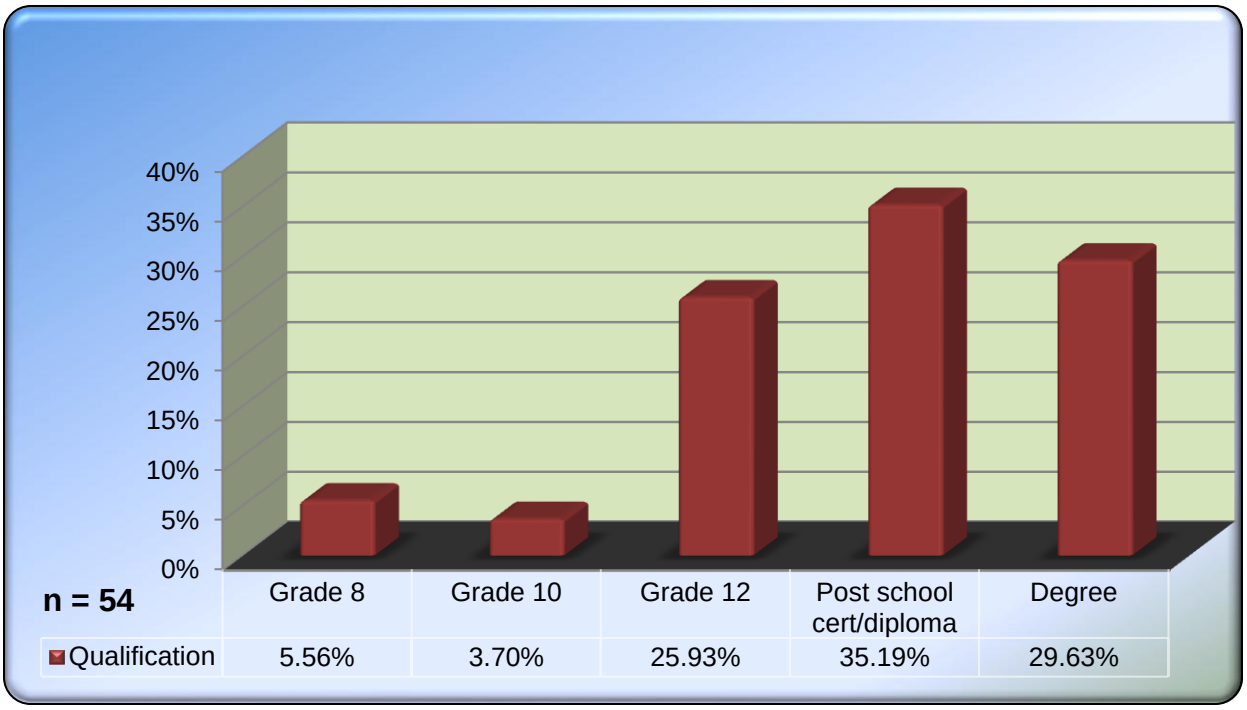


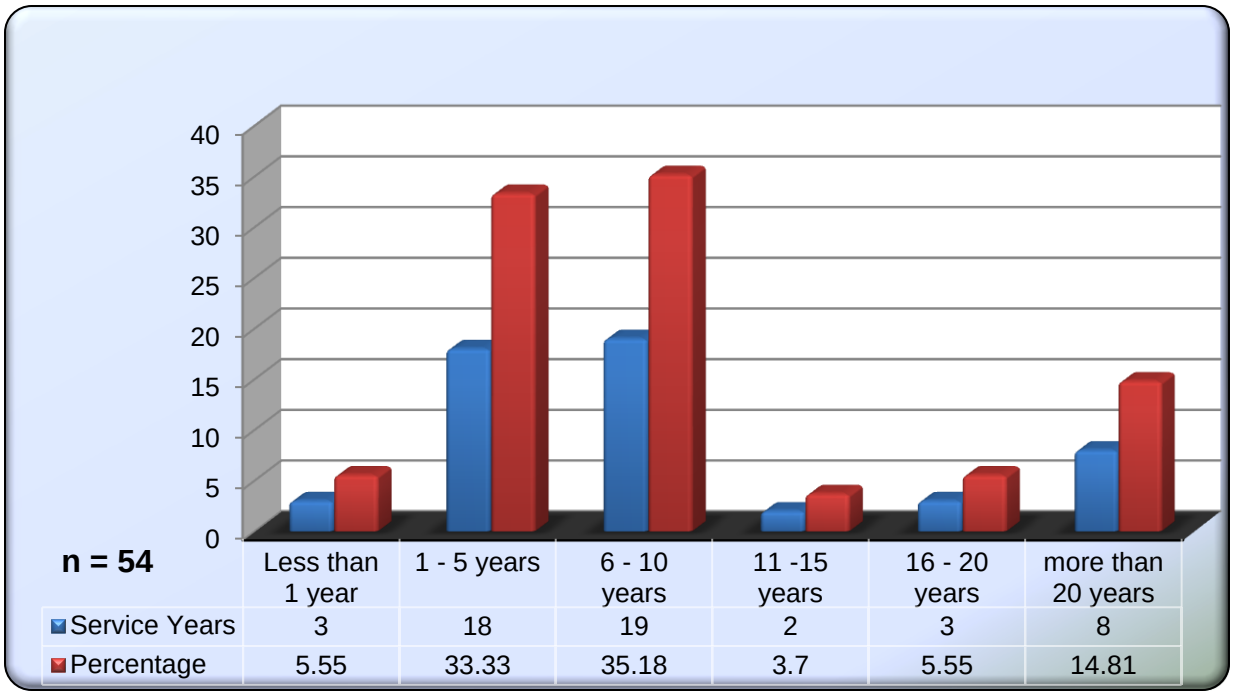
Figure 6: Highest qualifications

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.

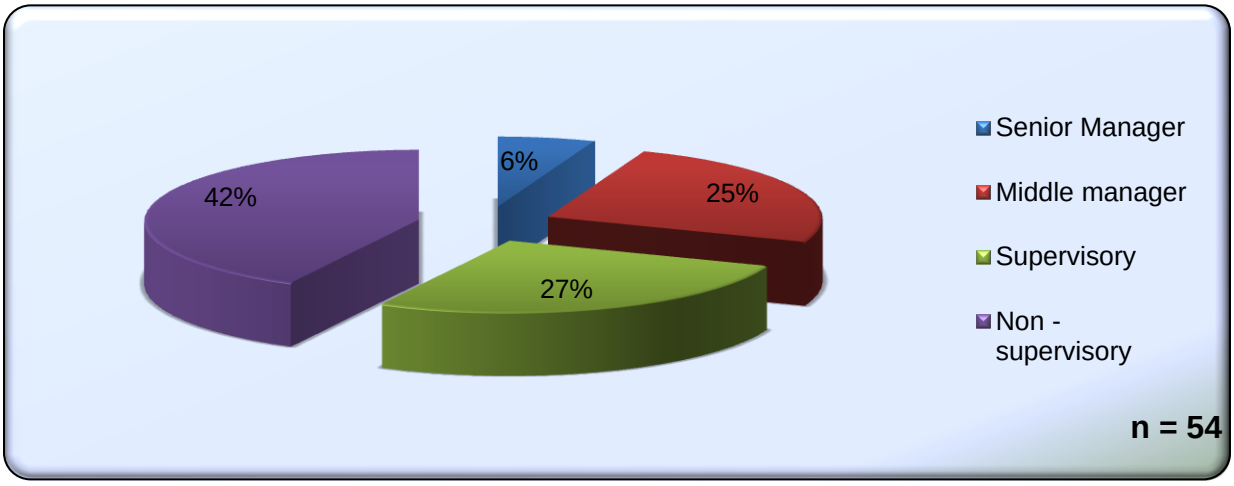


Figure 8: Level of functioning

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.

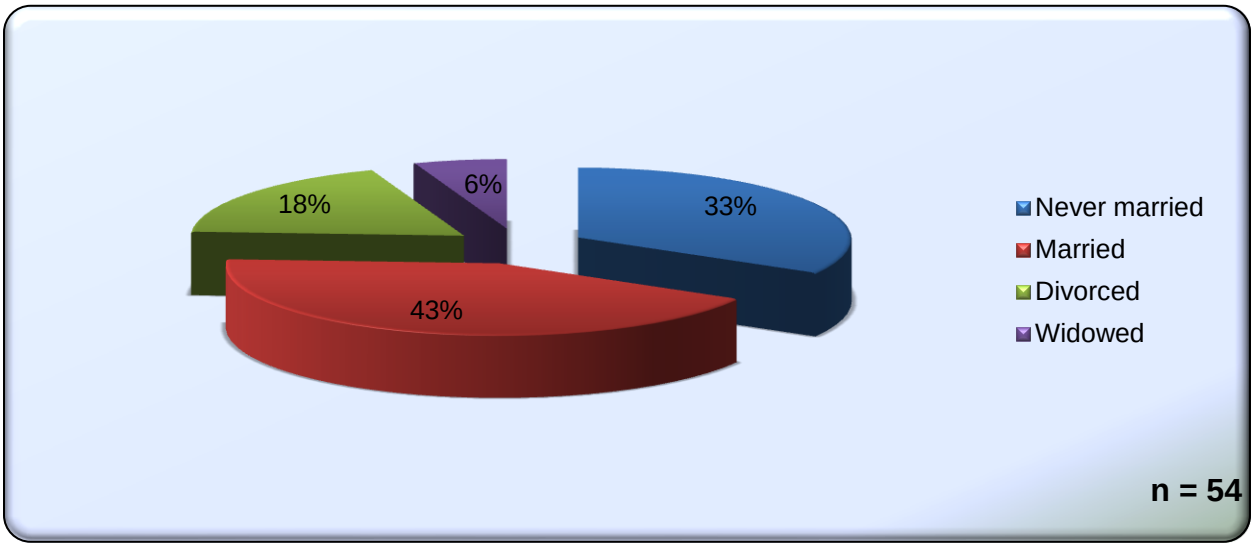


Figure 9: Marital status

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.

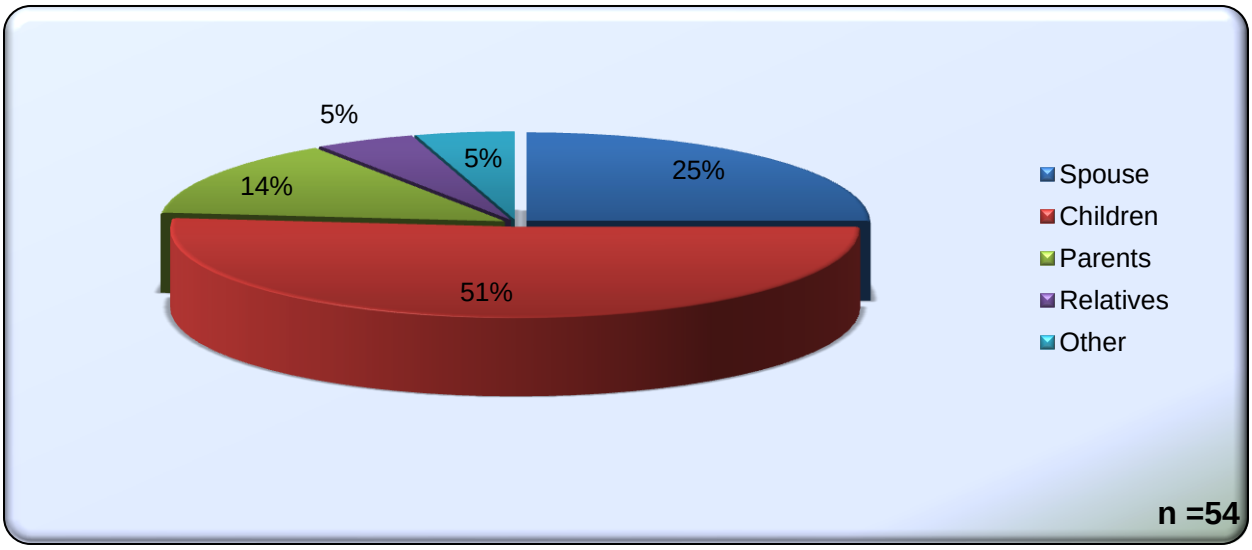


Figure 10: Dependants

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.

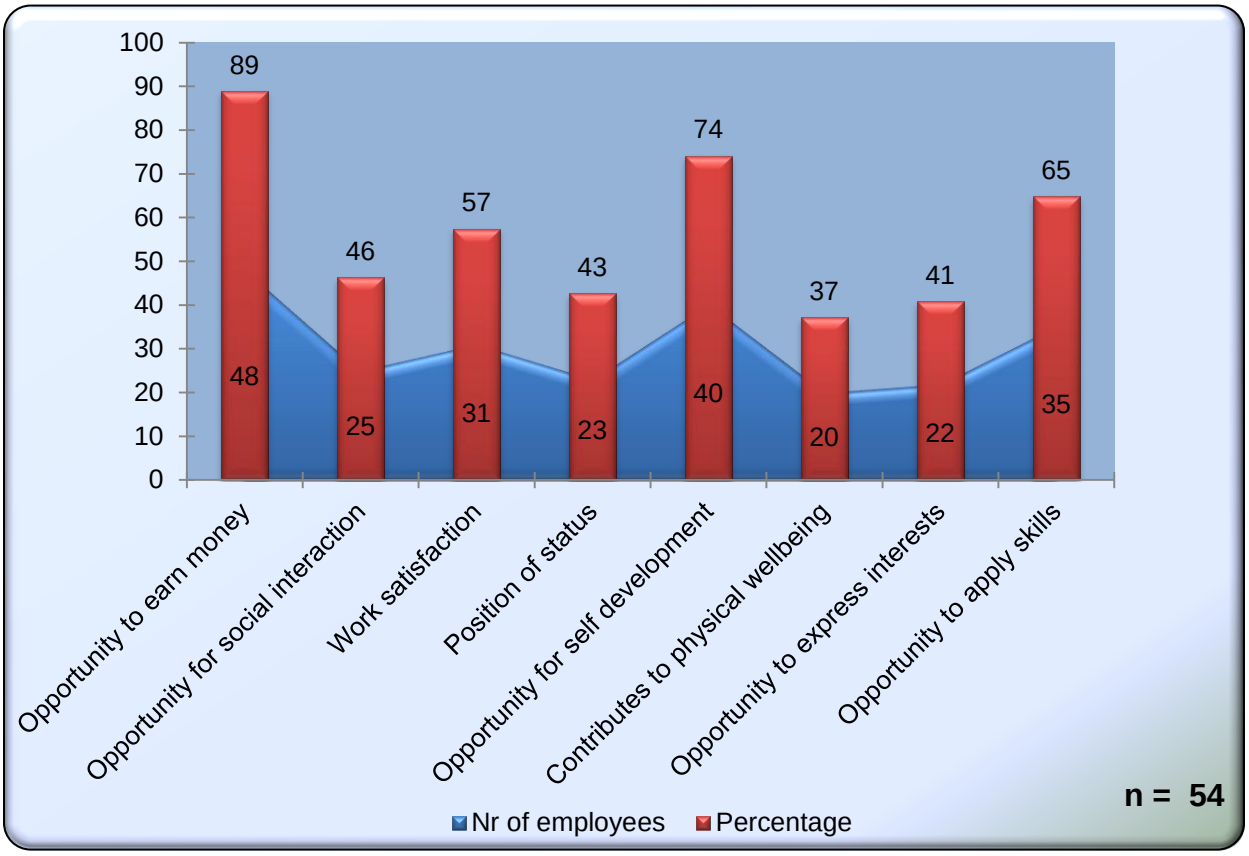


Figure11: Meaning of work

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.

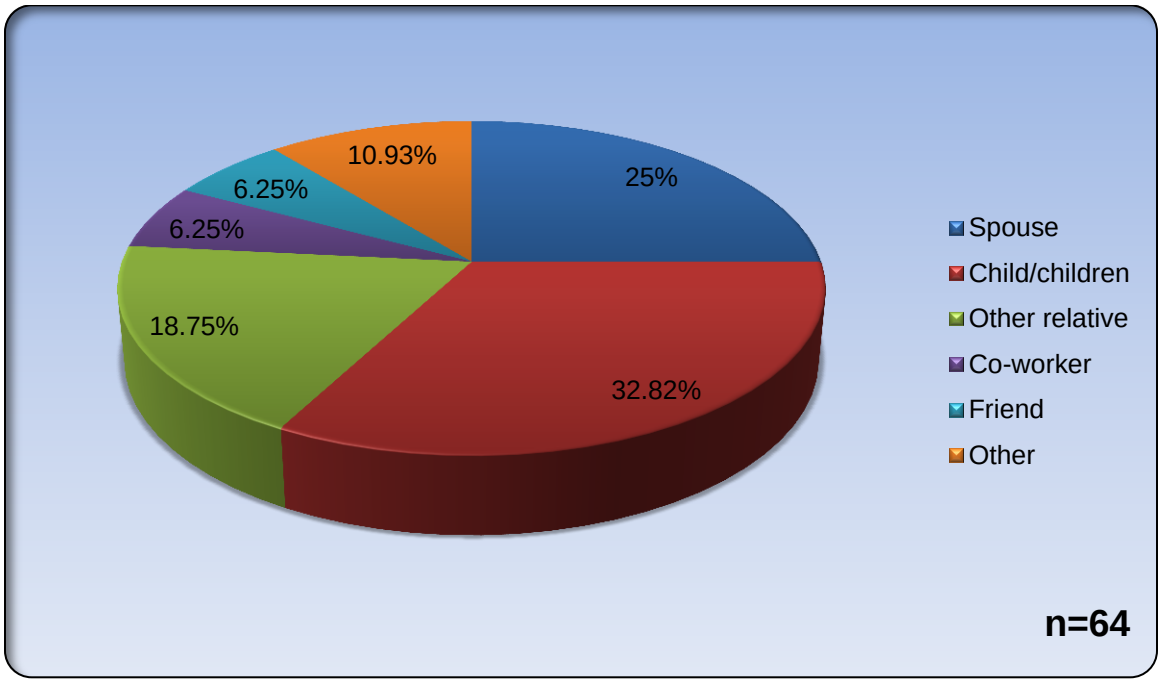


Figure 12: Relationship to person being exposed to critical incident (if not self)

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.

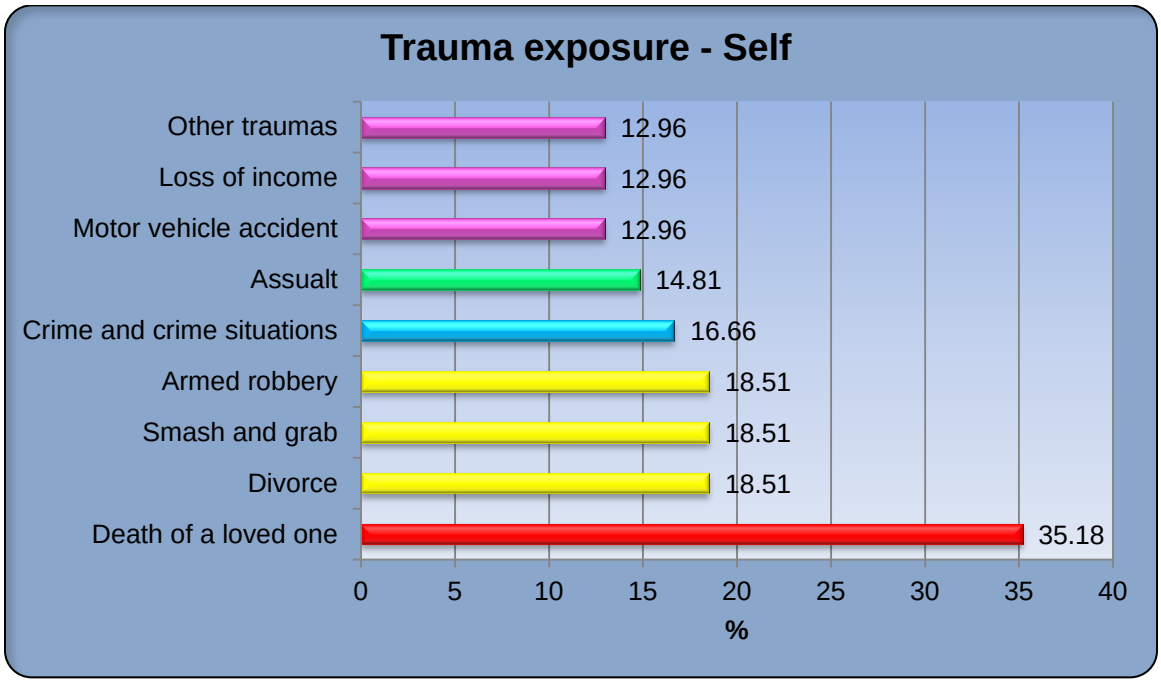


Figure 13: Trauma exposure – self

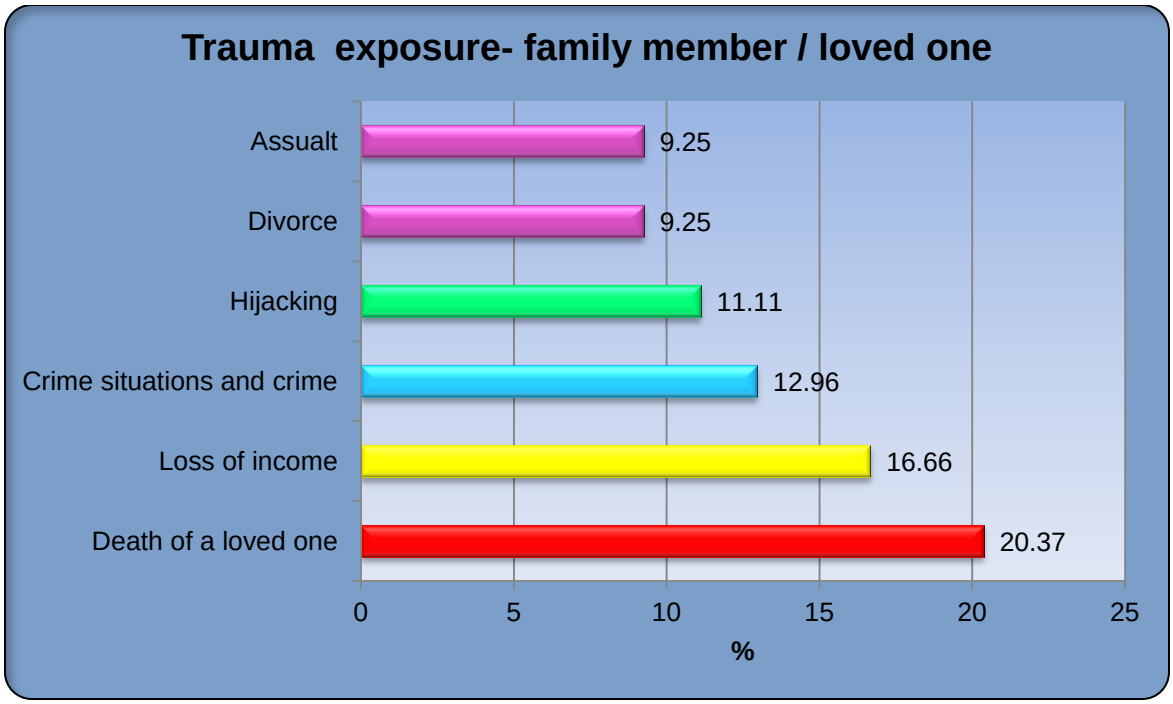


Figure 14: Trauma exposure – family member or loved one

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.

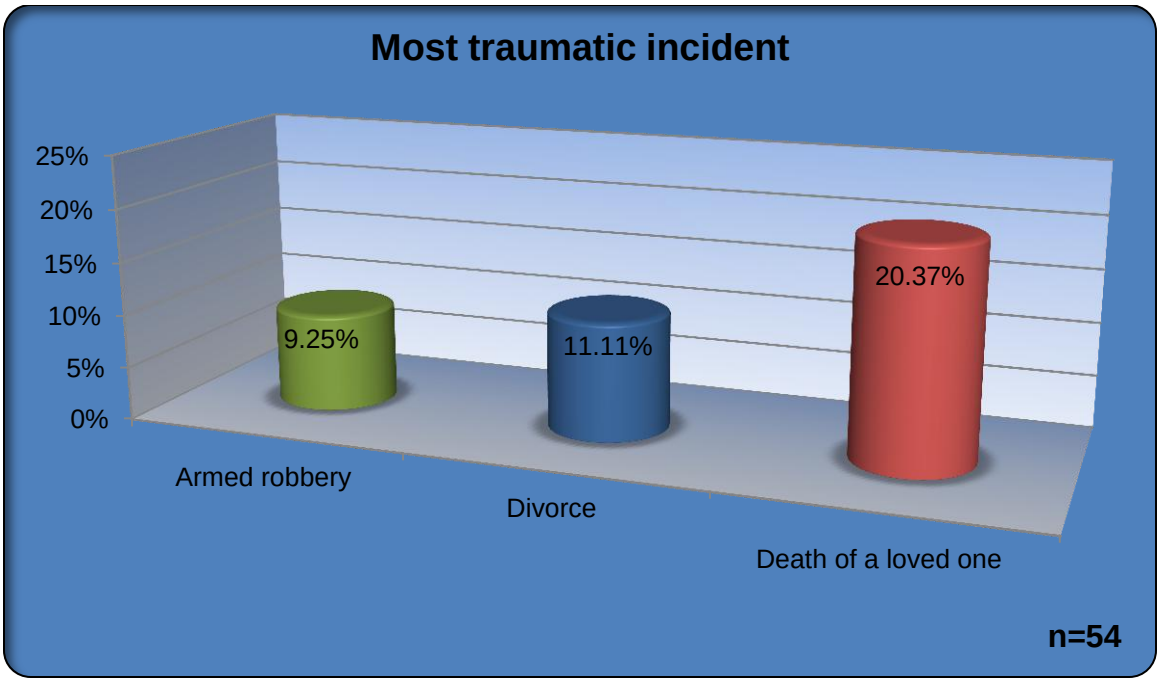


Figure 15: Top three incidents as indicated most traumatic by respondents

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.

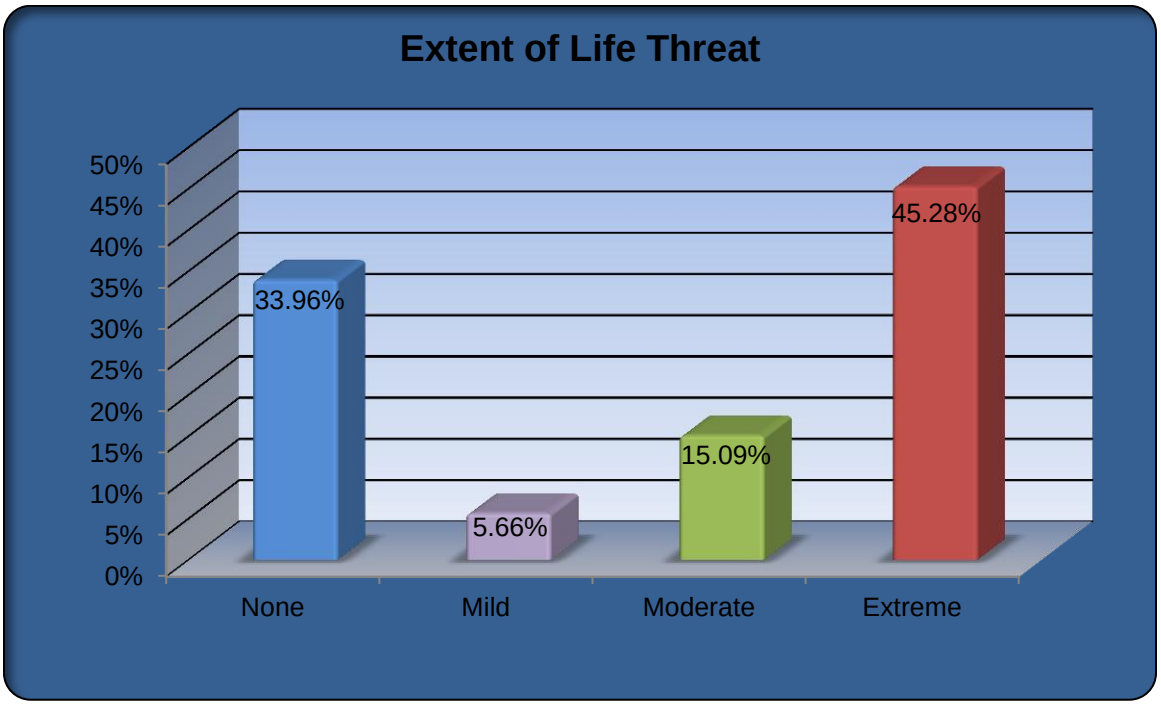


Figure 16: Extent of life threat

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.

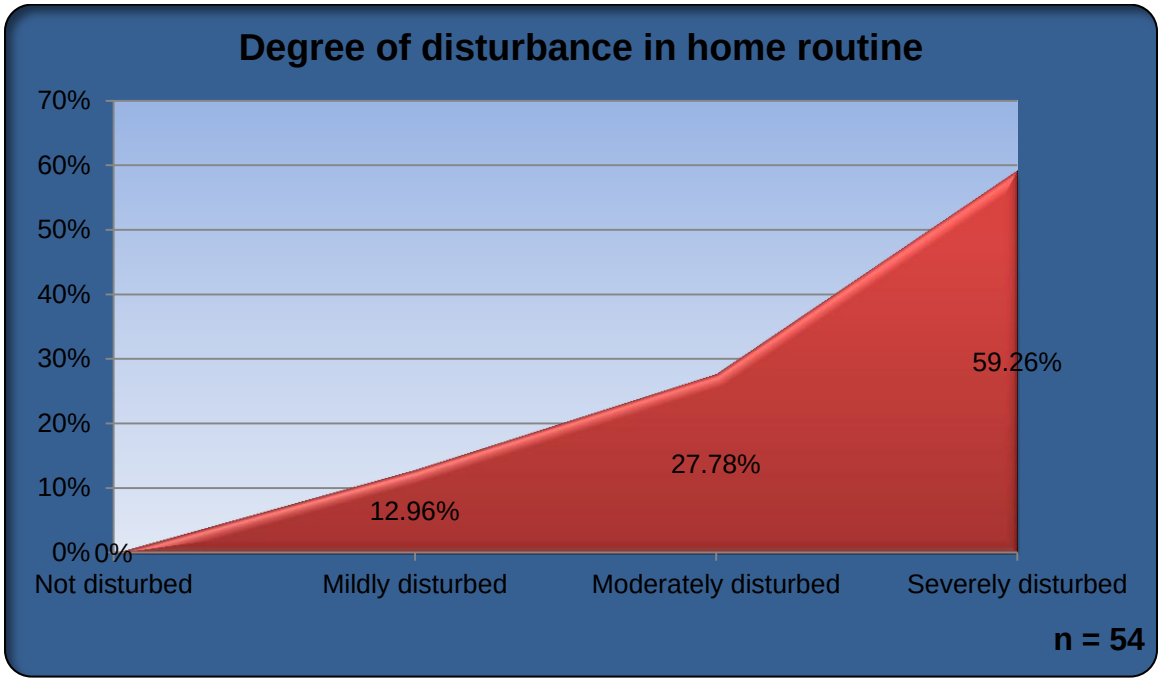


Figure 17: Degree of disturbance in home routine

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.

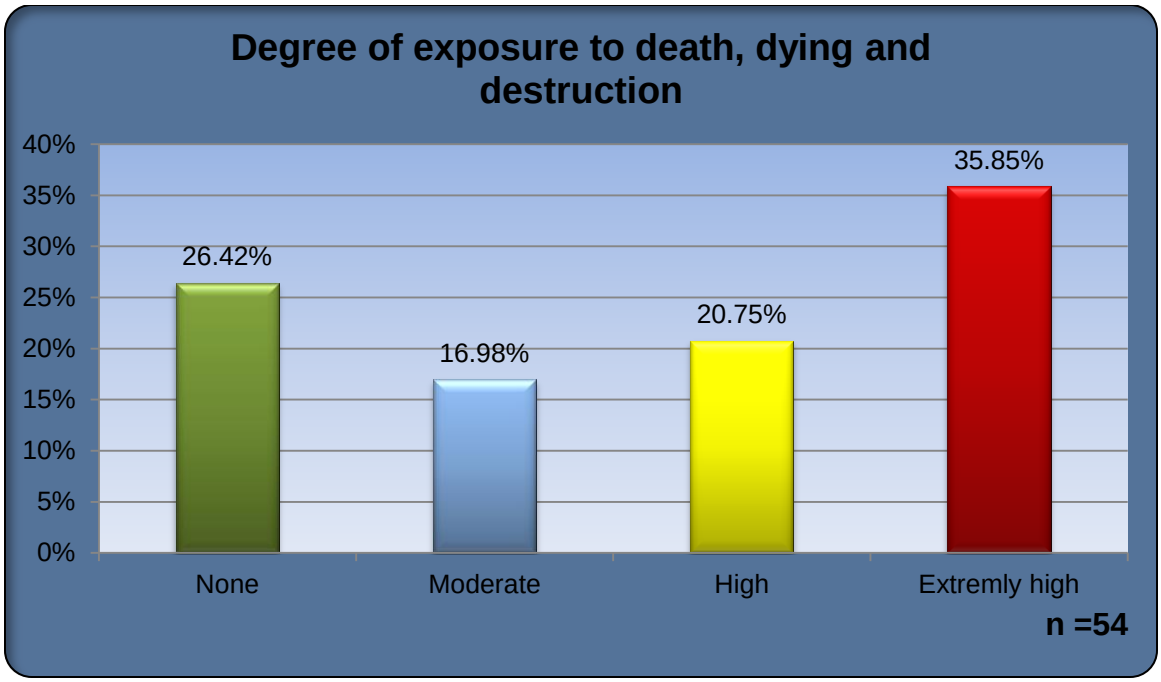


Figure 18: Degree of exposure to death, dying and destruction

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.

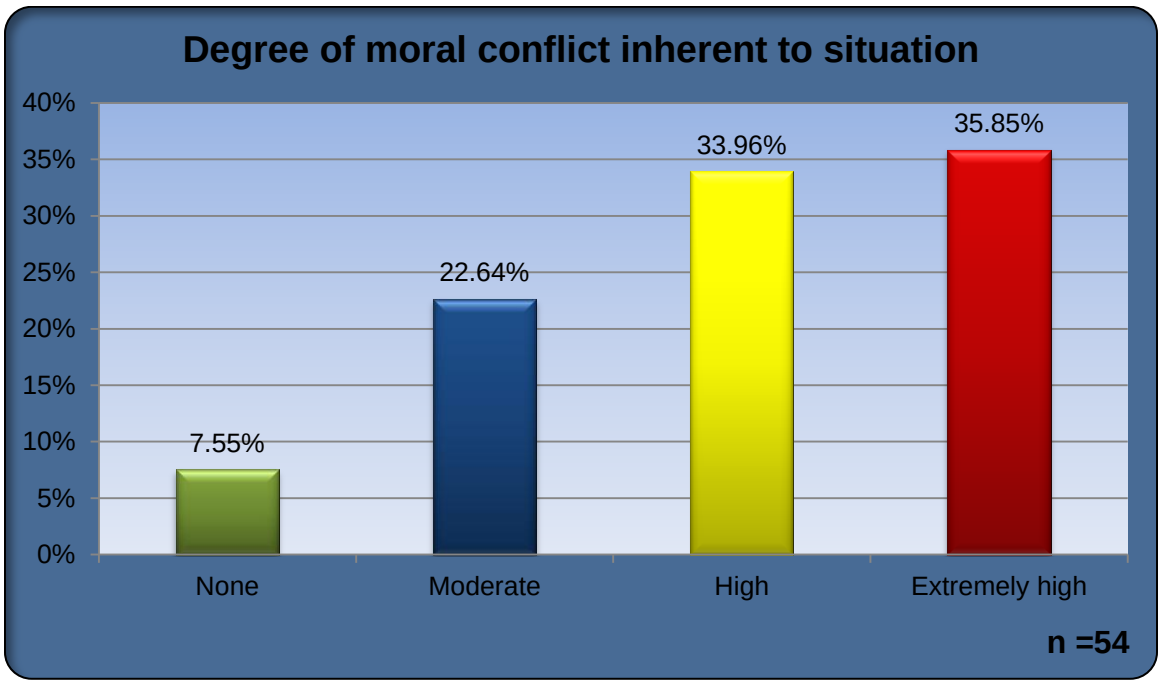


Figure 19: Moral conflict inherent to situation

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.

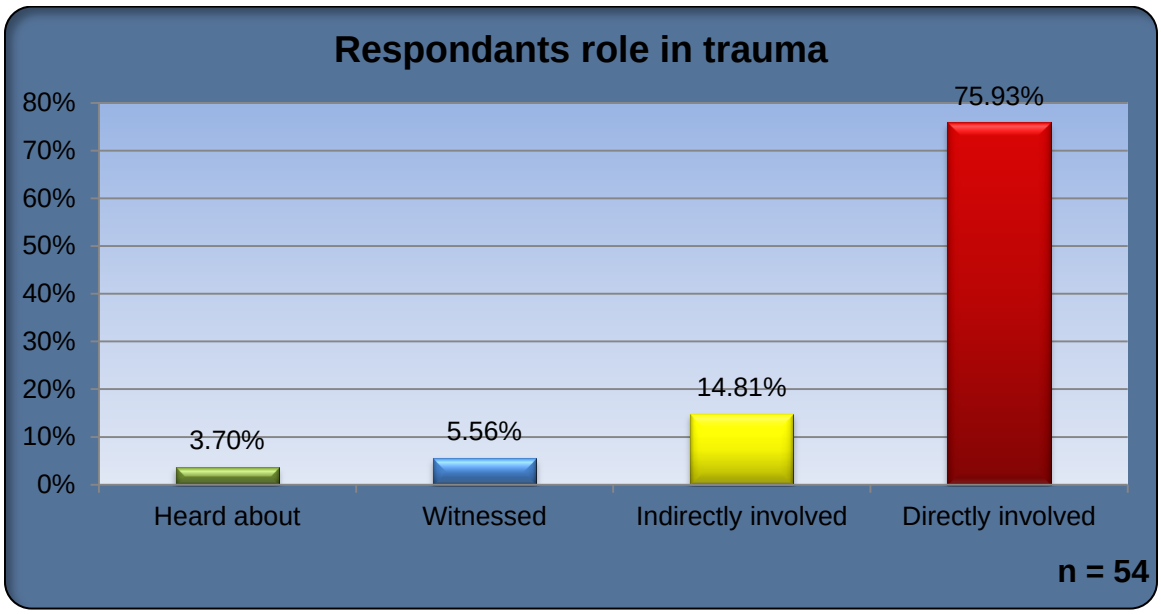


Figure 20: Respondents role in trauma

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.

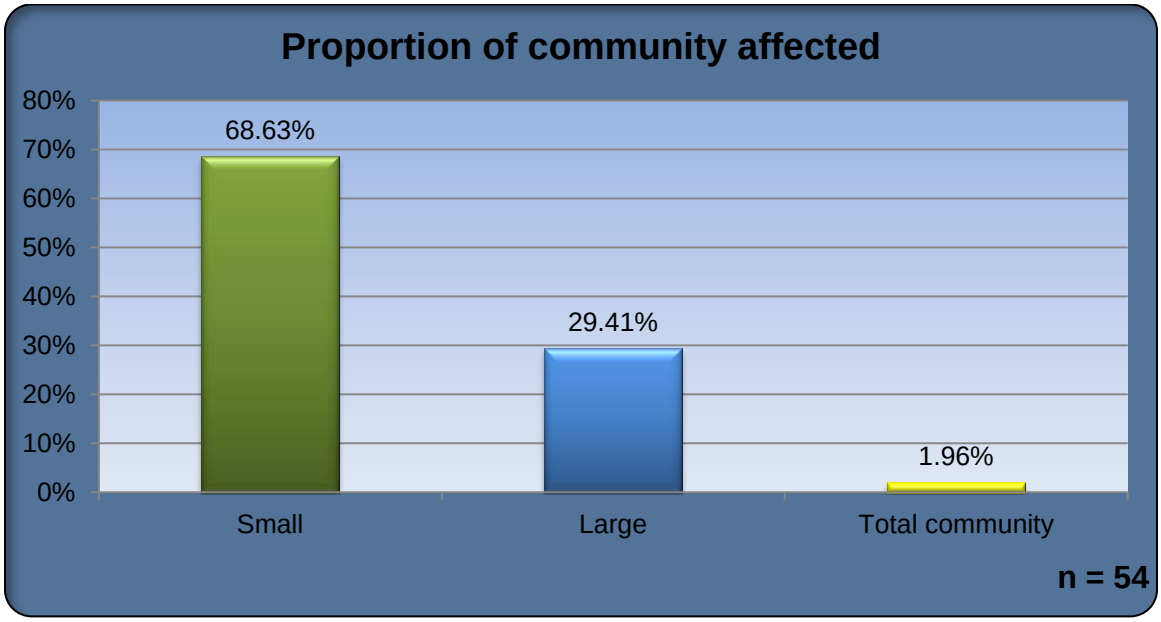


Figure 21: Proportion of the community affected

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.

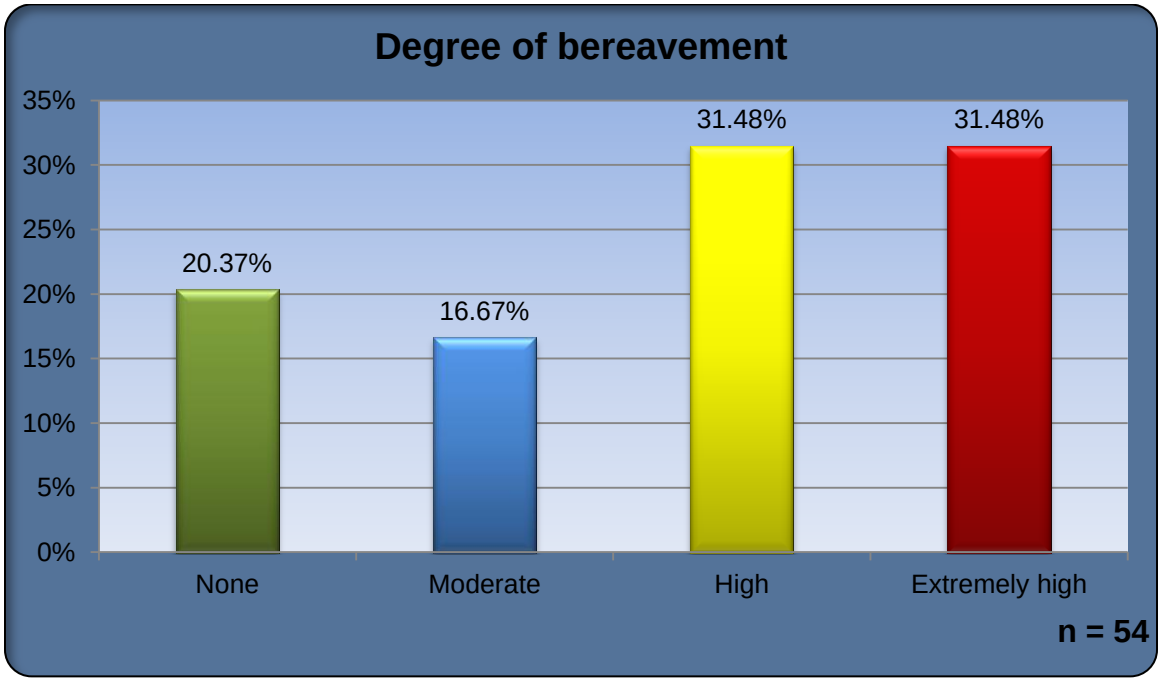


Figure 22: Degree of bereavement

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.

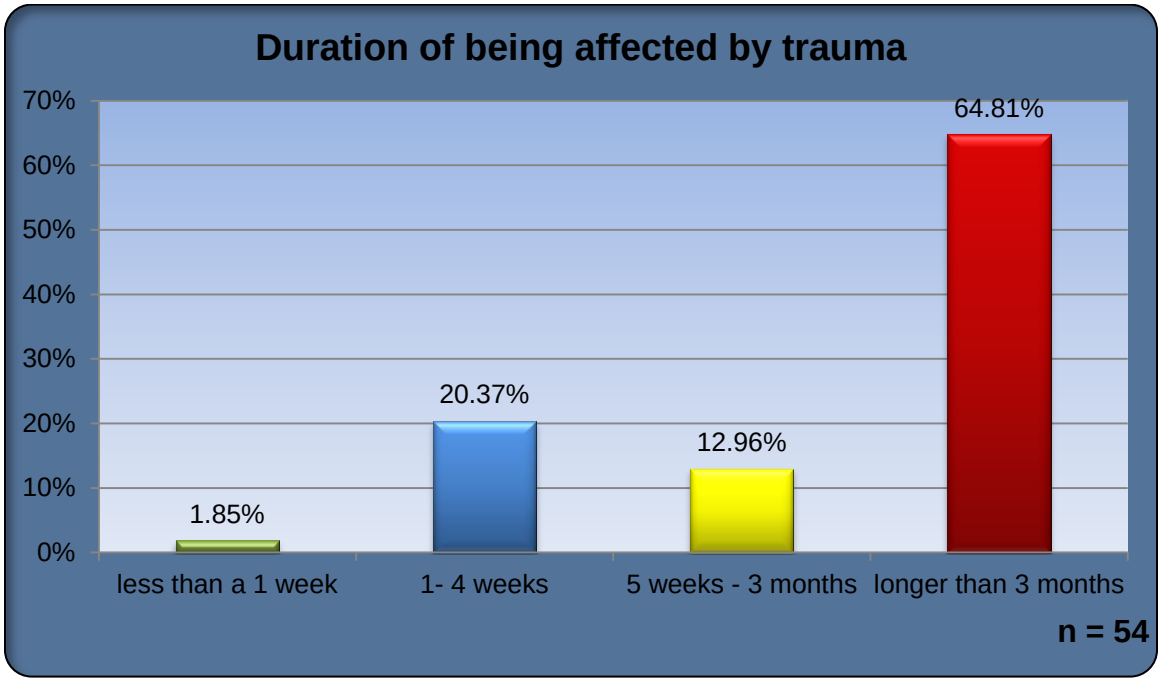


Figure 23: Duration of being affected by trauma

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.

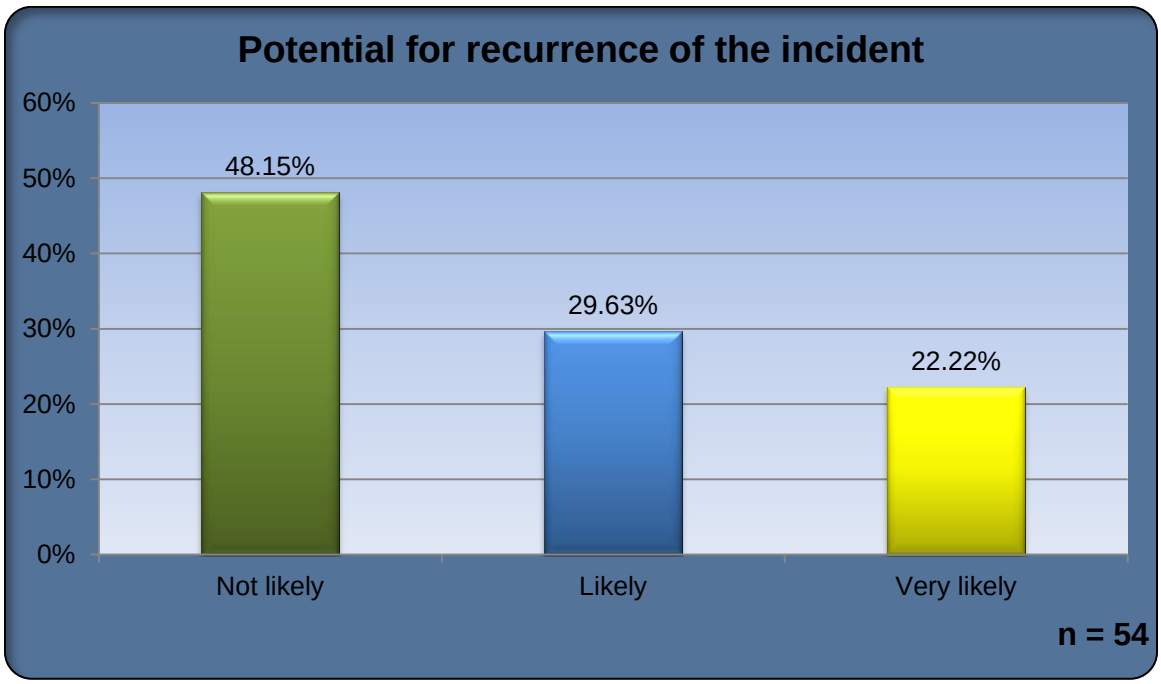


Figure 24: Potential for the recurrence of the incident

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.

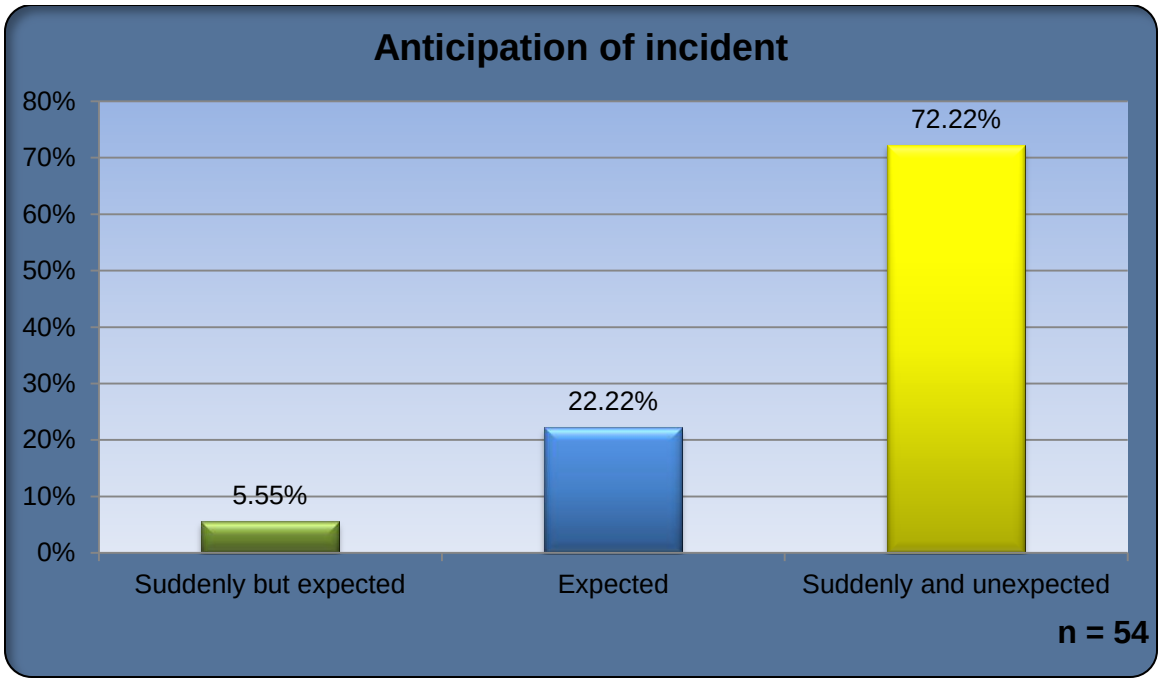


Figure 25: Anticipation of incident

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.

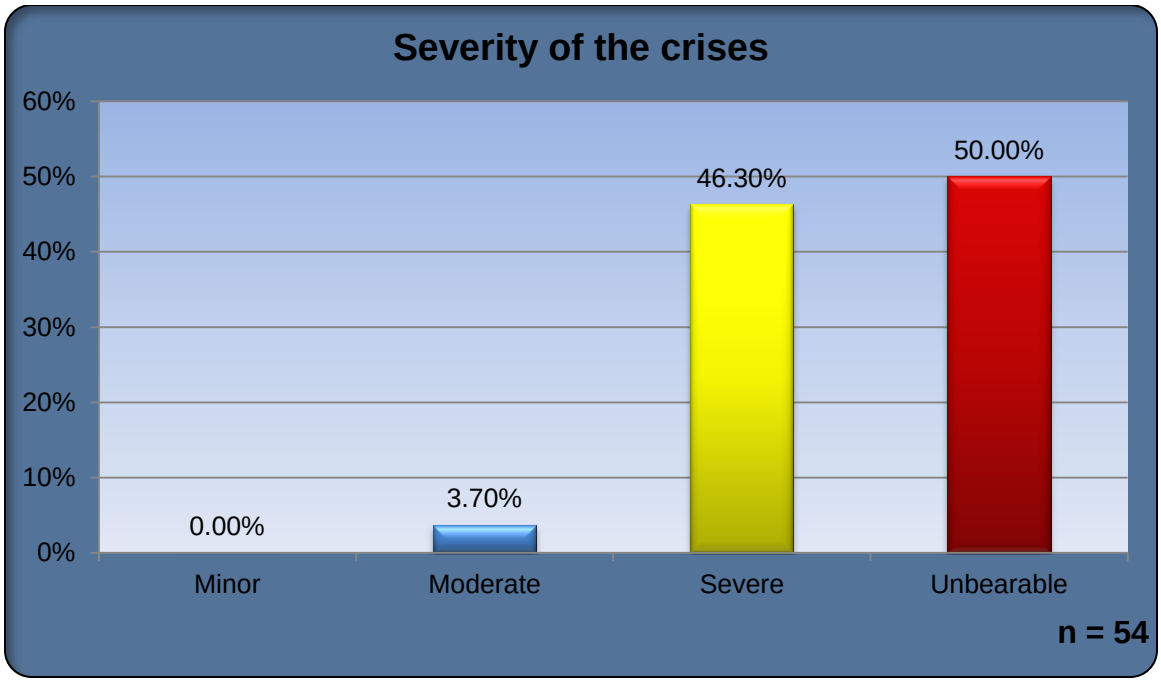


Figure 26: Severity of the crises

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.

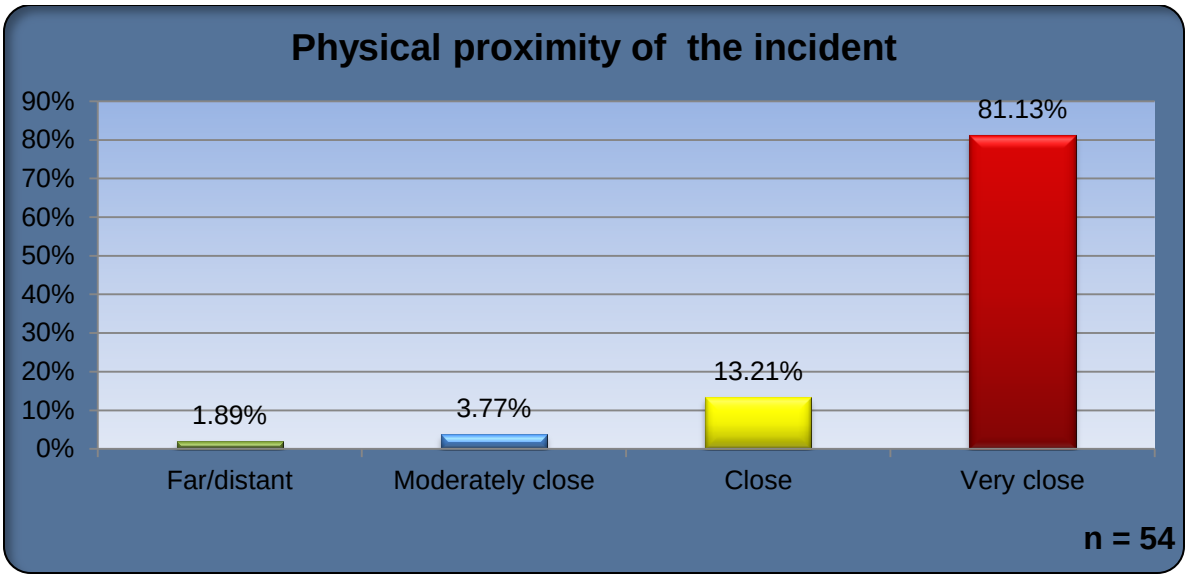


Figure 27: Physical proximity of the incident

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.

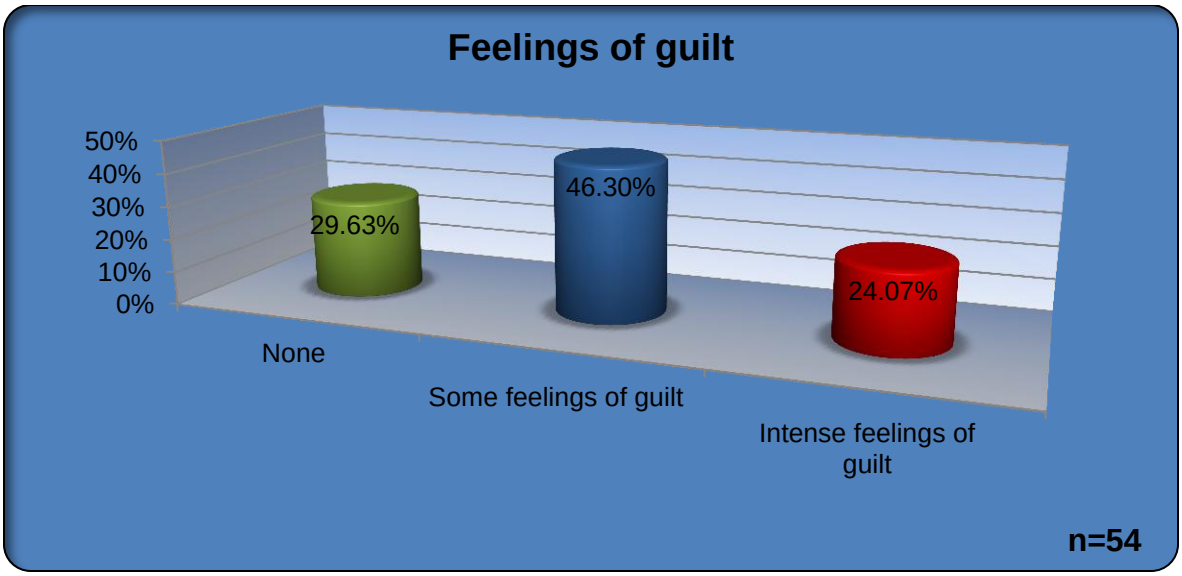


Figure 28: Feelings of guilt

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.

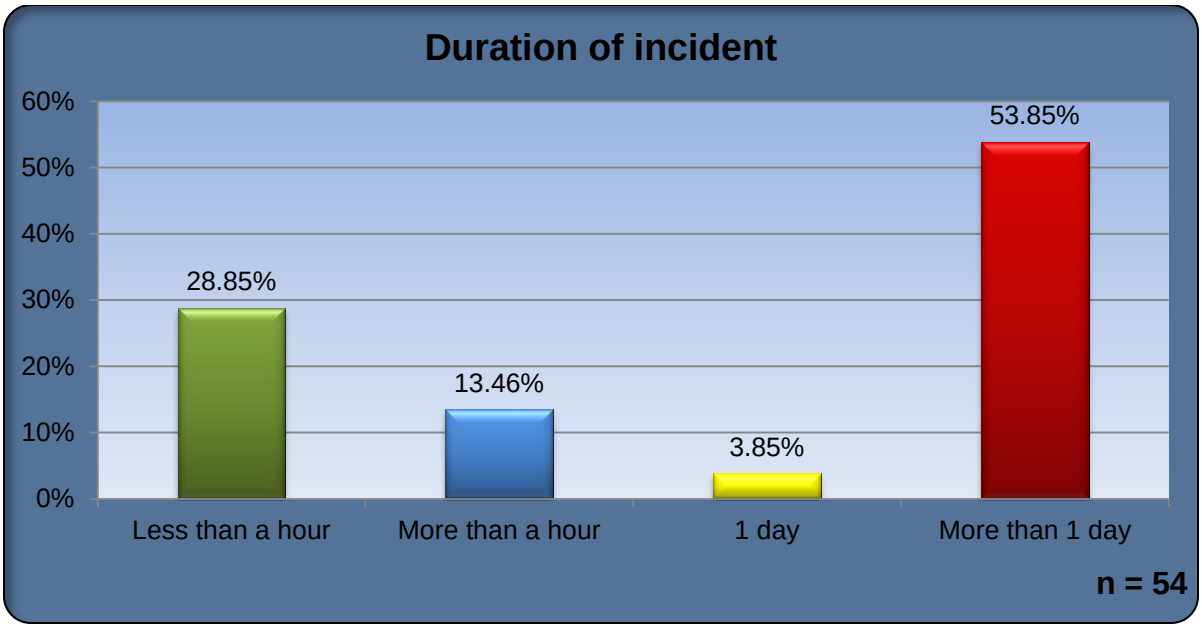


Figure 29: Duration of incident

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.

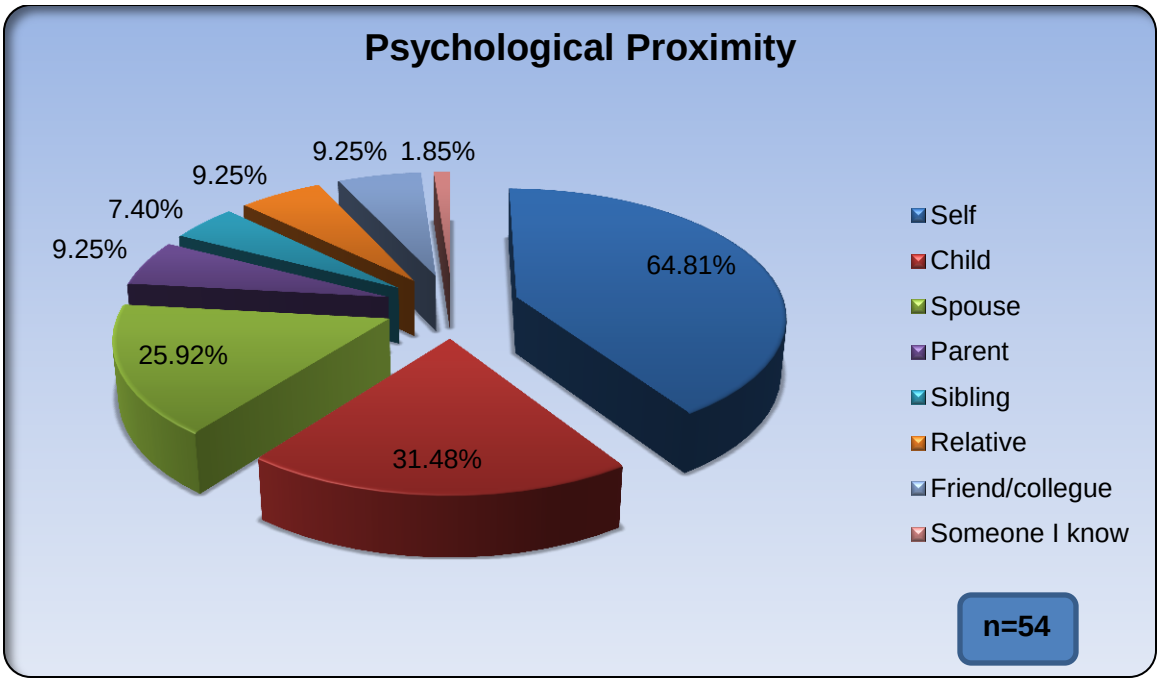


Figure 30: Psychological proximity

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.

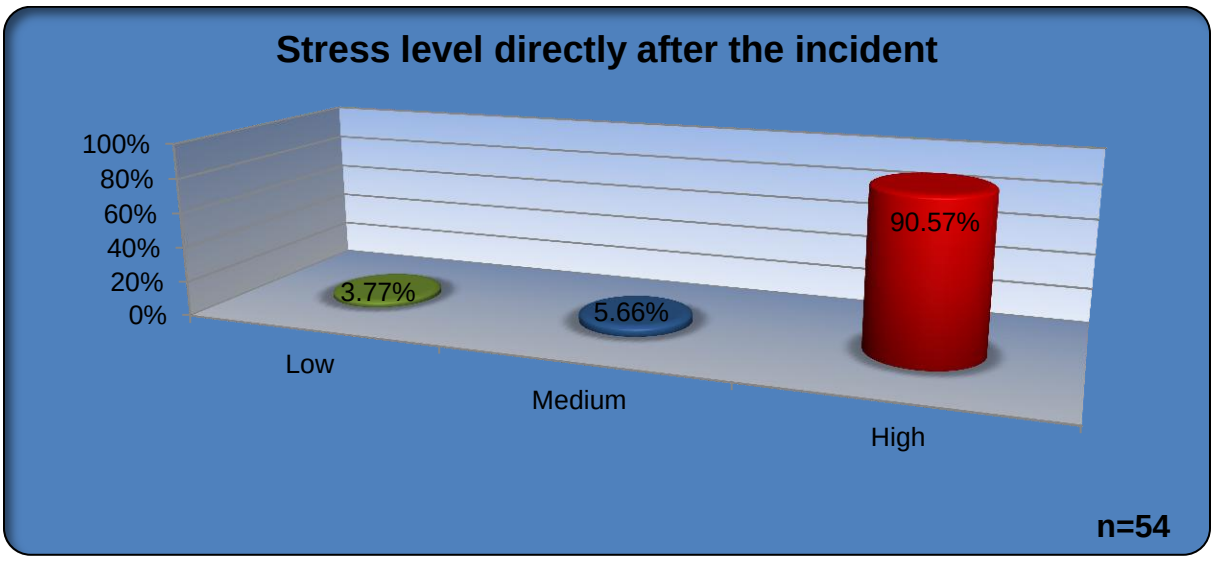


Figure 31: Stress level directly after the incident

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.

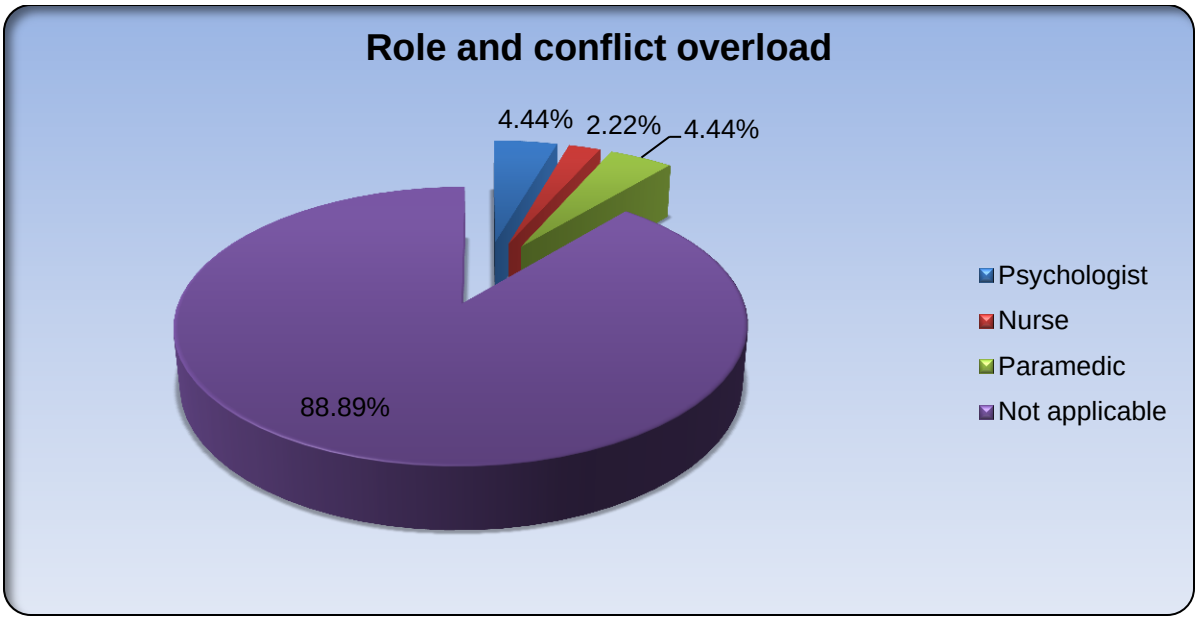


Figure 32: Role and conflict overload

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.

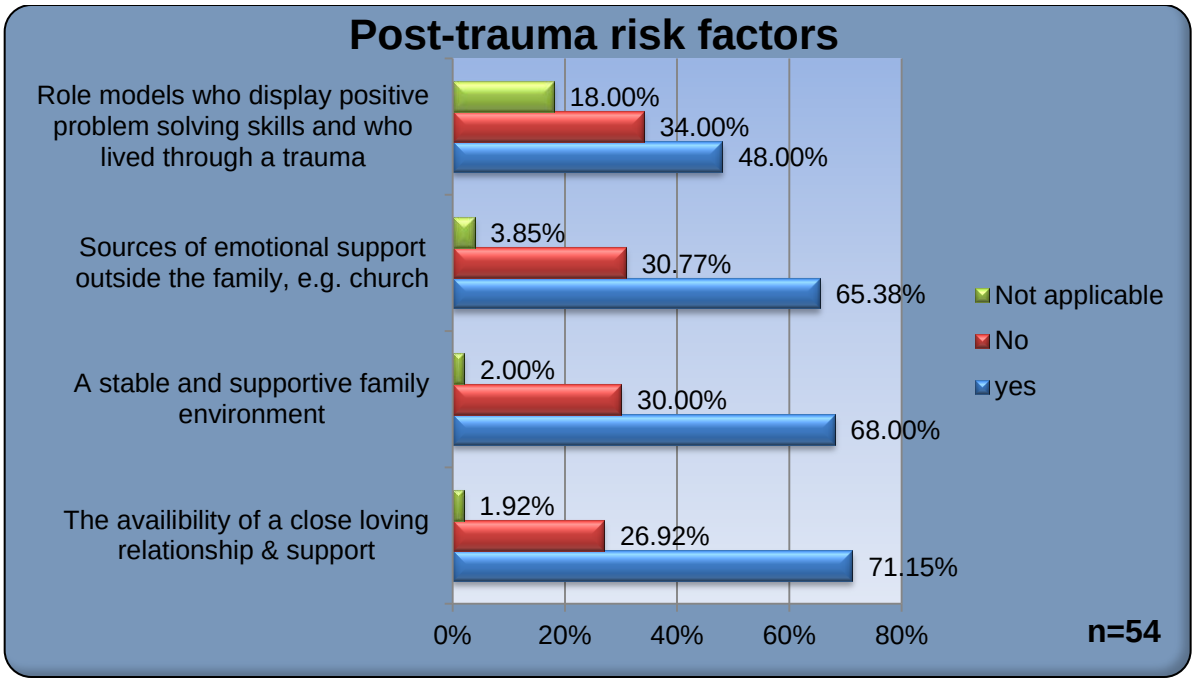


Figure 33: Post-trauma risk factors

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.

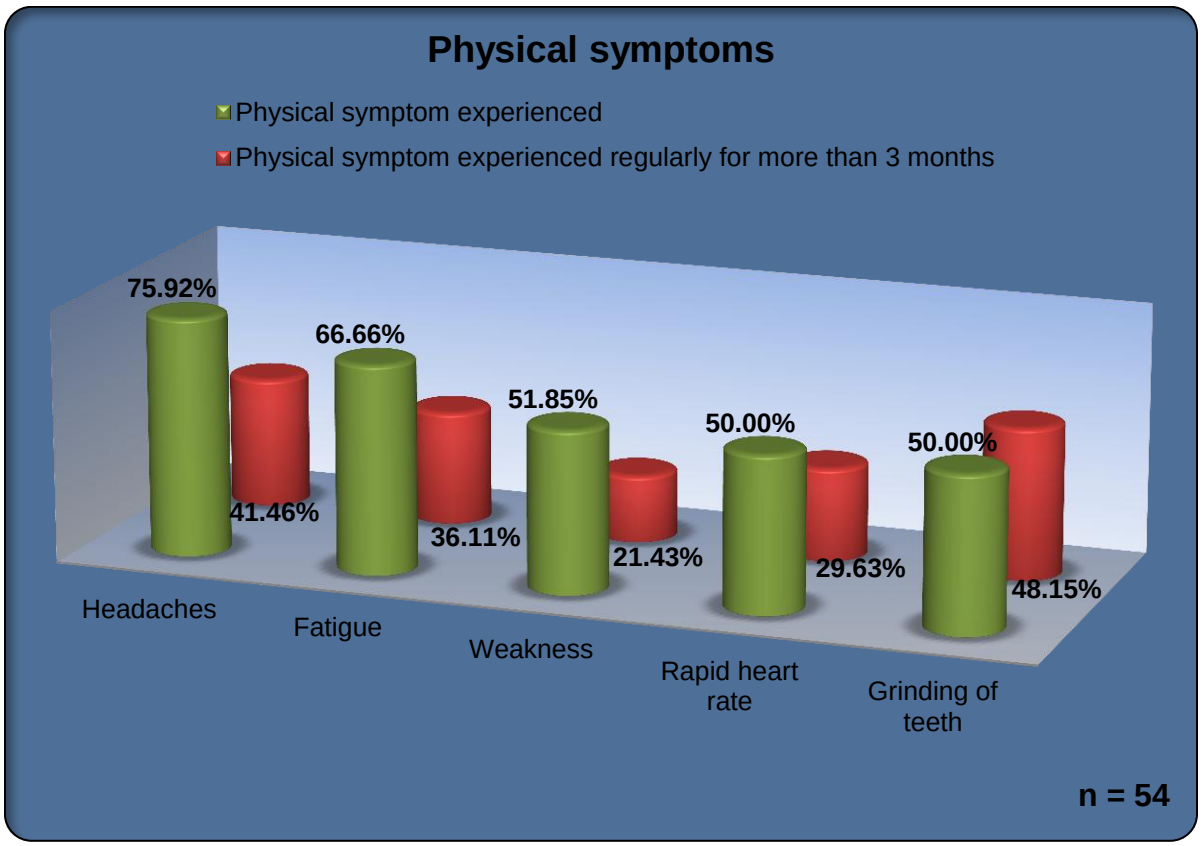


Figure 34: Physical symptoms

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.

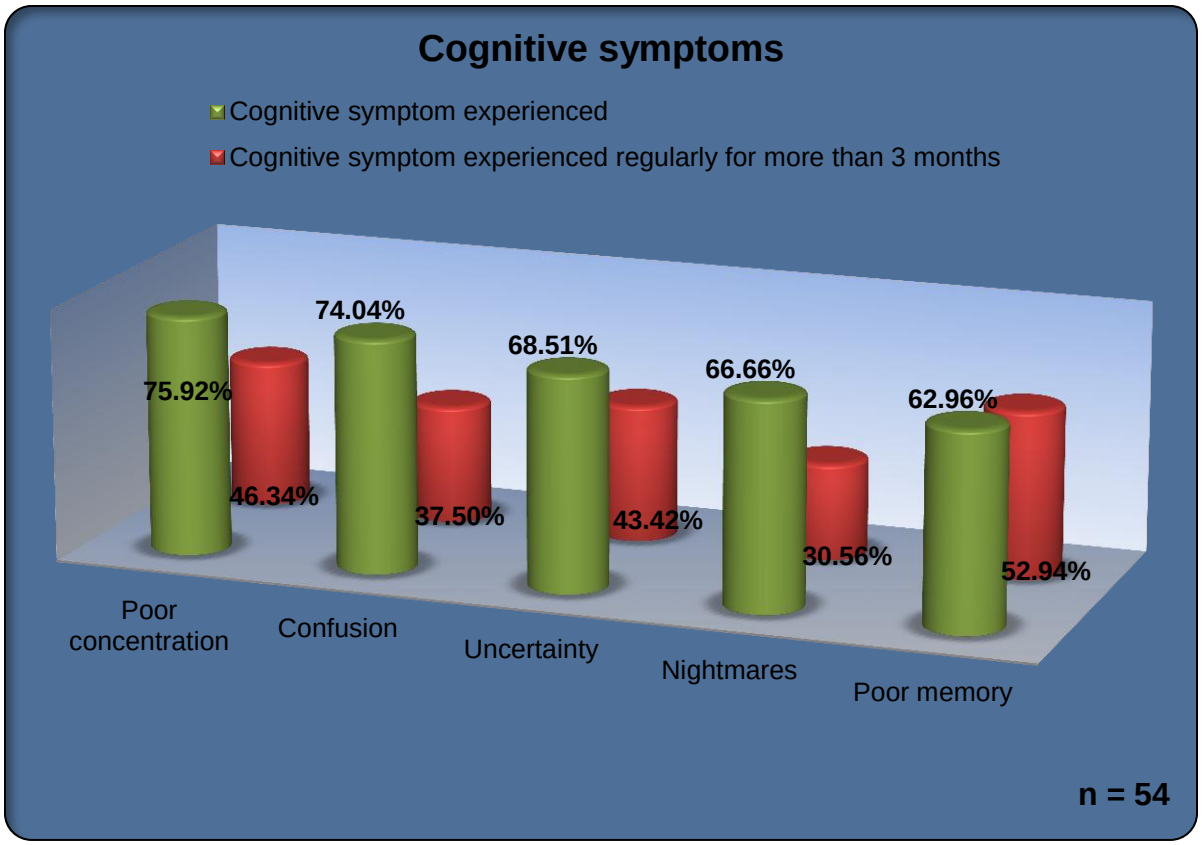


Figure 35: Cognitive symptoms

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.

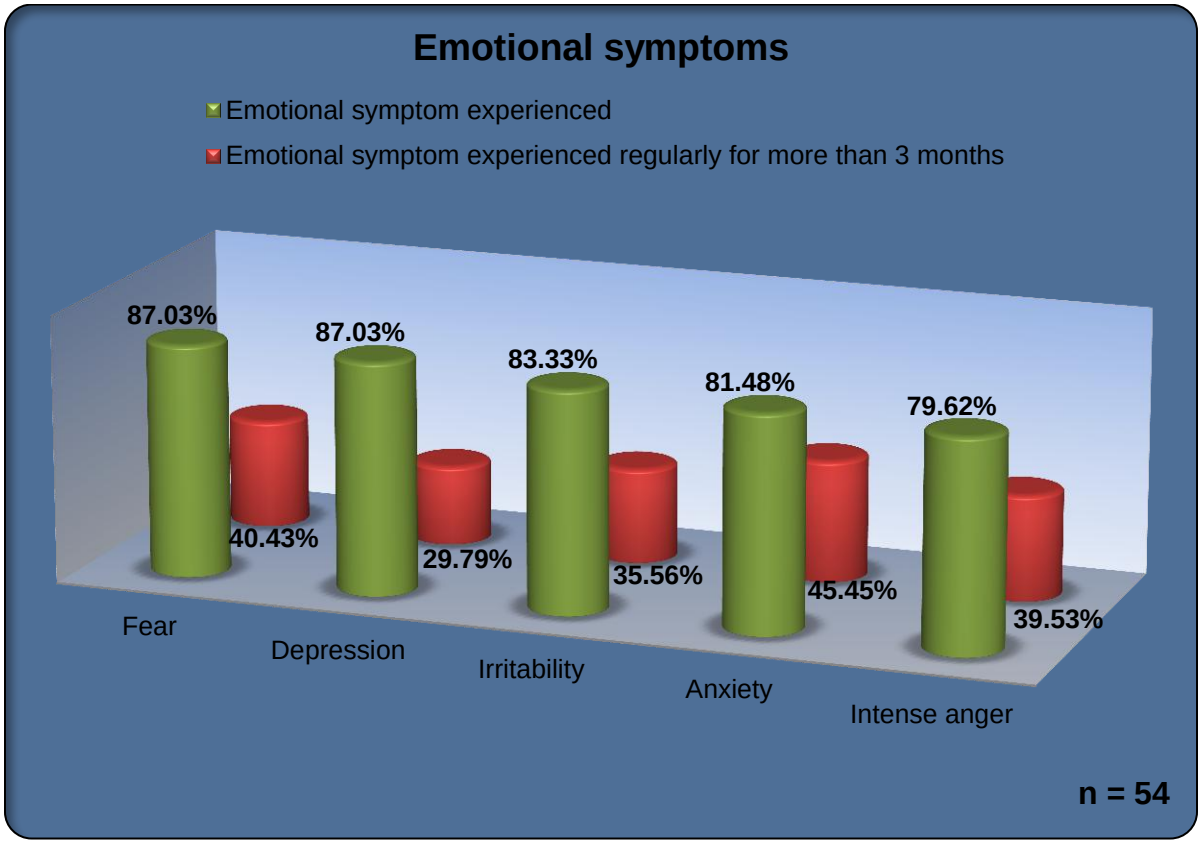


Figure 36: Emotional symptoms

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.

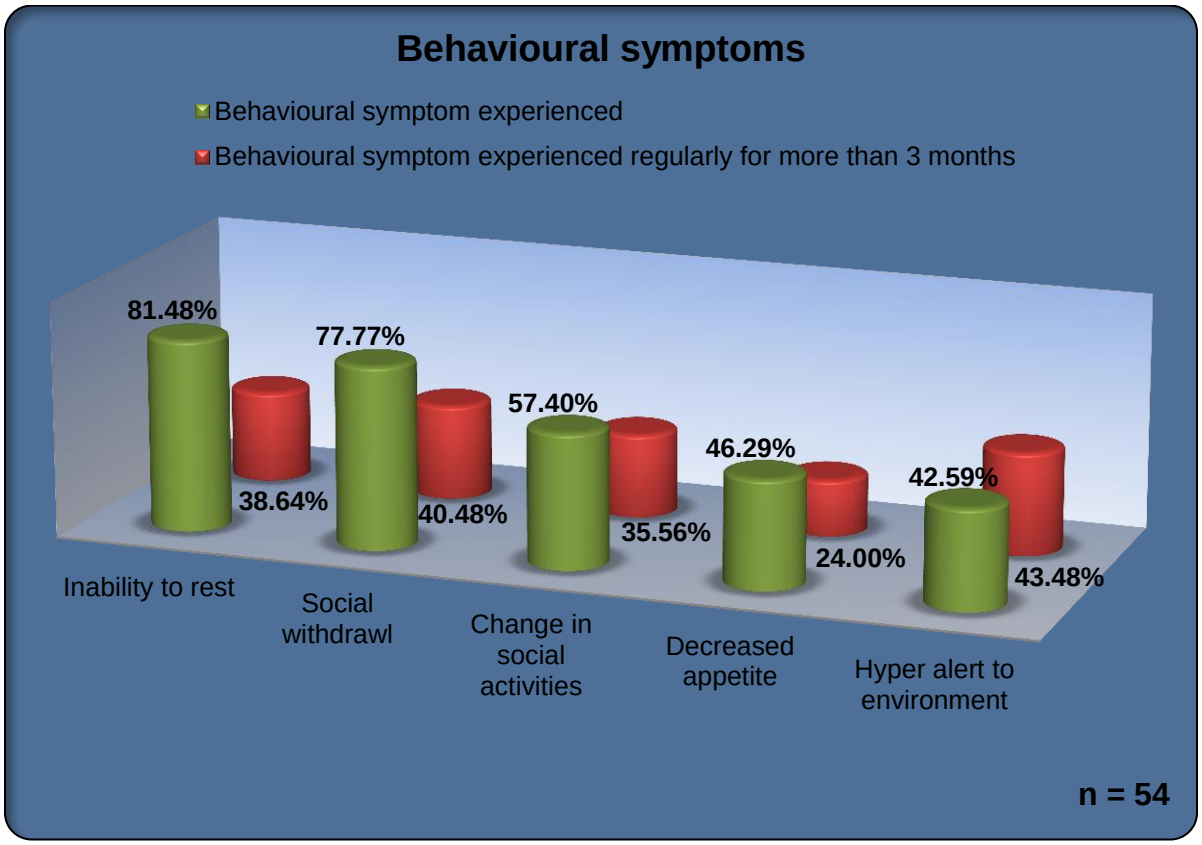


Figure 37: Behavioural symptoms

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.

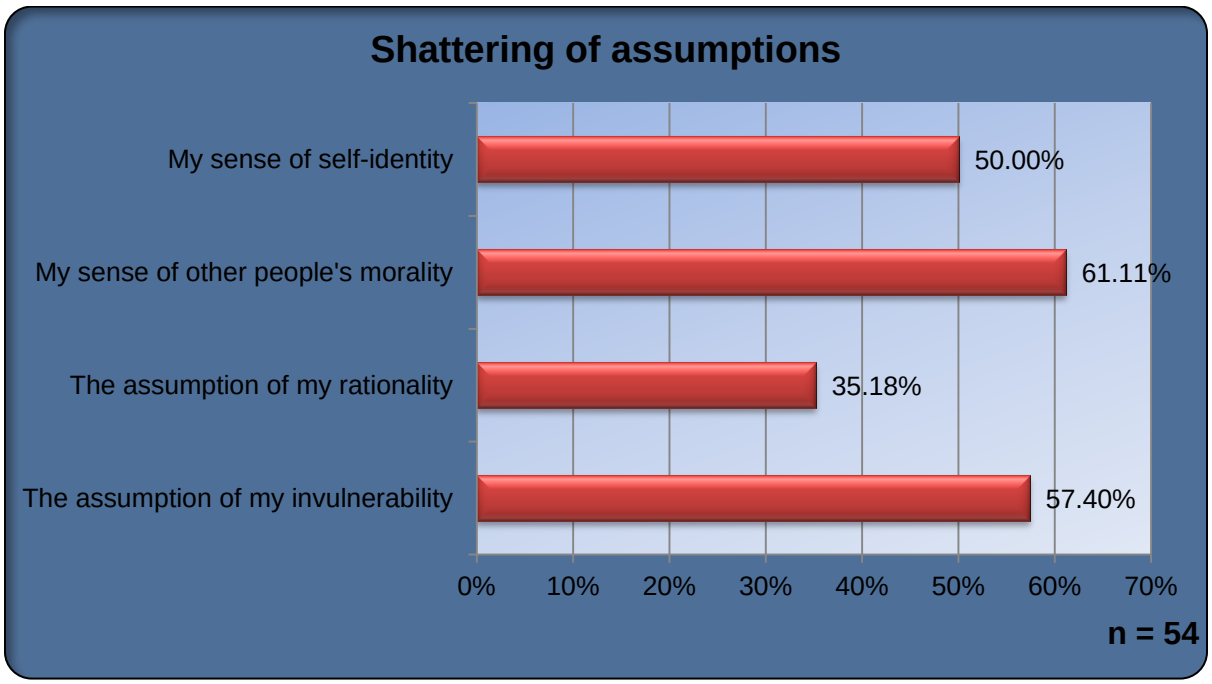


Figure 38: Shattering of assumptions

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.

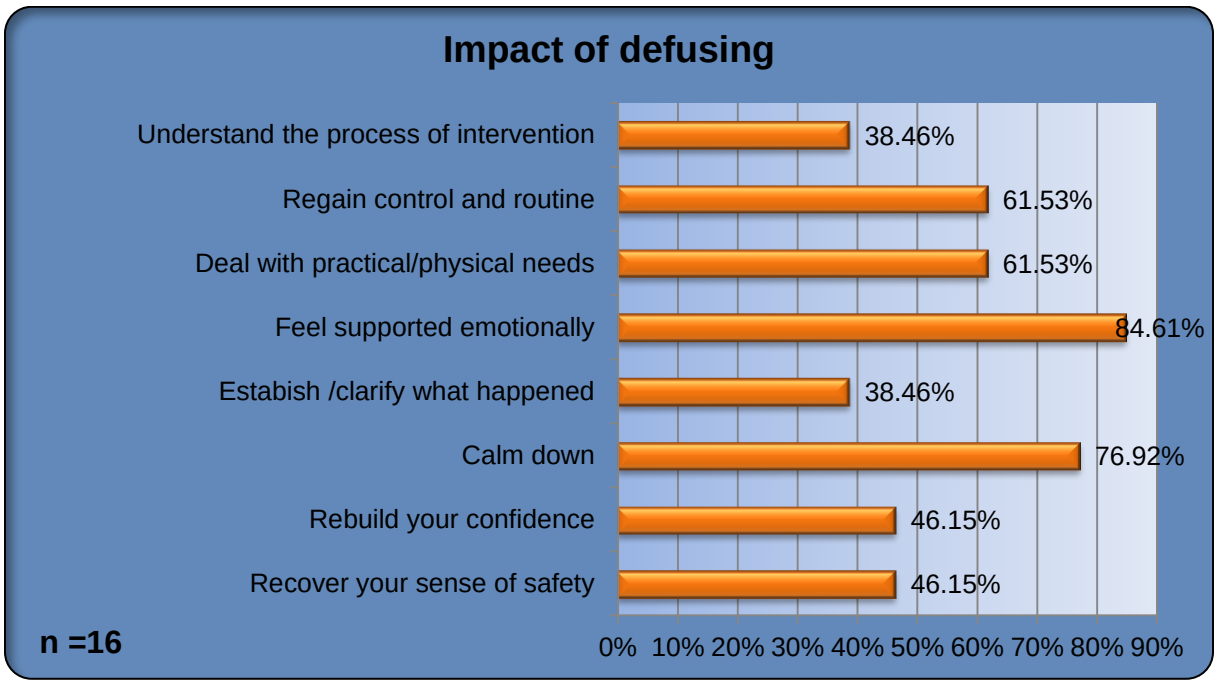


Figure 39: Impact of defusing

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.

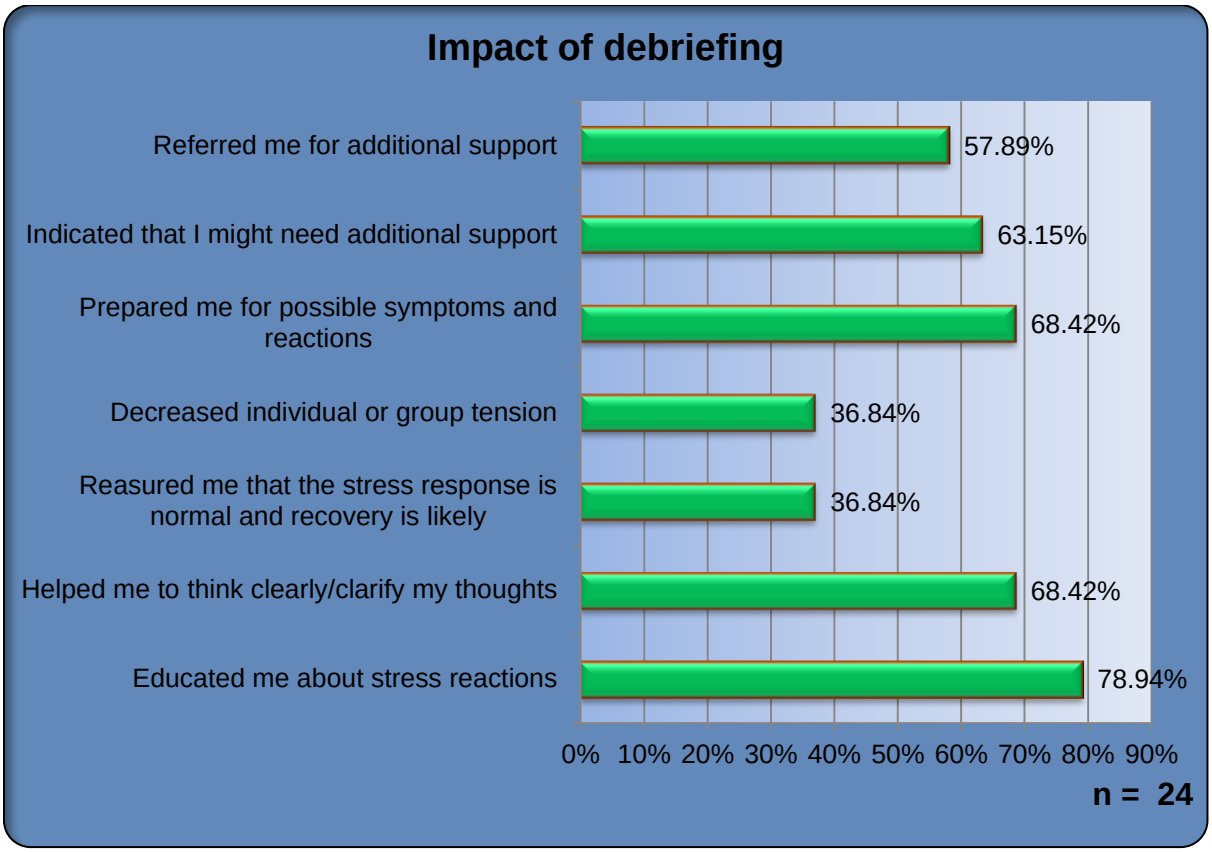


Figure 40: Impact of debriefing

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.

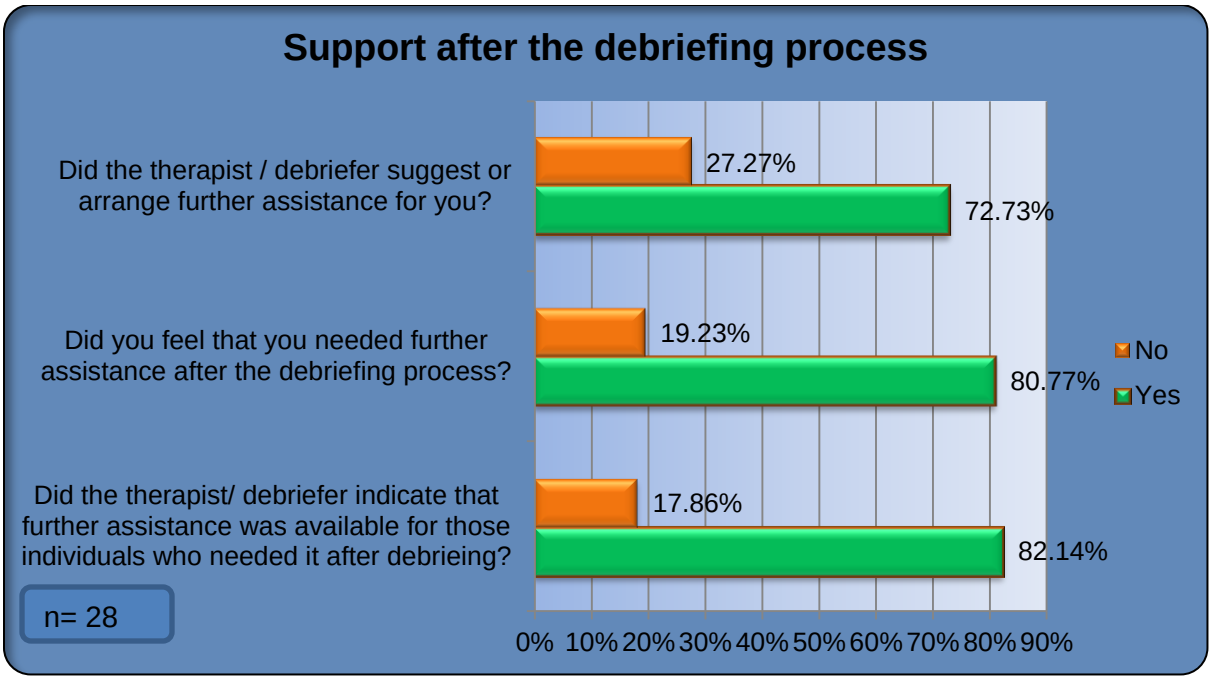


Figure 41: Support after the debriefing process

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.

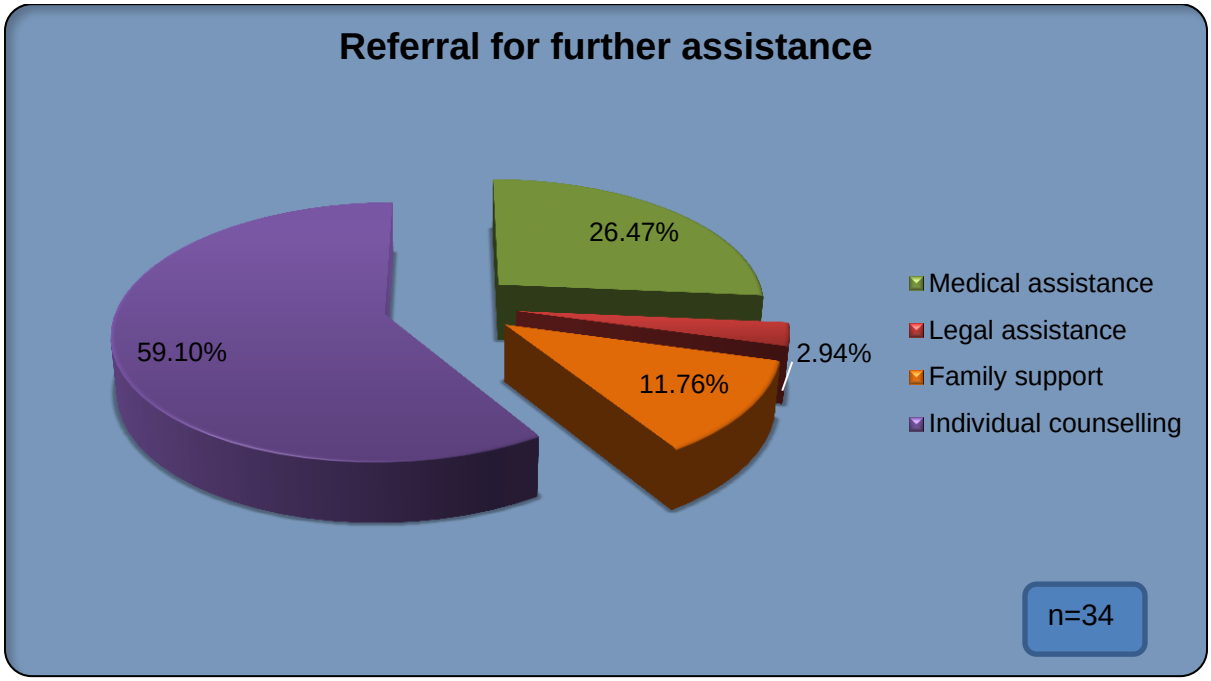


Figure 42: Referral for further assistance

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.

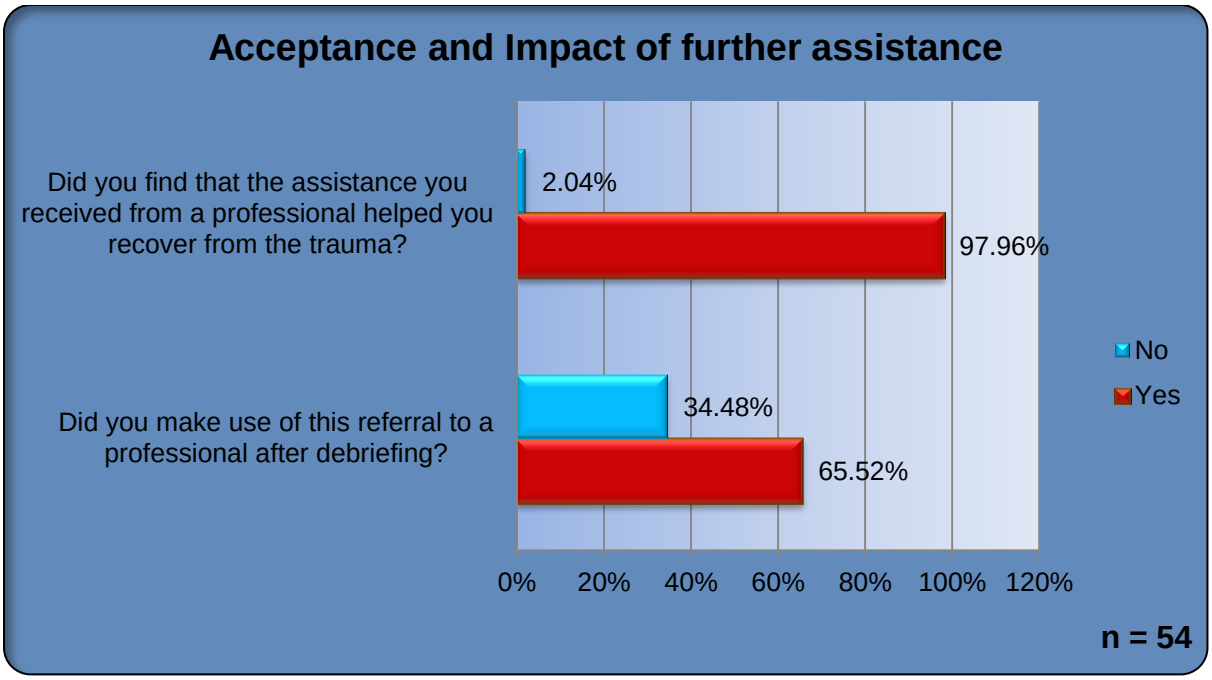


Figure 43: Acceptance and impact of further assistance

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.

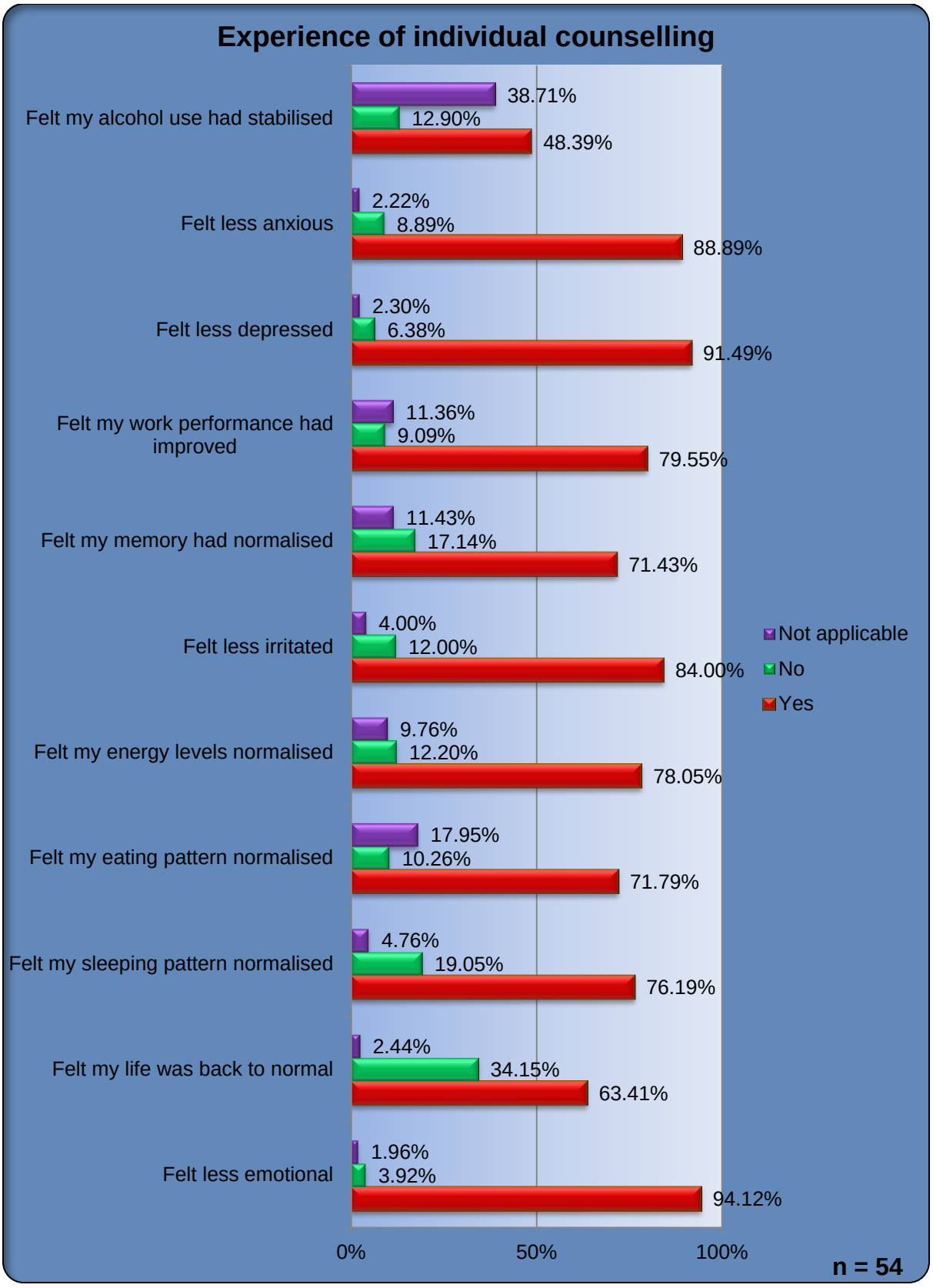


Figure 44: Experience of individual counselling

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.

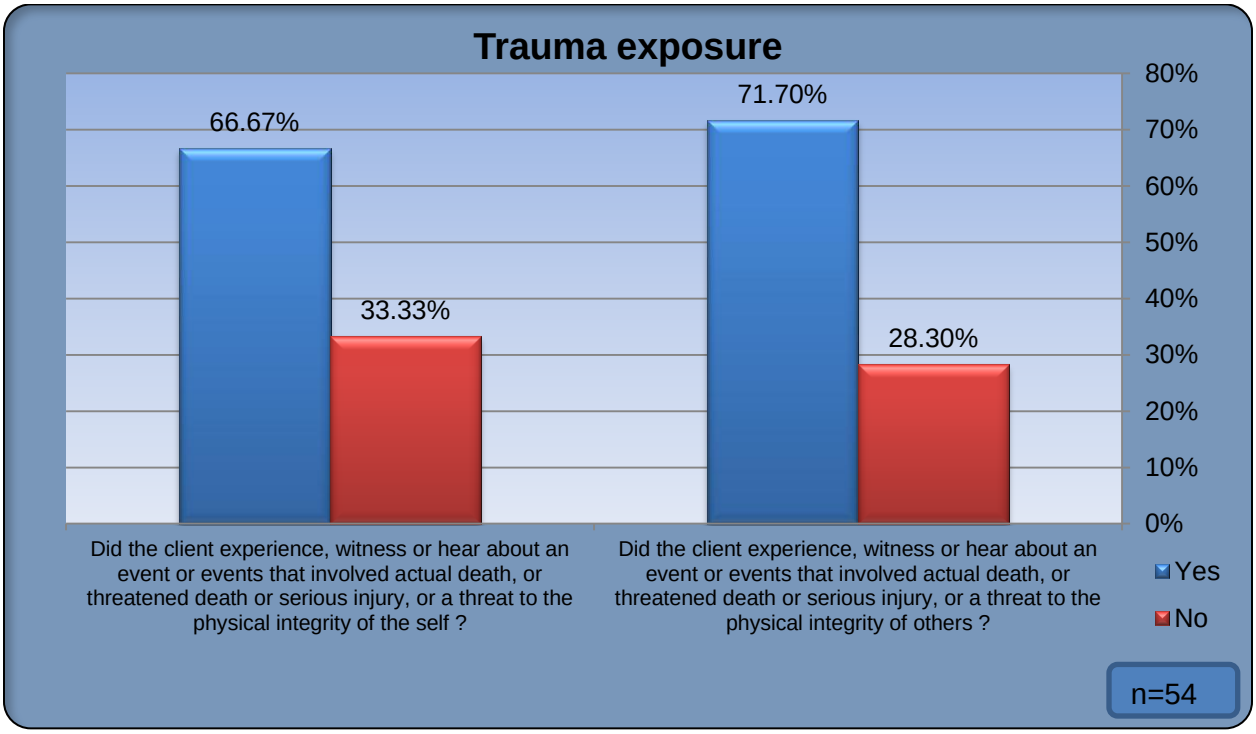


Figure 45: Trauma exposure

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.

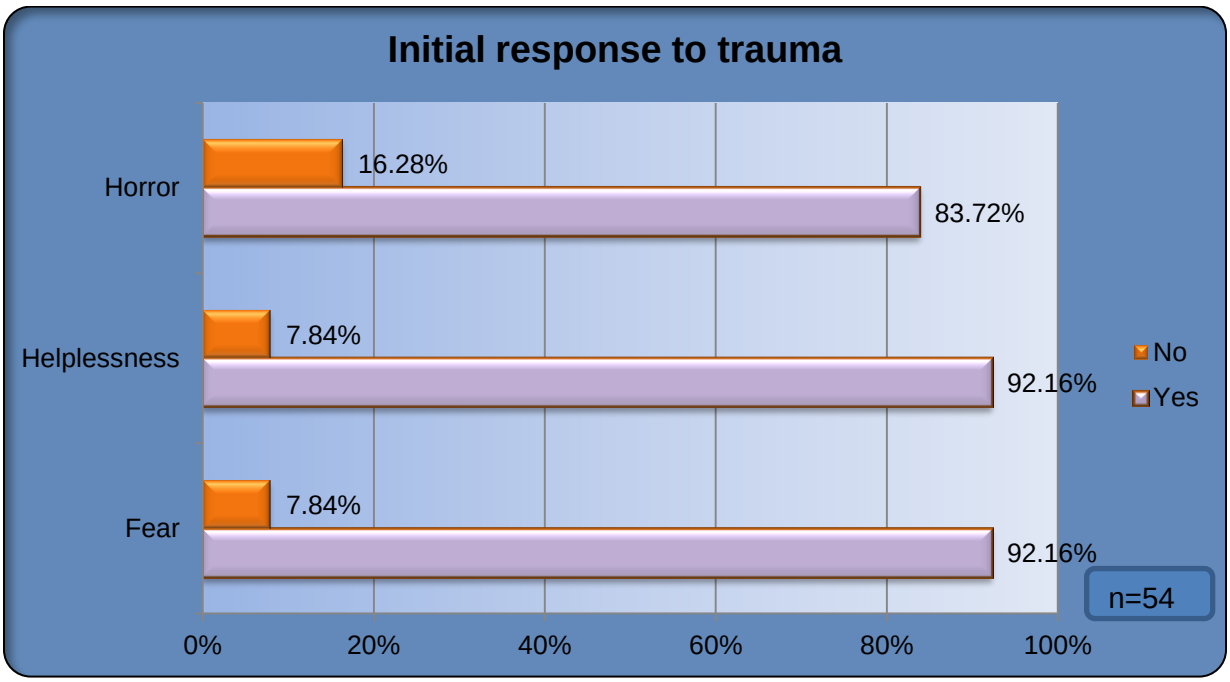


Figure 46: Initial response to trauma

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.

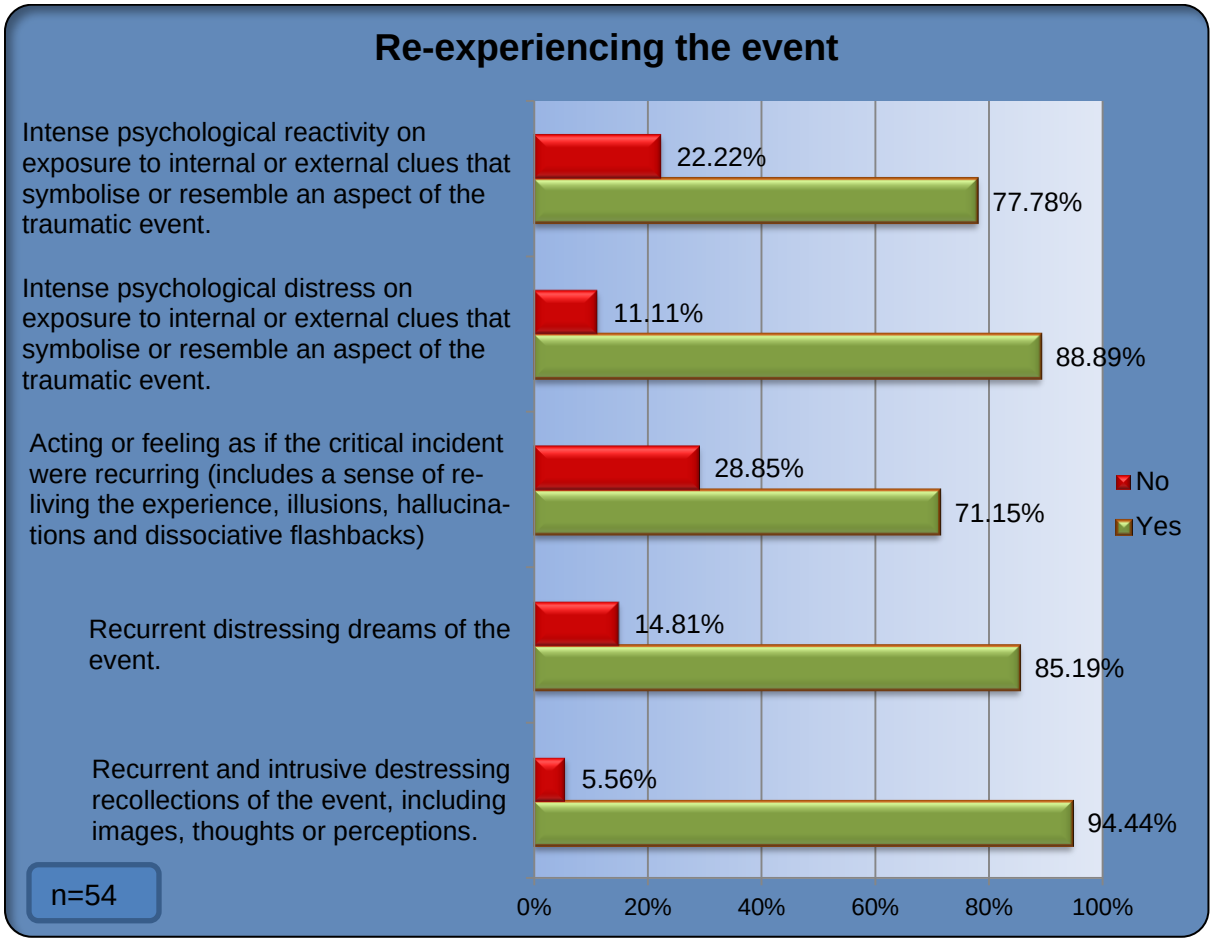


Figure 47: Re-experiencing of the event

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.

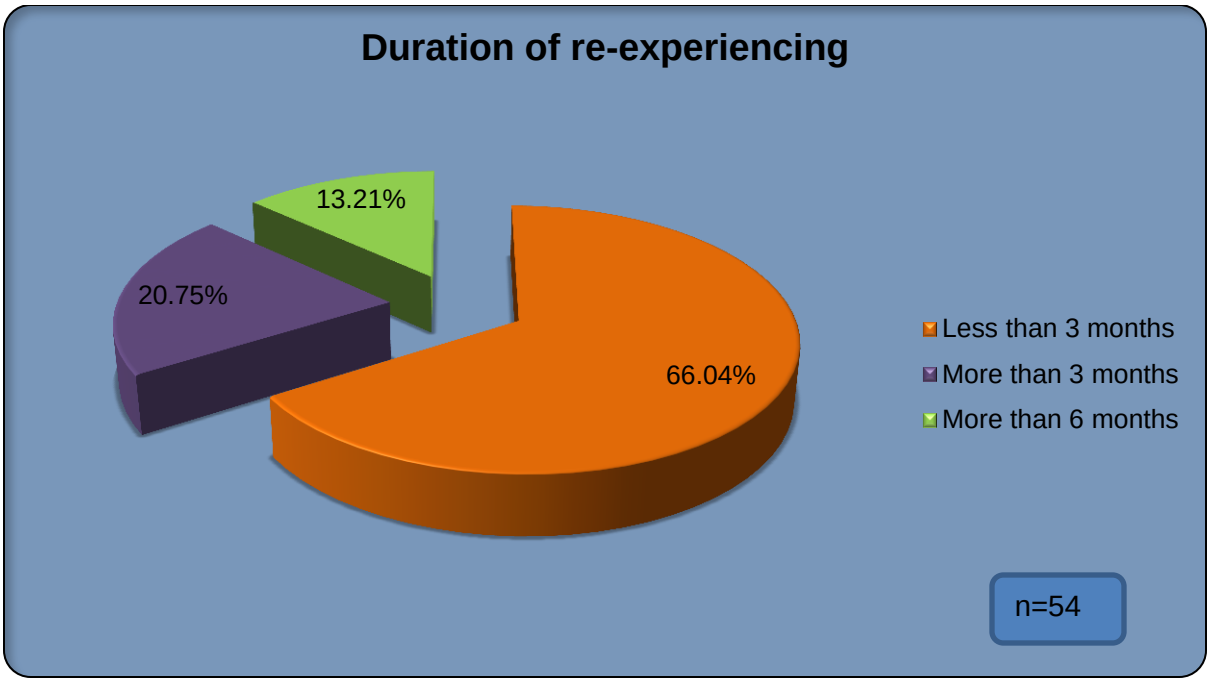


Figure 48: Duration of re-experiencing the event

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.

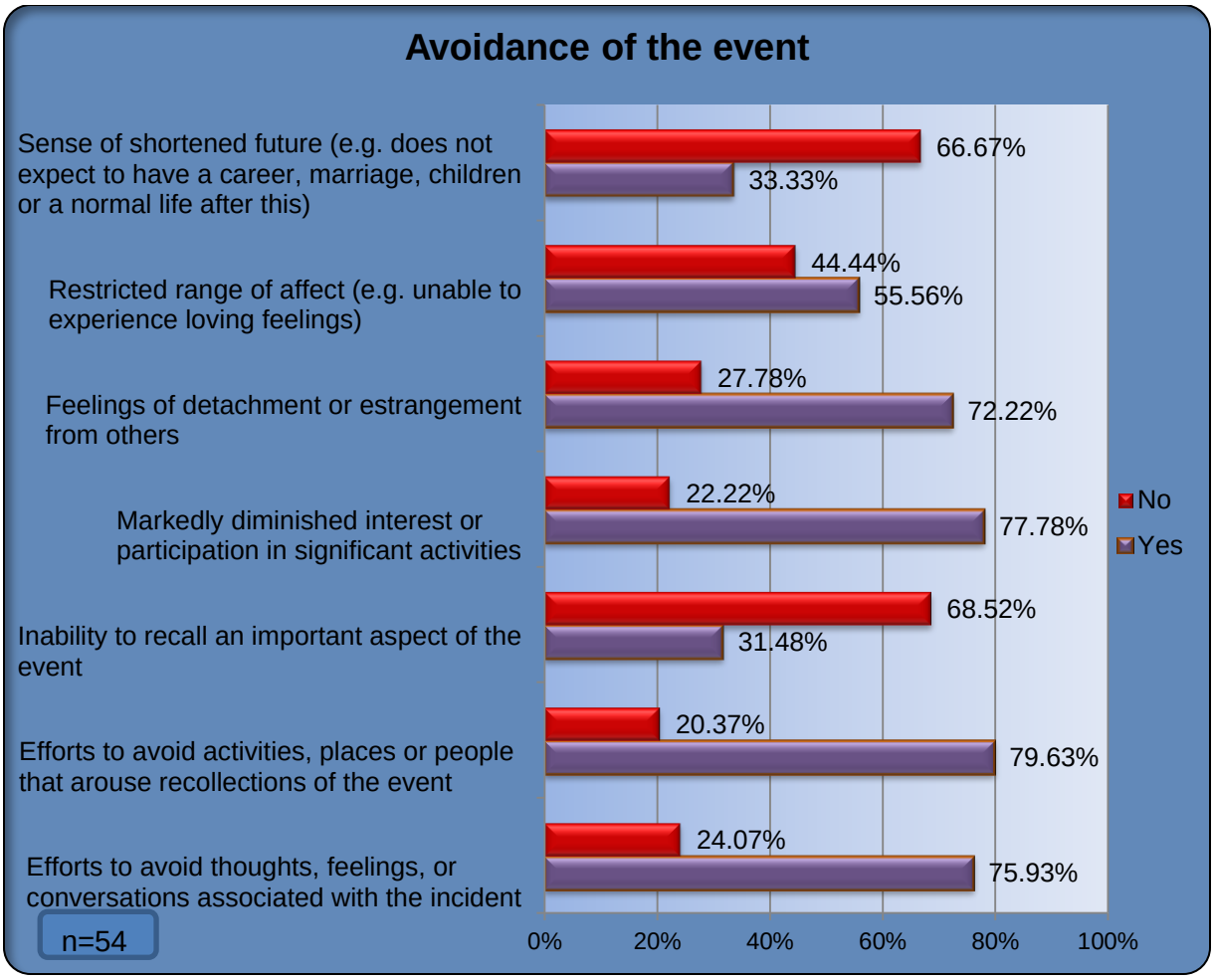


Figure 49: Avoidance of the event

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.

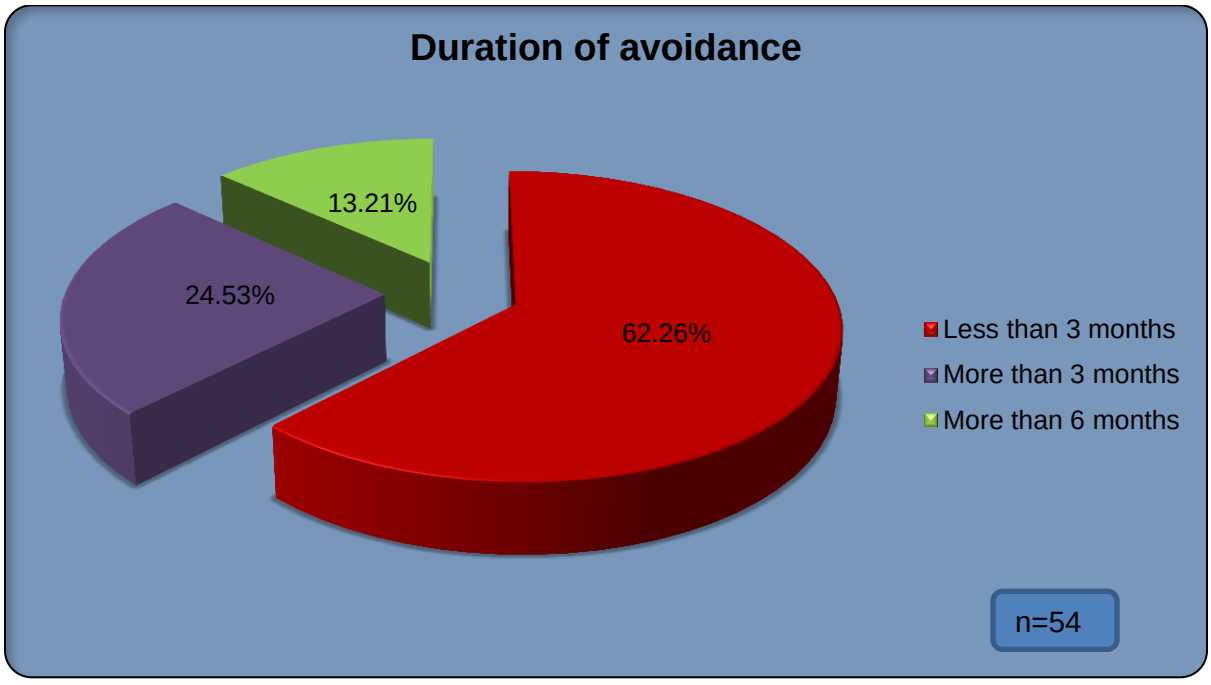


Figure 50: Duration of avoidance

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.

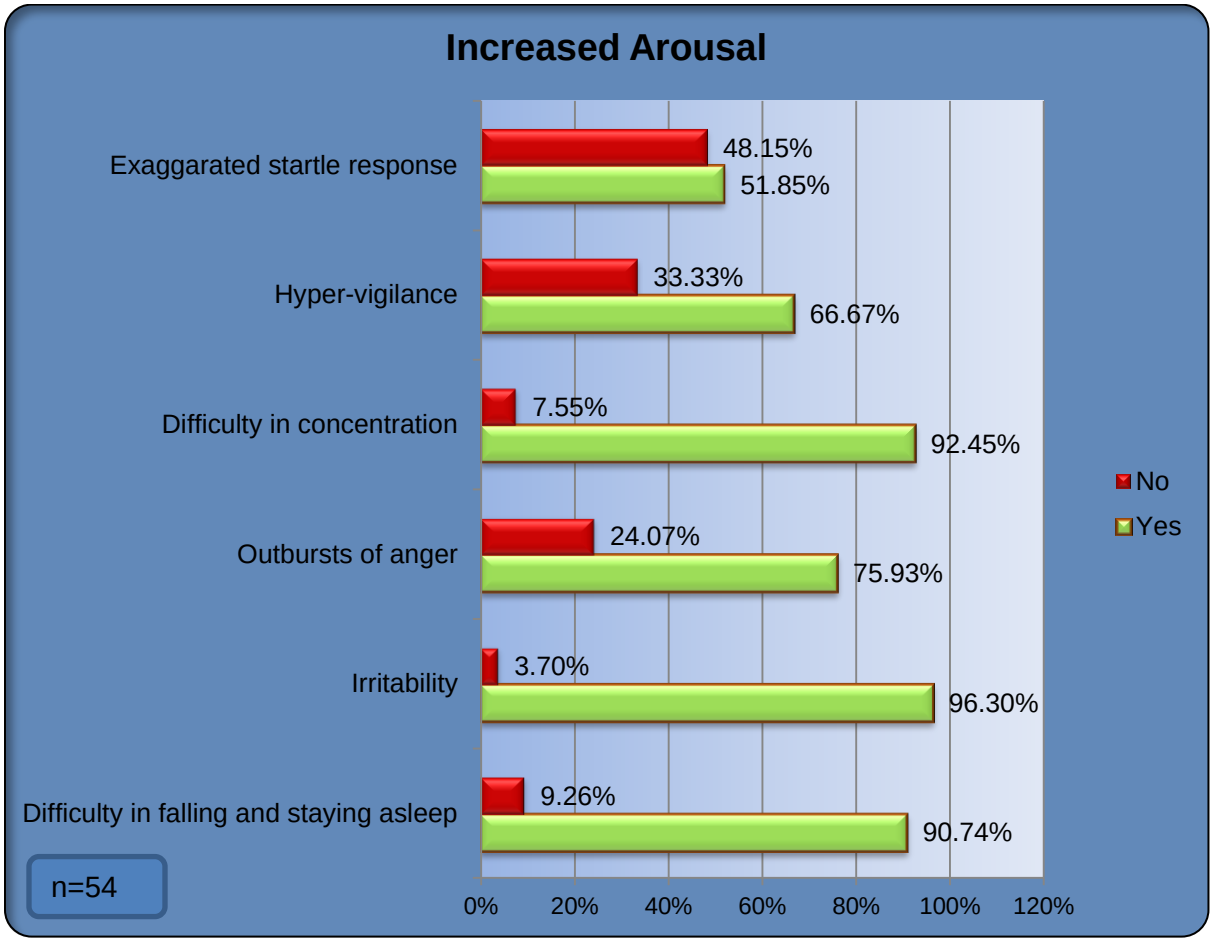


Figure 51: Increased arousal

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.

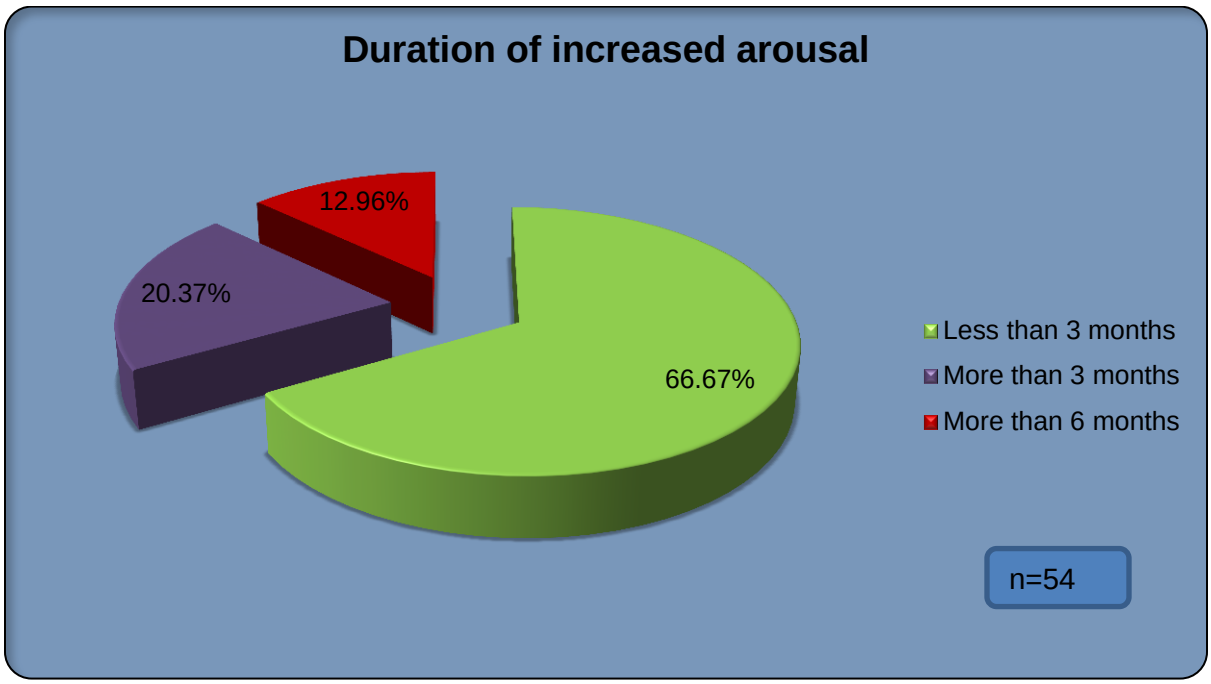


Figure 52: Duration of increased arousal

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.

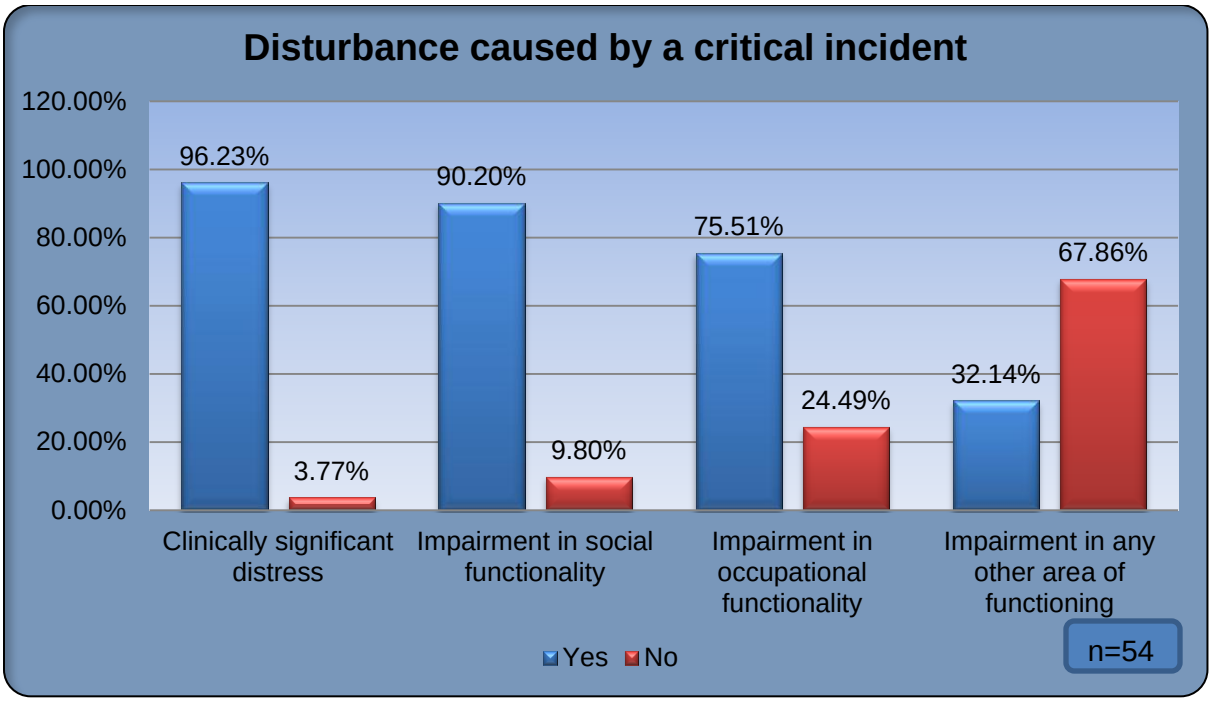


Figure 53: Disturbance caused by a critical incident

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.

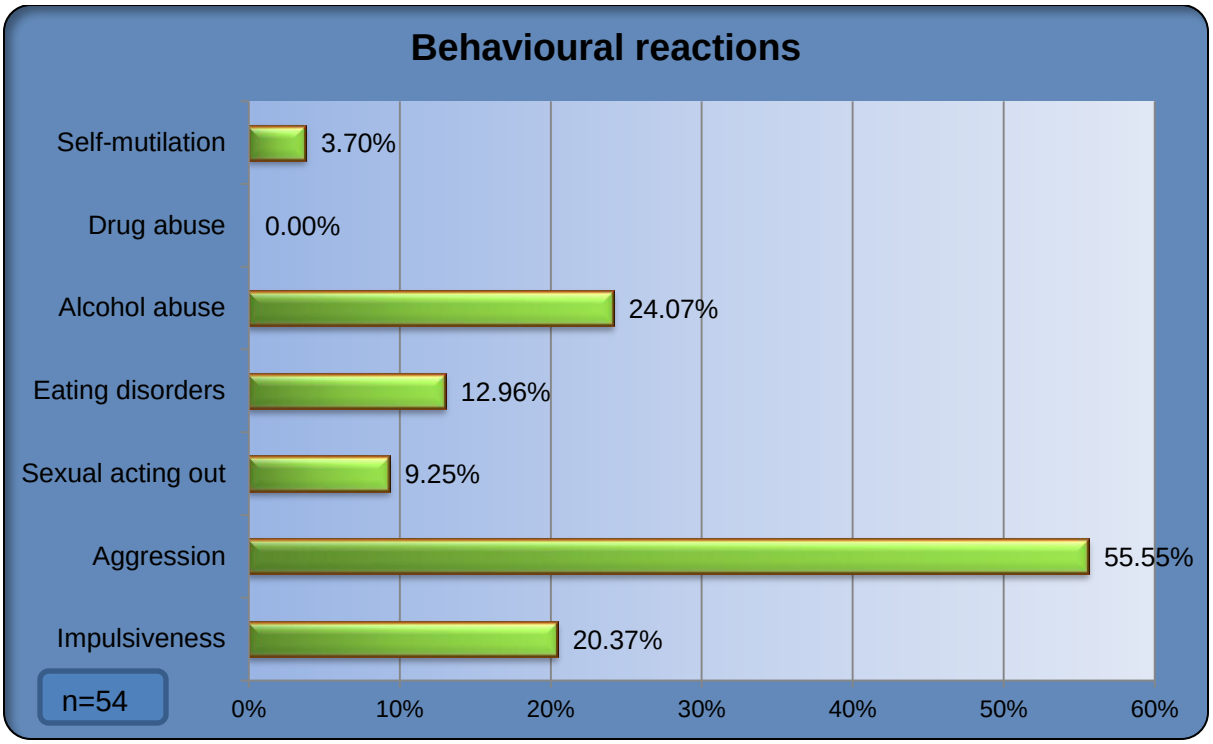


Figure 54: Behavioural reactions

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.

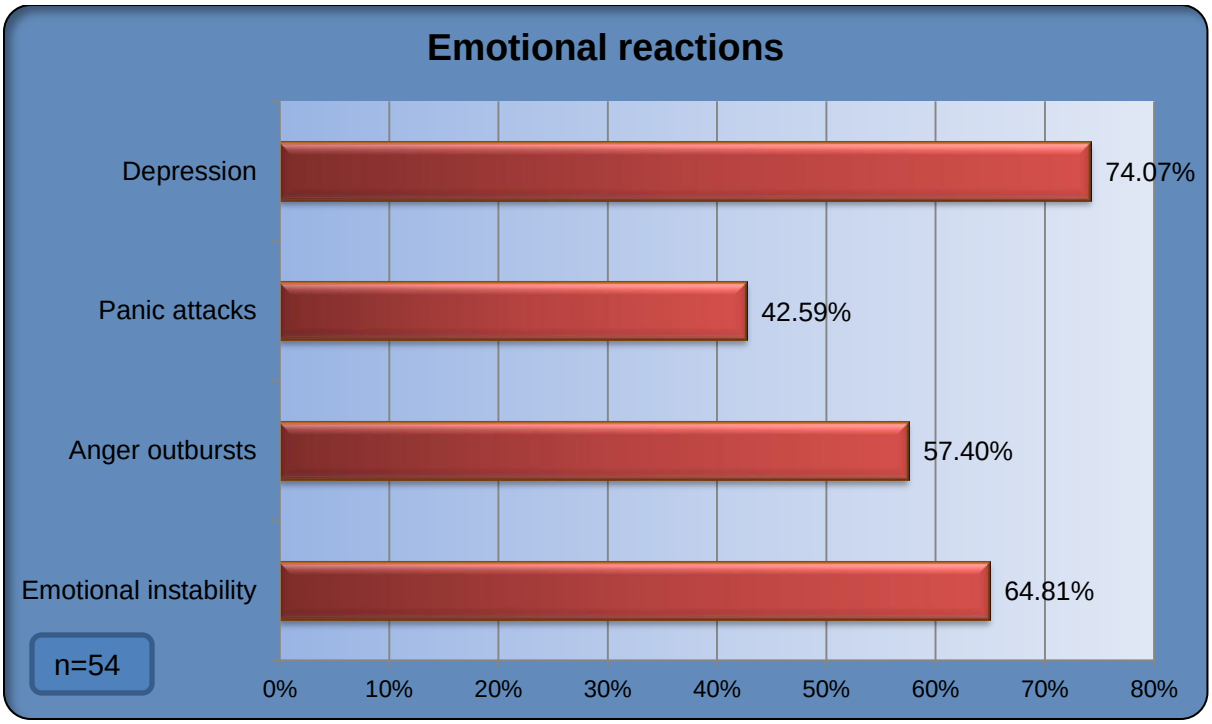


Figure 55: Emotional reactions

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.

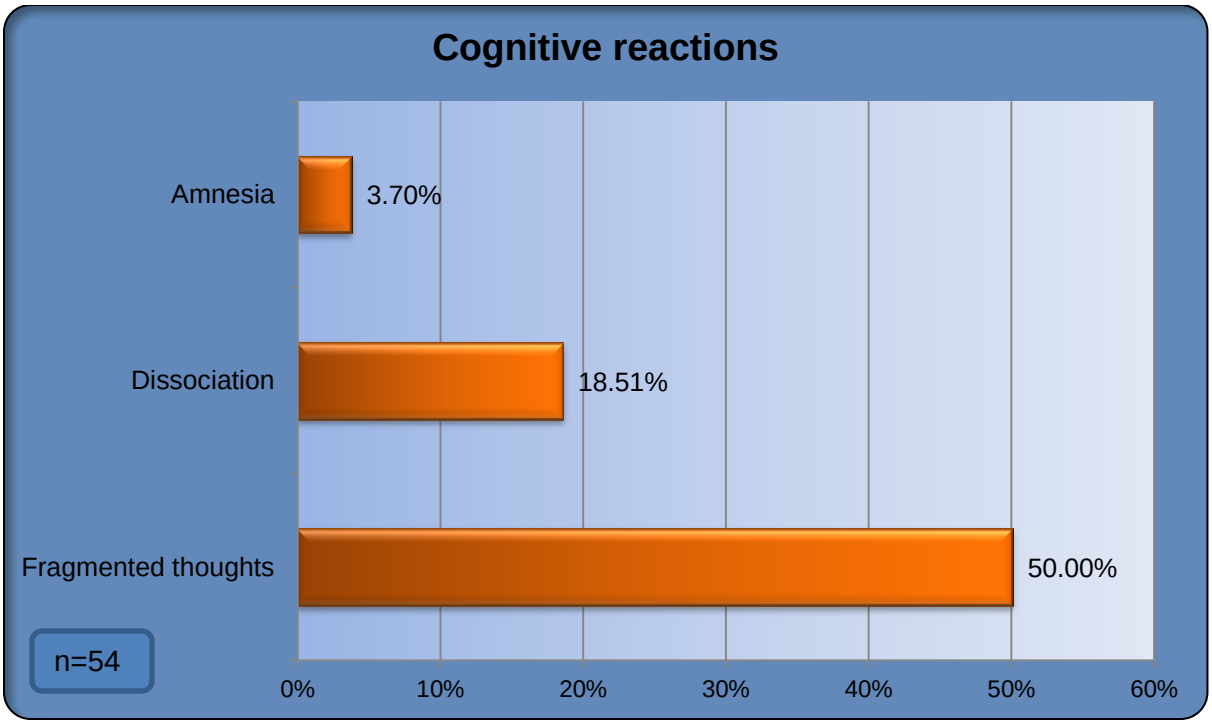


Figure 56: Cognitive reactions

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.

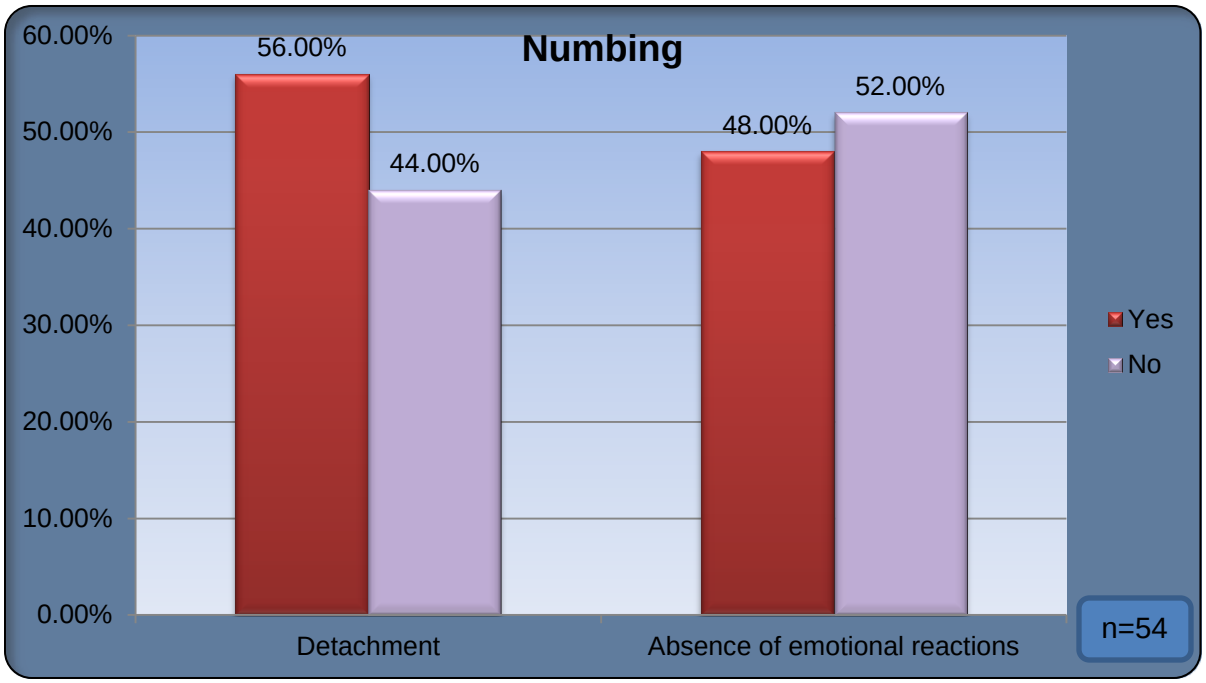


Figure 57: Numbing

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.

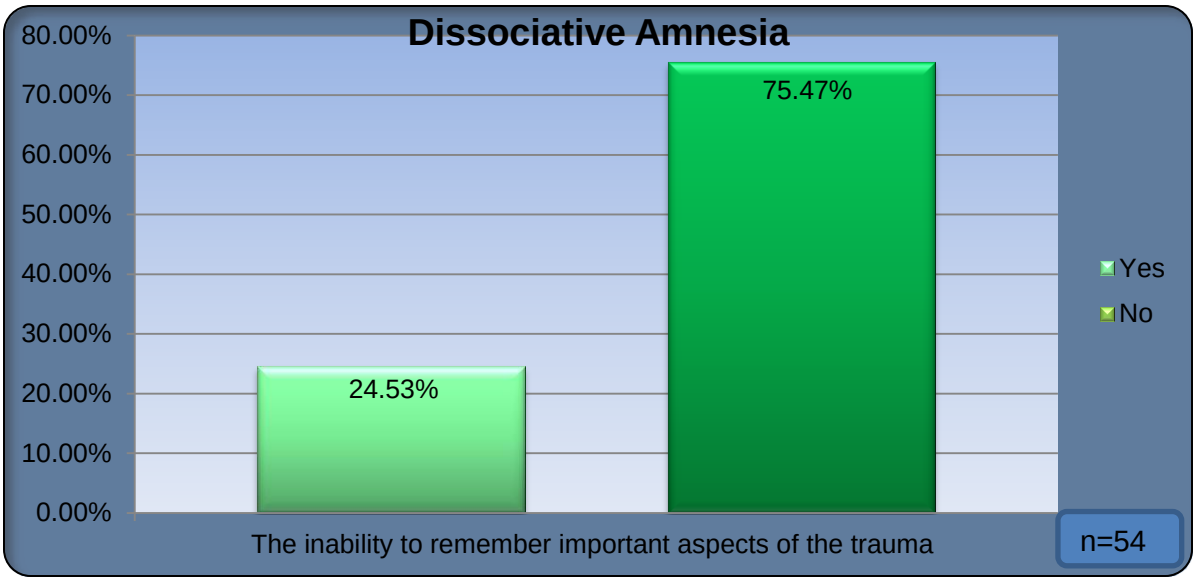


Figure 58: Dissociative amnesia

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.

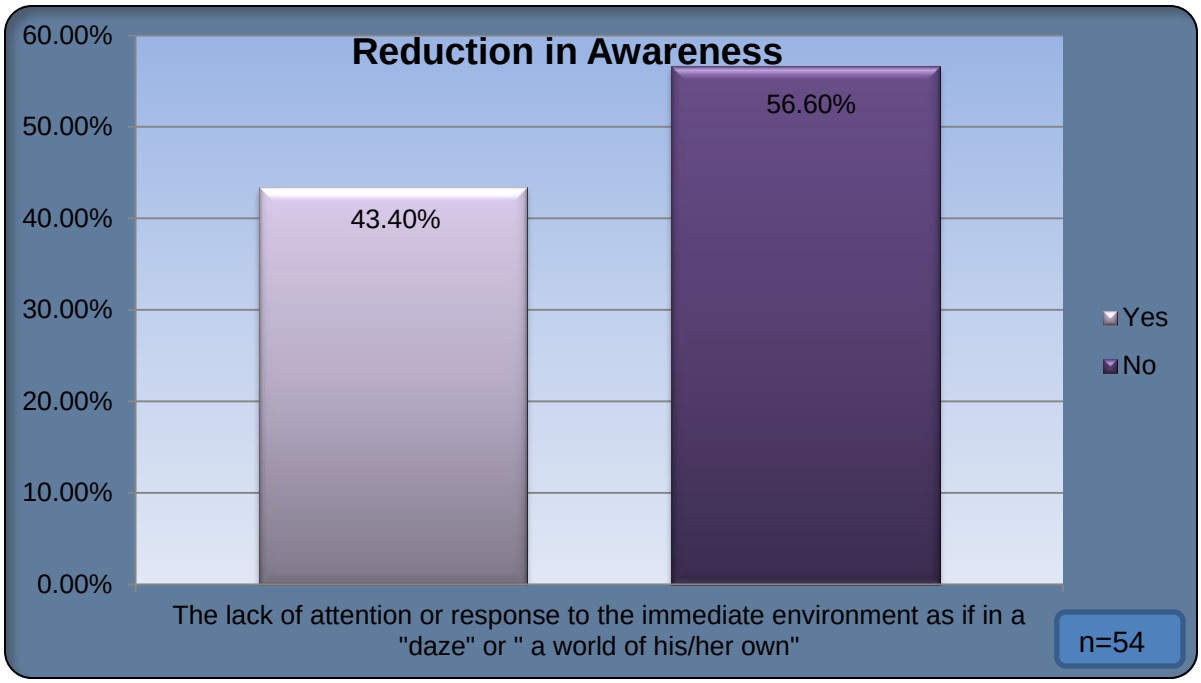


Figure 59: Reduction in awareness

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.

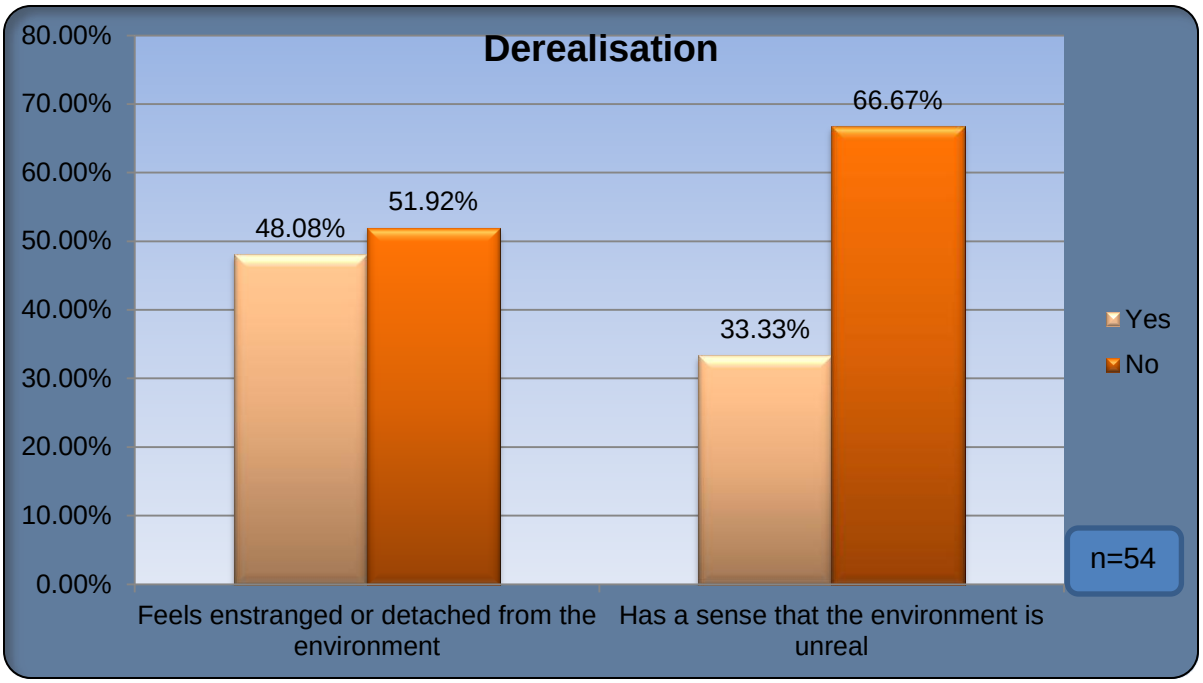


Figure 60: Derealisation

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.

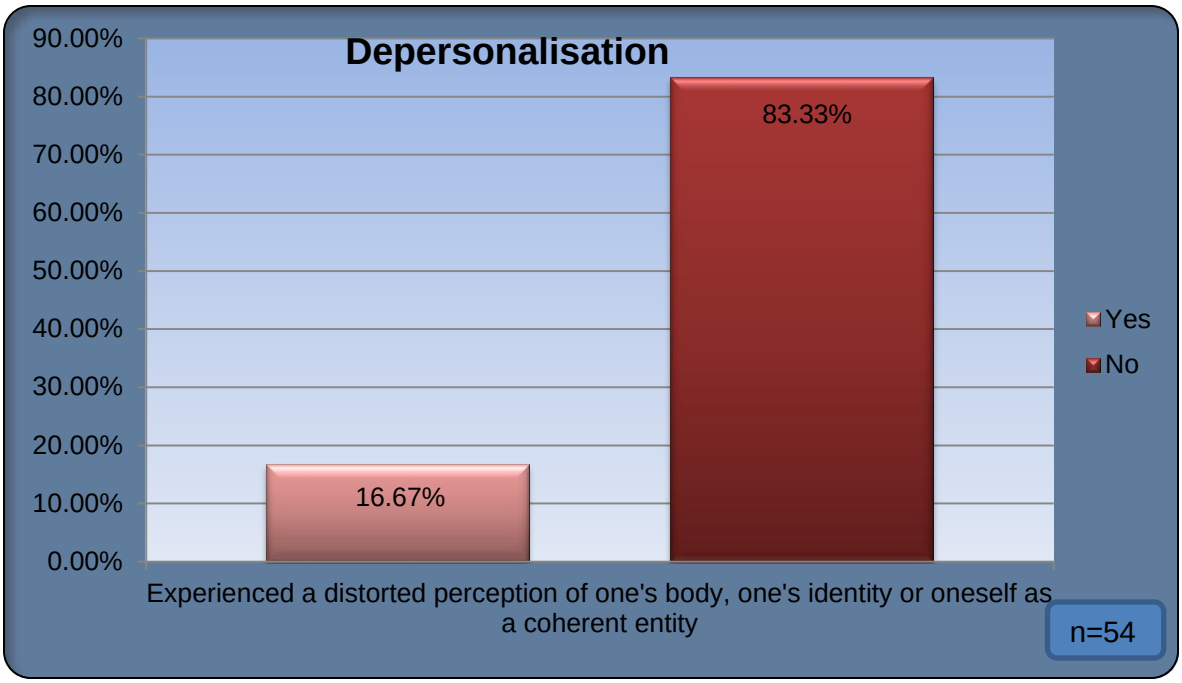


Figure 61: Depersonalisation

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.

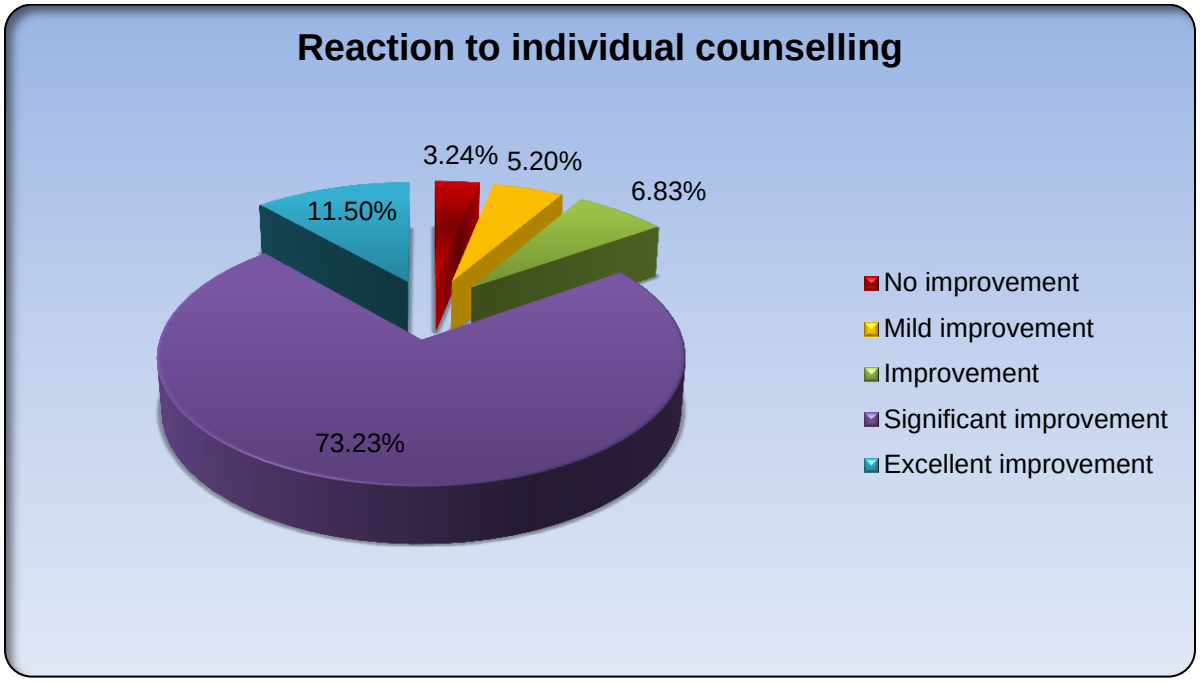


Figure 62: Reaction to individual counselling

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.

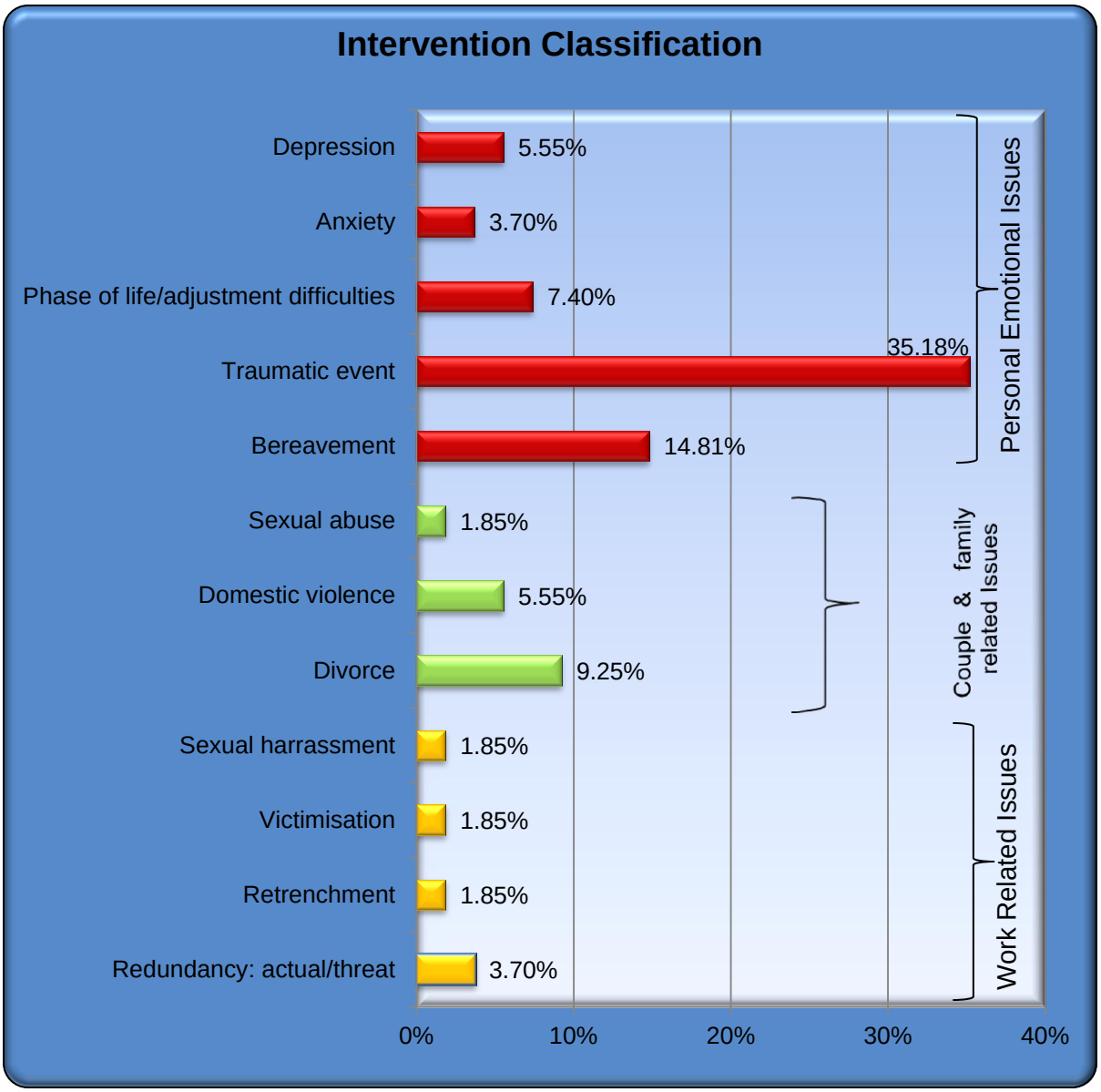


Figure 63: Intervention classification

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.

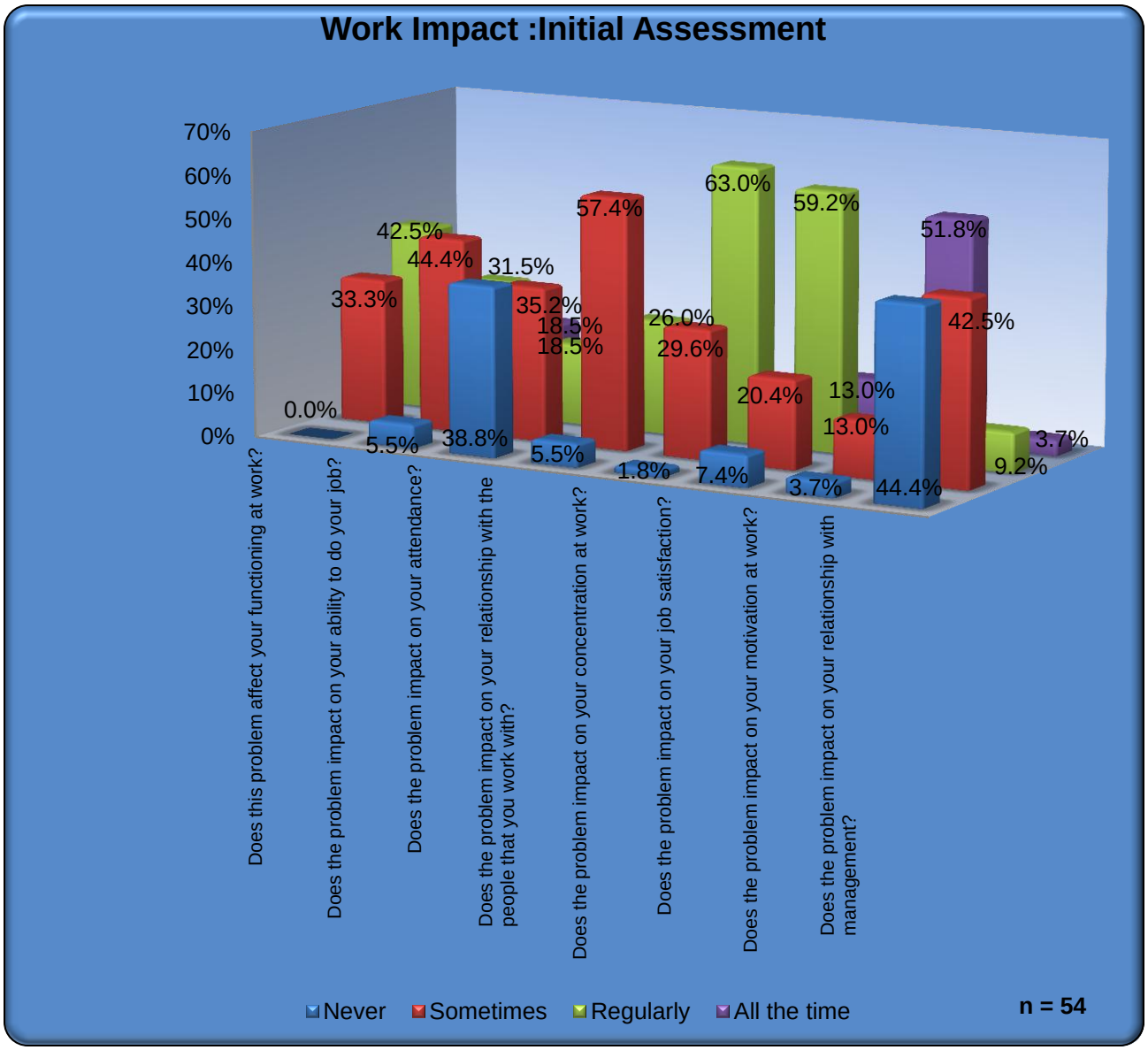


Figure 64: Work impact: initial assessment

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.

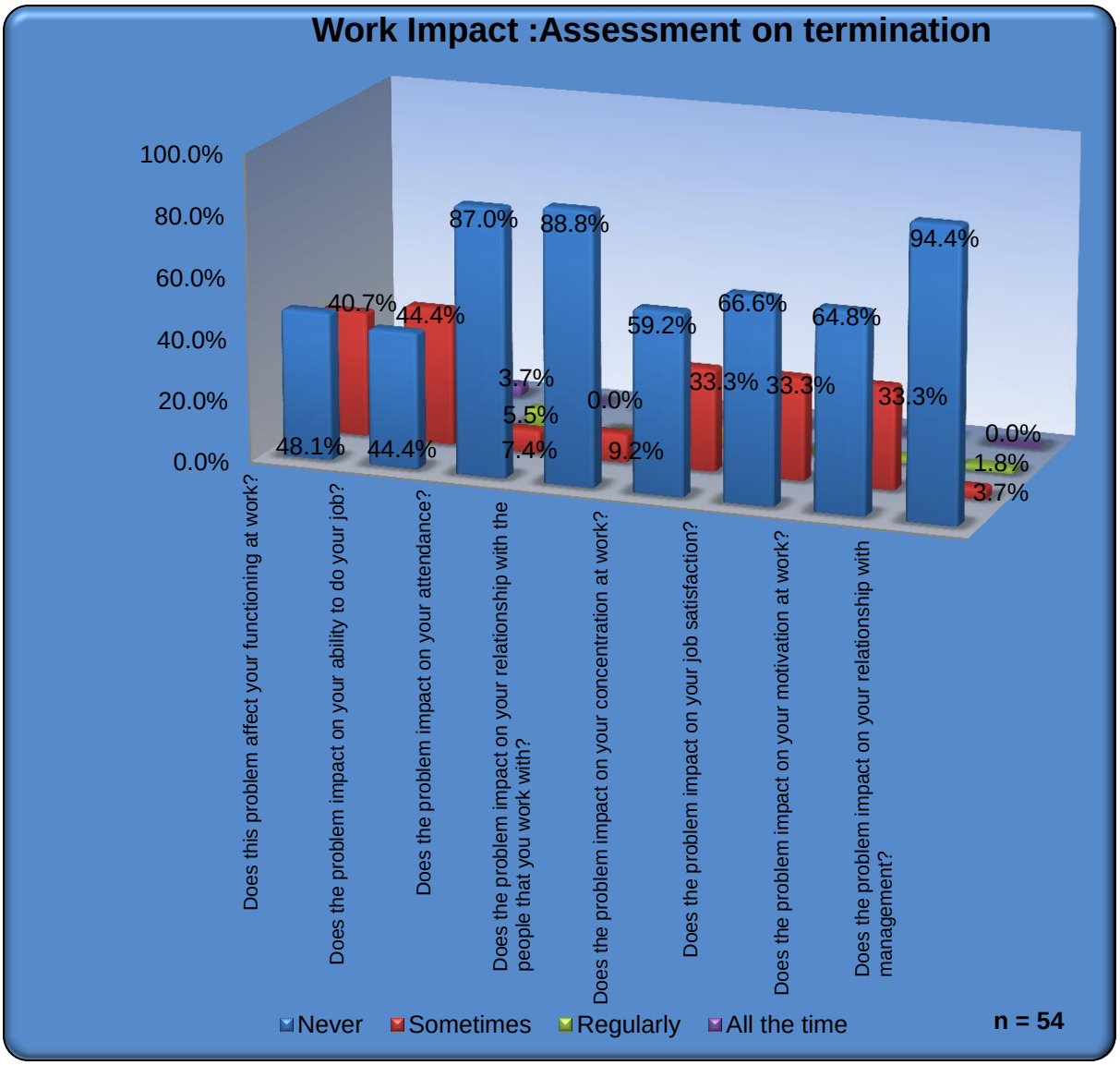


Figure 65: Work impact: initial assessment

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.

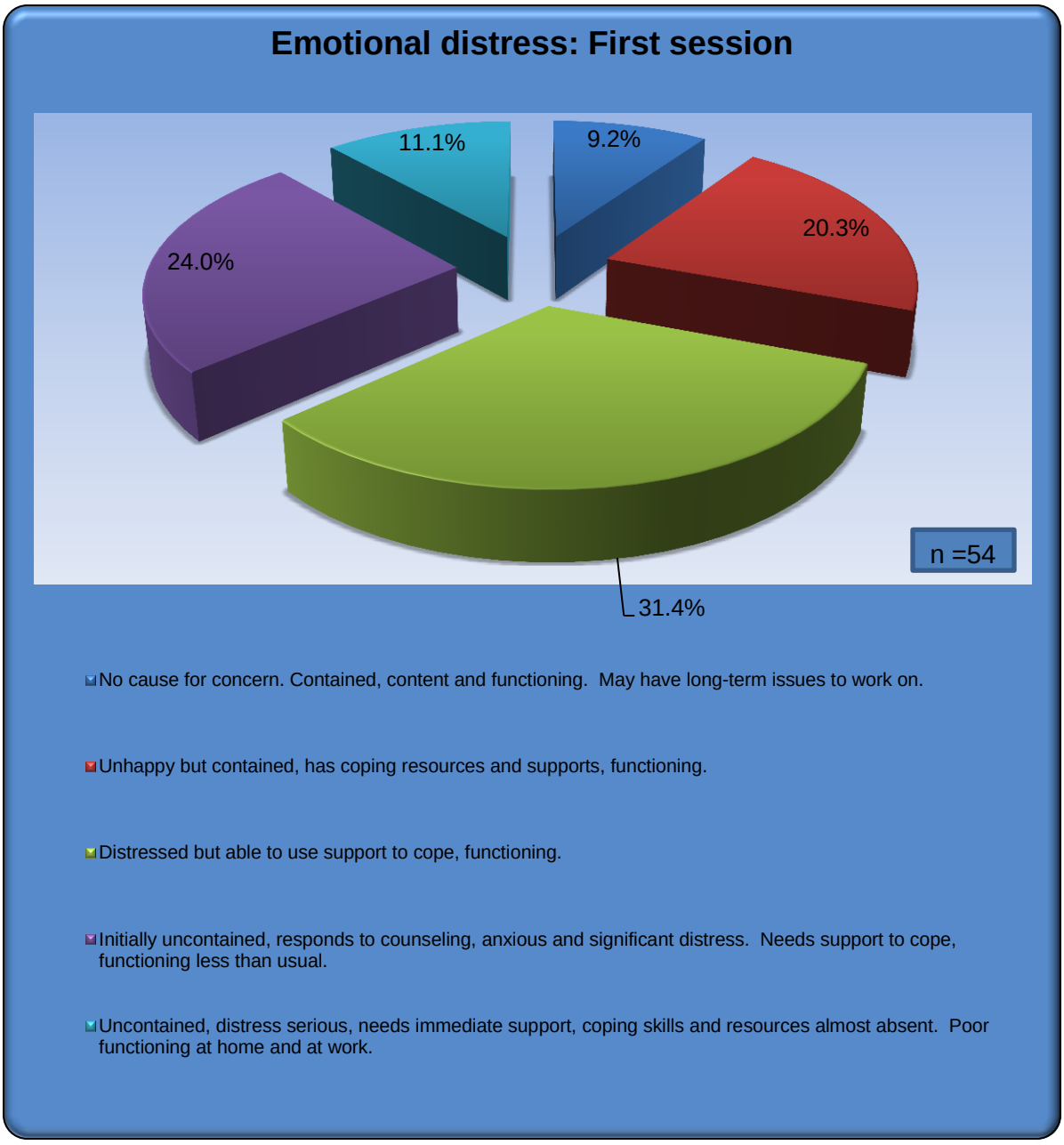


Figure 66: Emotional distress: first session

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.

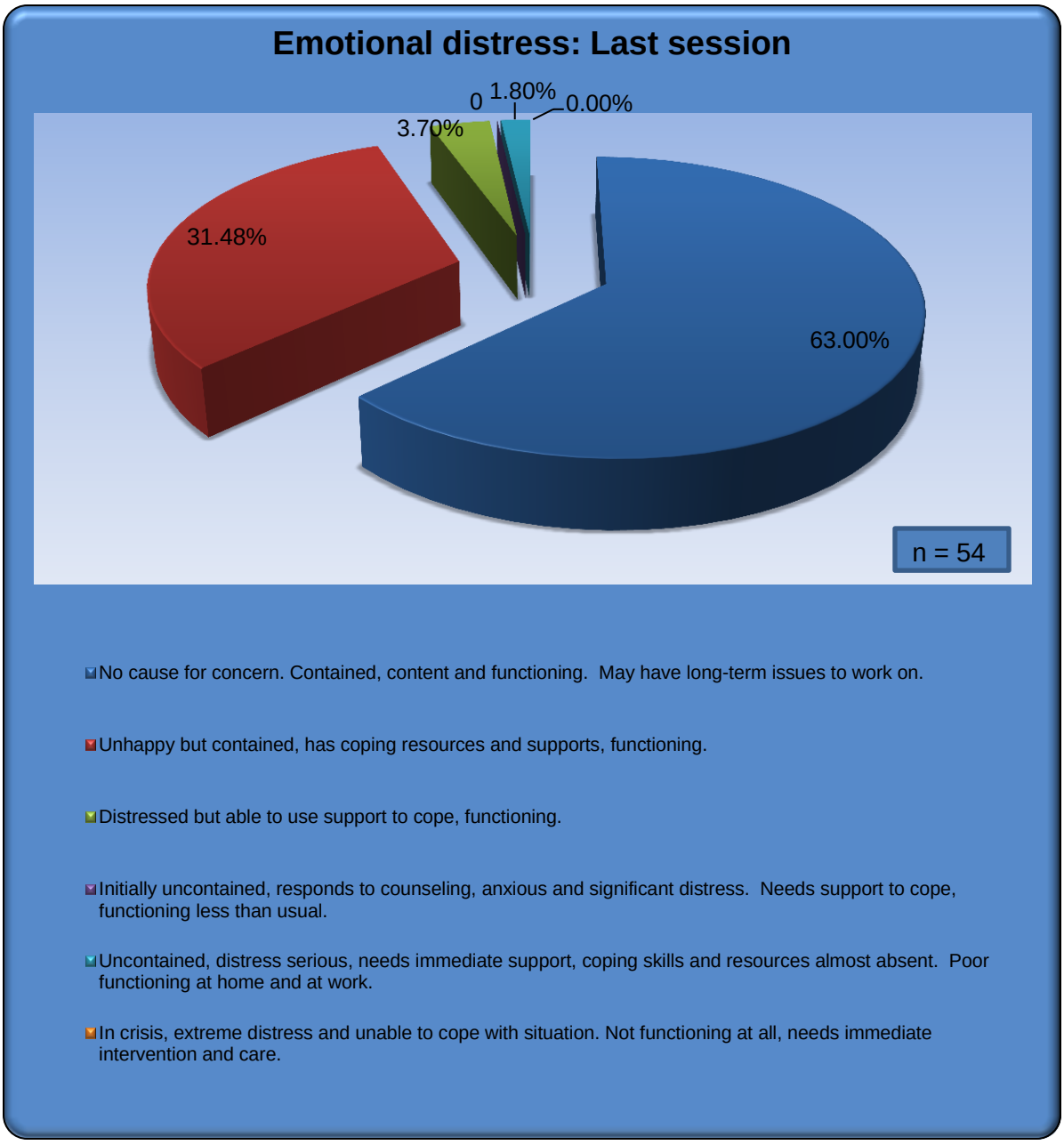


Figure 67: Emotional distress: last session

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.

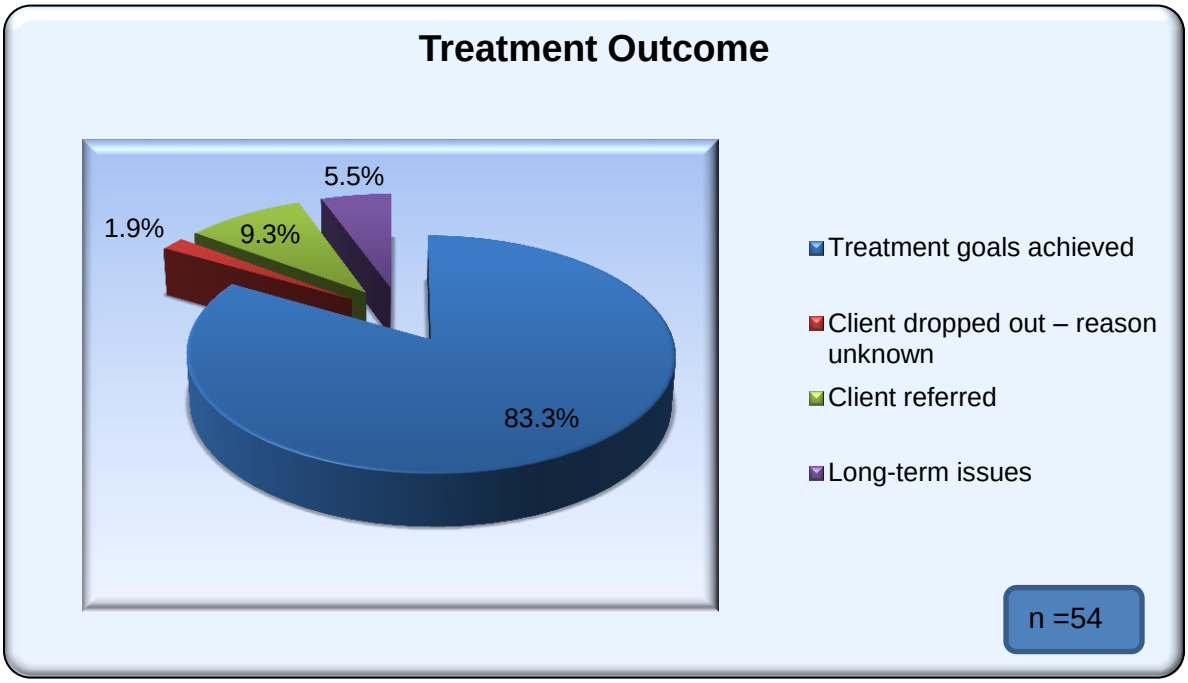


Figure 68: Treatment outcome

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.

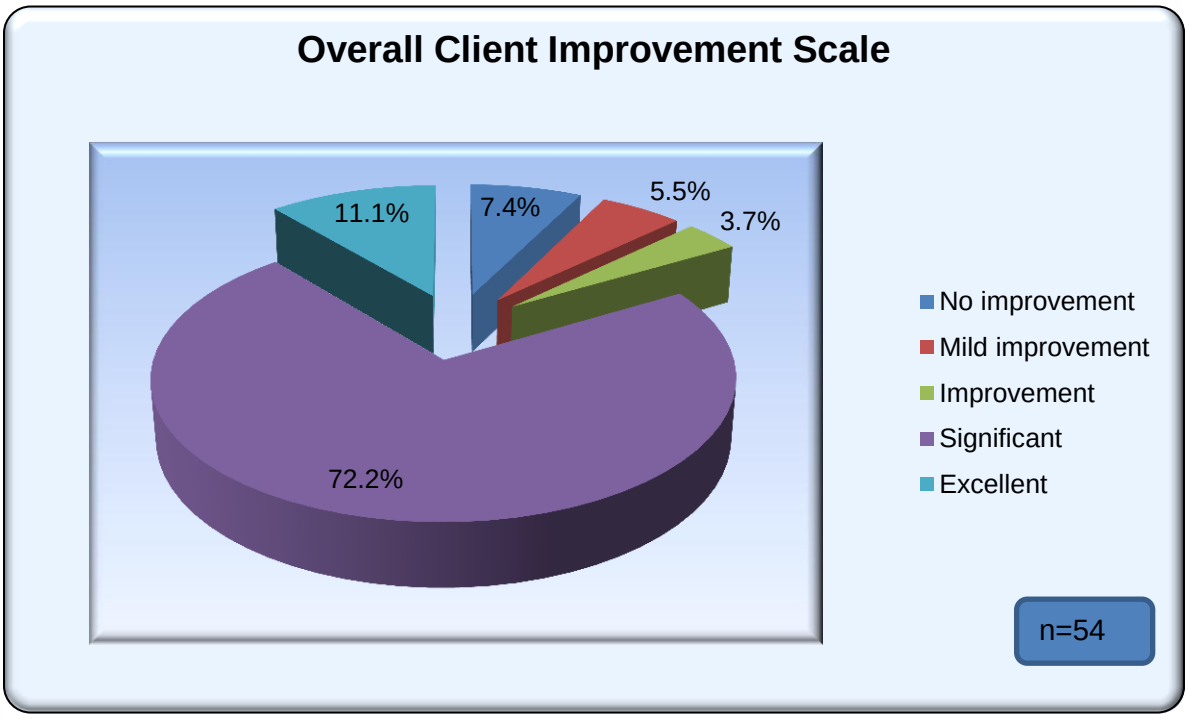


Figure 69: Overall client improvement scale

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.

Chapter 7

Conclusions and Recommendations

7.1 INTRODUCTION

The purpose of this research study was to explore how employees were affected by critical incidents, and to describe the psychosocial impact of the incident on the employee and how it affected the employee's work performance.

The following hypothesis and research questions were formulated:

Hypothesis and research questions

For the purpose of this study, the researcher posed a hypothesis as well as research questions.

Hypothesis

If an employee is exposed to a critical incident, the critical incident will have a negative effect on the psychosocial functioning and work performance of the employee – unless such an employee receives proper counselling or debriefing.

Research questions

- What is the impact of critical incidents on the psychosocial functioning and work performance of an employee exposed to a critical incident?
- What is the impact of counselling within the EAP framework on the psychosocial functioning and work performance of such an employee?
- What is the impact of trauma debriefing on the wellbeing, production and business effectiveness of the corporate client?

In this chapter the researcher provides conclusions and recommendations as they became evident from the empirical data. The researcher further provides evidence from the empirical data to substantiate the hypothesis and research questions.

7.2 CONCLUSIONS AND RECOMMENDATIONS

7.2.1 Conclusions and recommendations based on data collected from employees (part 1 of the study)

7.2.1.1 Demographical information

Conclusions

- Age: The majority of respondents were between 31 and 40 years old.
- Gender: The majority of respondents were female.
- Qualifications: The majority of respondents had tertiary qualifications.
- Service years: The majority of respondents had been working at their current company between 6 and 10 years.
- Level of functioning: The majority of respondents had managerial responsibilities.
- Marital status: The majority of respondents were married.
- Dependents: The majority of respondents indicated that their children were still dependent.

The typical profile of respondents in the study therefore was a female employee between the ages of 31 and 40, with a tertiary qualification, between 6 to 10 years with the company and had managerial responsibilities. She was married and had children.

The pre-trauma risk factors mentioned by Friedman (2003:21–23) are gender, age, education, childhood adversity, previous exposure to critical incidents in childhood, prior psychiatric disorders and a 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. In a study by Brewin, Andrews and Valentine (2000:748–763), 14 pre-risk factors were investigated to determine the impact of trauma. Results proved that during a critical incident gender, age and education were determining factors regarding the reactions to the critical incident and the effect thereof. Authors have consensus that women are more at risk than men, younger people under the age of 25 are more at risk and people with a lower education are more at risk to be more seriously affected by trauma and to develop PTSD. The literature further suggests that people who are happily married with a good support structure are likely to be less affected than a person being alone with limited support or no support systems.

In this study, in terms of the demographical information, the pre-trauma risk factor that contributed to the increased risk of respondents was gender, as the majority of respondents were female. The pre-trauma risk factor that seemed to be in favour of respondents being less affected, was age, as the respondents were older than the identified risk age group of younger than 25. Concerning education, the majority of respondents had tertiary education, had managerial duties and were married and, therefore, expected to have a good support system.

Recommendations

Demographical information should be considered when assessing the possible reactions victims may experience, identifying at risk victims at an early stage and planning intervention as part of the CISM intervention.

7.2.1.2 Meaning of work

Conclusions

The reason a person chooses to work has an impact on the person's motivation to work and, therefore, plays 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.

The main reasons why employees work, as indicated in the study, are indicated as:

- The opportunity to earn money
- The opportunity for self-development
- The opportunity to apply skills.

It can, therefore, be concluded that respondents –according to the empirical data– found work meaningful and, therefore, work played a role in the motivation of employees to restore their work functioning as soon as possible after a critical incident as it provided them with a sense of meaning.

Recommendations

It is important that employers realise that work satisfaction and the meaning of work for an employee, and the resulting motivation to work, play an important role in the recovery process and option to return to work. Employers, therefore, have a duty to optimise working conditions

for employees, ensuring that work is conducive to self-actualisation and the motivation of the employee.

7.2.1.3 Critical incident

Conclusions

The critical incidents that were experienced as most traumatic by respondents were (in order of severity):

- Death of a loved one
- Divorce
- Armed robbery.

It is concluded that these incidents were most difficult for respondents to resolve and integrate. These incidents had the most impact on their work performance and psychosocial functioning.

Recommendations

As respondents experienced these critical incidents as most traumatic, employers can be guided to develop protocols in the intervention of these cases by either allowing therapeutic intervention to continue after the six to eight sessions provided according to a short-term focused model or to refer employees who were affected in this way to specialists in order to restore psychosocial functioning and work performance in the shortest possible time.

7.2.1.4 Trauma risk factors

Conclusions

It is evident from the study that the following trauma risk factors were present:

- Degree of life threat: the majority of respondents experienced the degree of life threat as extreme
- Onset of the incident: the majority of respondents experienced the onset of the incident as unexpected
- Degree of disturbance of home routine: the majority of respondents experienced disturbance of home routine as severely disturbing
- Degree of exposure to death, dying and destruction: the majority of respondents experienced their exposure as extremely high

- Degree of moral conflict inherent to incident: the majority experienced the moral conflict inherent to the incident as extremely high
- Role in trauma: the majority of respondents were directly involved in the trauma
- Proportion of the community affected: the majority of respondents' perception was that a small proportion of the community was affected by the incident
- Degree of bereavement: the majority of respondents experienced the degree of bereavement as high and extremely high
- Duration of being affected by die incident: the majority indicated that they were affected for a period of three months and longer
- Potential for recurrence: the majority of respondents felt the potential of recurrence of the incident was not likely.

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.

Trauma risk factors played a pivotal role in the respondents' reactions to the incident and the development of stress related disorders, for example acute stress disorder or PTSD. It can, therefore, be concluded that, with the exception of the proportion of the community affected and the potential for recurrence, all the other trauma risk factors were experienced as severe by the respondents. The conclusion can be made that the impact of the trauma was severe, as indicated by their reaction to the trauma risk factors and, therefore, more severe reactions to the incident, and more impact on the psychosocial functioning and work performance could be expected.

Recommendations

It is recommended that trauma risk factors should be considered as a possible indicator of reaction to trauma and the intervention needed. Therefore, trauma risk factors should be incorporated when planning CISM interventions.

7.2.1.5 Situational factors

Conclusions

It is evident from the study that the following situational factors were present:

- Anticipation of the incident: the majority of respondents experienced the incident as sudden and unexpected
- Nature of the incident: the majority of respondents reported the incident to be a man-made incident
- Severity of the crisis: the majority of the respondents described the incident as unbearable
- Physical proximity of the incident: the majority of the respondents experienced the incident as being very close
- Feelings of guilt: the majority of respondents indicated that they experienced some feelings of guilt associated with the incident
- Duration of incident: the majority of respondents indicated that the incident lasted for more than one day
- Psychological proximity: the majority of respondents indicated that their children were victims of the critical incident, indicating a close psychological proximity
- Stress level directly after the critical incident: the majority of respondents indicated that their stress levels were high directly after the incident
- Role and conflict overload: the majority of respondents indicated that there was no role or conflict overload due to the fact that they were exposed to a critical incident as a result of the duties of their profession.

In conclusion, it is evident that most of the situational factors were experienced as significant enough to have an impact on the severity of the reactions and the coping skills of the employee, therefore, having an impact on the psychosocial functioning and the work performance of the employee.

Recommendations

It is recommended that situational factors should be considered as a possible indicator of reaction to trauma. Possible outcomes to situational factors should be considered when planning CISM intervention. This will make CISM interventions more effective.

7.2.1.6 Post-trauma risk factors

Conclusions

It is evident from the study that the following post-trauma risk factors were present:

- The majority of respondents reported the availability of a close loving relationship and support
- The majority of respondents reported a stable and supportive family environment
- The majority of respondents reported sources of emotional support outside the family, for example from their church
- The majority of respondents reported role models who displayed positive problem solving skills and who had lived through a trauma.

In terms of respondents' reactions, it can be concluded that the post-trauma risk factors were supportive in providing resilience to the critical incident.

Recommendations

It can be recommended that post-trauma risk factors are recognised as a possible indicator of reaction to trauma. Post-trauma risk factors should be determined to improve understanding of the possible reactions employees might have. These risk factors should be considered and incorporated when planning CISM interventions.

7.2.1.7 Reactions

Conclusions

It is evident from the study that the following reactions were present:

- Physical reactions: headaches were reported as the physical reaction most commonly experienced by respondents as well as the reaction that remained the longest after the incident
- Cognitive reactions: poor concentration was reported as the cognitive reaction most commonly experienced by respondents and poor memory was reported as the reaction that remained a problem for the longest period after the incident
- Emotional reactions: fear was reported as the emotional reaction most commonly experienced by respondents and anxiety was reported as the reaction that remained the longest after the incident

- Behavioural reactions: inability to rest was reported as the behavioural reaction most commonly experienced by respondents, and hyper-vigilance was reported as the reaction that remained the longest after the incident.

It can, therefore, be concluded that respondents experienced a variety of physical, emotional, cognitive and behavioural reactions in reaction to the trauma and some of these reactions remained for up to three months after the incident. The presence and experience of these reactions impacted on the employees' psychosocial functioning and work performance.

Recommendations

The presence and duration of physical, emotional, cognitive and behavioural reactions should be determining factors in assessing a person in terms of acute stress disorder, chronic stress disorder, PTSD and planning interventions in order to manage and resolve these reactions in the shortest possible time.

7.2.1.8 Interventions

Conclusions

It can be concluded that respondents experienced intervention in the following ways:

- Defusing: the majority of respondents were not defused after the critical incident. Those respondents who were defused experienced "emotional support" and being "calmed down" as the main benefit of defusing. The overall response of those respondents who were defused was that it had a positive impact.
- Debriefing: the majority of respondents were not debriefed after the critical incident. Those respondents who were debriefed confirmed he benefit of debriefing to be:
    - Education on stress reactions
    - Preparation for possible symptoms and reactions
    - Clarifying of thoughts

  The overall response of those respondents who were debriefed was that it had a positive impact on their recovery.
- Individual counselling: the majority of respondents were referred for individual counselling after the debriefing session. An overwhelming majority of respondent's reported the benefits from the counselling. The reported benefits were as follows:
    - Felt less emotional
    - Felt less anxious

- Felt less depressed
- Felt own work performance has improved.

In conclusion, it can be mentioned that those individuals who were defused, debriefed or individually counselled after the critical incident benefited from the intervention. Individual counselling seemed to have been very effective in relieving symptomatic reactions and restoring work performance.

Recommendations

It is recommended that each company should develop protocols for defusing, debriefing and individual counselling in case of a critical incident, as it is evident from this research that these interventions are beneficial for employees who have been traumatised and that these interventions assist employees in working through their reactions and restoring their work performance.

7.2.2 Conclusions and recommendations based on data collected from therapists (part 2 of the study)

7.2.2.1 Trauma reactions associated with PTSD

It is evident from the study that the majority of the respondents experienced the following symptoms associated with PTSD, as assessed by the therapists:

- Initial fear was experienced by 92,16% of the respondents, helplessness by 92,16% and horror by 83,72% of the respondents
- Respondents re-experienced the event in the following ways:
  - Recurrent and distressing recollection of the event (94,44%)
  - Recurrent distressing dreams (85,19%)
  - Intense psychological distress (88,89%)
  - Intense psychological reactivity (77,78%)

  Re-experienced reactions were experienced by the majority of respondents (66,04%) for less than three months.
- Avoidance of the event in the following ways:
  - Efforts to avoid activities, places or people who aroused recollection (79,63%)
  - Markedly diminished interest and participation in significant activities (77,78%)

- Efforts to avoid thoughts, feelings or conversations associated with the event (75,93%)
- Feelings of detachment and estrangement from others (72,22%)

The majority of respondents (62,26%) experienced the avoidance of events for less than three months.

- Increased arousal after the event in the following ways:
  - Irritability (96,30%)
  - Concentration difficulties (92,45%)
  - Difficulty falling and staying asleep (90,74%)
  - Outburst of anger (75,93%)

  The majority of respondents (66,67%) experienced increased arousal after the incident for less than three months
- Disturbance caused the following:
  - Clinically significant distress (96,23%)
  - Impairment of social functioning (90,20%)
  - Impairment of occupational functioning (75,51%)

Conclusion

Taking the above information into consideration, it can be concluded that the majority of respondents 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 respondents. 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 it is not clear exactly how long respondents had experienced the reactions, only that they were for less than three months, it can be concluded that the majority of the respondents although traumatised, there was no specific evidence for PTSD. Of the respondents, 33,96% re-experienced the incident for more than three months, 37,74% of the respondents experienced avoidance for longer than three months and 33,33% of respondents 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.

Although the purpose of the study was not to diagnose, it can be concluded that just more than a third of the participants in the study presented with symptoms associated with chronic PTSD, according to the assessment by the therapists.

7.2.2.2 Symptoms associated with complex PTSD

In addition to the symptoms of PTSD, the following reactions associated with complex PTSD were reported, as assessed by the therapist:

- Behavioural reactions: aggression featured in 55% of the respondents, followed by alcohol abuse (24,07%).Impulsiveness (20,37%), eating disorders (12,96%), sexual acting out (9,25%) and self-mutilation (3,70%) also featured
- Emotional reactions: suppression featured in 74,07% of the respondents, followed by emotional instability (64,81%), anger outbursts (57,40%) and panic attacks (42,59%)
- Cognitive reactions: fragmented thoughts were experienced by 50% of the respondents, dissociation by 18,51% and amnesia by 3,70%.

Conclusion

Most authors argue against the diagnosis of complex PTSD in that 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 experienced by only some of the respondents to some degree, making it difficult to clearly distinguish if it was complex PTSD or PTSD.

7.2.2.3 Trauma reactions associated with acute stress disorder

It is evident from the study that respondents experienced the following symptoms associated with acute stress disorder as assessed by the therapist:

- Numbing: 56% of the respondents experienced detachment and 48% experienced an absence of emotional control

- Dissociative amnesia:75,47% of the respondents reported that they were unable to remember important aspects of the trauma
- Reduction in awareness:43,40% of the respondents reported a reduction in awareness of their immediate environment
- Derealisation:33,33% of the respondents reported a sense that their environment is unreal and 48,08% felt estranged or detached from their environment.
- Depersonalisation:16,67% respondents reported that they experienced a distorted perception of their body, their identity or themselves as a coherent entity.

Conclusions

According to Friedman (2003:17) acute stress disorder is diagnosed directly after the trauma an 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.

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

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

In summary, it can be concluded that the majority of respondents were traumatised as a result of the incident. Some presented with symptoms associated with acute stress disorder and a third of the respondents presented with symptoms associated with chronic PTSD.

7.2.2.4 Intervention

It is evident from the study that therapists felt that employees benefited from the counselling as 98,15% indicated that their clients benefited. In 73,23%, significant improvement was indicated as reaction to therapy and 11,50% indicated excellent improvement.

Conclusion

It can be concluded that therapists perceived their intervention as being effective as clients benefited from the intervention and showed significant improvement.

Recommendations

As it is evident that the majority of respondents' reactions to the critical incident indicated traumatisation, it is recommended that:

- More awareness and empathy surrounding reactions to a critical incident should be developed within companies who have an EAP
- De-stigmatisation of reactions to critical incidents should be promoted via companies' internal communication and policies
- Managers and supervisors should be trained to understand the impact and possible reactions to a critical incident
- Managers and supervisors should be trained to identify indicators of work-related impairment and impairment related to psychosocial functioning
- Managers and supervisors should be trained to refer affected employees for the necessary intervention
- Managers and supervisors should be equipped with the knowledge and skills to support the affected employee in the workplace after the intervention.
- A CISM policy should be developed for assessment of employees. Interventions such as defusing, debriefing, aftercare and referral for individual counseling should be managed and directed if recommended
- CISM as an intervention should be proactive as early intervention can decrease the probability for PTSD or acute stress disorder and will optimise the employee's ability to resume normal duties as soon as possible.

7.2.3 Conclusions and recommendations based on data collected through the document study (data in the clinical notes of therapists)

7.2.3.1 Intervention classification

The majority of interventions were classified as personal emotional (68,64%), followed by couple- and family-related issues (20,26%) and then work-related issues (11,1%).This "classification" provided an indication of the nature of the critical incident.

Conclusion

It can be concluded that the majority of critical incidents were personal emotional by nature, followed by incidents that were couple and family related and then incidents that were work related.

7.2.3.2 Work impact

It is evident from the study that the majority of respondents improved from the initial assessment done by the therapist in comparison to the assessment done at termination in terms of the following criteria:

- **"Does the problem affect your functioning?"**
  In the initial assessment, all respondents' work functioning was affected to some degree, compared to the assessment in the termination session where 26 of the respondents' work functioning was not affected and the balance showed improvement in terms of work functioning.

- **"Does the problem impact on your ability to do your job?"**
  In the initial assessment only three respondents' problem did not impact on their ability to do their job, compared to the assessment at termination where 24 of the respondents' problems did not impact on their ability to work. Counselling thus had a positive impact on work performance.

- **"Does the problem impact on your attendance?"**
  In the initial assessment, 21 respondents' problems did not impact on their attendance, compared to the assessment at termination where 47 of respondents' confirmed the

problem did not affect their attendance and the balance confirmed improvement in terms of attendance.

- **"Does the problem impact on your concentration at work?"**
  In the initial assessment, one respondent's problems did not impact on his concentration, compared to the assessment at termination where 32 of the respondents' confirmed that problems did not impact on the concentration at work and the balance confirmed improvement in terms of their concentration at work.

- **"Does the problem impact on your job satisfaction?"**
  In the initial assessment, four respondents' problems did not impact on their job satisfaction, compared to the assessment at termination where 36 of the respondents' confirmed that problems did not impact on their job satisfaction at the time of termination of counselling and the balance confirmed improvement in terms of their job satisfaction.

- **"Does the problem impact on your motivation at work?"**
  In the initial assessment, two respondents' problems did not impact on their motivation at work, compared to the assessment at termination where 35 respondents' confirmed their problems did not impact on their motivation at work and the balance confirmed improvement in terms motivation at work.

- **"Does the problem impact on your relationship with management?"**
  In the initial assessment, 30 respondents' problems impacted on their relationship with management, compared to the assessment at termination where three respondents' confirmed that problems impacted on their relationship with management and the balance confirmed improvement in terms of their relationship with management.

Conclusion

The majority of respondents improved on all the criteria in terms of the initial assessment in comparison to the assessment at termination. It can, therefore, be concluded that respondents' work was affected as a result of the critical incident and that the individual therapy was effective in reducing the impact the incident had on their work performance.

7.2.3.3 Emotional distress

It is evident from the study that the majority of respondents were less emotionally distressed in the assessment done at termination in comparison to the initial assessment. These are the criteria that were used in both assessments:

- **"No cause for concern. Contained, content and functioning. May have long term issues to work on."**
  - In the initial session, two respondents were classified as "no cause for concern"
  - At termination 34 respondents who were classified as "no cause for concern".
- **"Unhappy but contained, has coping resources and supports, functioning."**
  - In the initial session, 17 respondents were classified as "unhappy but contained"
  - At termination 5 respondents who were classified as "unhappy but contained".
- **"Distressed but able to use support to cope, functioning."**
  - In the initial session, 11 respondents were classified as being "distressed"
  - At termination two respondents were classified as "distressed".
- **"Initially uncontained, responds to counselling, anxious and significant distress. Needs support to cope, functioning less than usual."**
  - In the initial session, 17 respondents were classified as "initially uncontained"
  - At termination no respondents who was classified as "initially uncontained".
- **"Uncontained, serious distress, needs immediate support, coping skills, and resources almost absent. Poor functioning at home and at work".**
  - In the initial session, 13 respondents were classified as "uncontained, serious distress"
  - At termination one respondent who was classified as "uncontained, serious distress".
- **"In crisis, extreme distress and unable to cope with situation. Not functioning at all, needs immediate intervention and care."**
  - In the initial session, six respondents were classified as "in crisis"
  - At termination no respondents who was classified as "in crisis".

Conclusion

The majority of respondents showed significantly less emotionally distress at termination, were contained and showed no cause for concern. At termination there was no respondent

who was in crisis, with only one who was uncontained and two who were still distressed. It can, therefore, be concluded that respondents were emotionally distressed initially and that the individual therapy was effective in reducing emotional distress significantly.

7.2.3.4 Emotional – post-event assessment

7.2.3.4.1 Treatment outcome

In the majority of cases, the treatment goals were achieved (45).Some clients needed further intervention and were referred (five) and three cases were referred due to having long-term issues that could not be addressed within the solution focused short-term therapy model. One case was closed due to the client not returning to therapy.

7.2.3.4.2 Overall client improvement scale

The majority of clients showed significant improvement (39 cases); in six cases improvement was excellent. Only three cases confirmed mild improvement and four cases confirmed no improvement.

Conclusion

The emotional post-event assessment indicated a very positive treatment outcome where the majority of respondents achieved their therapeutic goals and the majority showed significant improvement. It can, therefore, be concluded that the treatment plan was applicable for the majority of clients and that they benefited as they manage to improve significantly in terms of their initial emotional functioning.

Recommendations

It is evident that emotional distress was significantly less after the intervention than before and that the treatment outcomes indicated that the majority of respondents achieved their treatment goals were achieved and significant improvement was proven. The following can be recommended:

- Referral for assessment and individual counselling after a critical incident should be part of a company's CISM protocol.
- Companies not having an EAP or employee wellness programme (EWP) should consider outsourcing this service to a service provider specialising in EAP or EWP services that has a well-developed CISM protocol and therapists trained in the solution focused brief

therapy model. Such protocol may assist the affected employees effectively and restore work performance and psychosocial functioning in the shortest possible time.

- The impact of intervention after a critical incident should be tracked and monitored in terms of the changes in work performance and psychosocial functioning.
- For those employees who may need assistance after individual counselling, a company should have protocols in place in terms of referral and long-term support.

7.2.4 Conclusions and recommendations based on data collected through the semi-structured interviews with employees (part 3 of the study) and managers (part 4 of the study)

Employees response	Managers response
Still affected as a result of the critical incident	
Majority still felt affected in some way	Majority response was that employees were no longer affected
Critical incident impact on work performance	
Affected the majority of respondents' work performance (91,67%)	Affected all the employees' work performance
Critical incident's impact on work performance	
Mostly feelings of tiredness, irritability, concentration, stressed and being negative	Mostly concentration, tiredness, stressed, irritability and anger
Work performance at the present moment	
The majority felt their work performance was good at the present moment	The majority of employees' work perform-ance was good at the present moment
Impact on work attendance	
The majority of respondents felt that their work attendance was not affected	The majority of employees' work attendance was not affected
Impact on relationship with colleagues	
The majority of respondents indicated that relationships with colleagues were not affected	The majority of employees' relationships with colleagues were not affected
Relationship with colleagues at the moment	

Majority of respondents' relationships with colleagues were good at the present moment	Majority of employees' relationships with colleagues were good at the present moment
Impact on family and family life	
All respondents indicated that the critical incident impacted on their family and family life	The majority of employees' family and family life were affected

Conclusion

In conclusion, the empirical data from the semi-structured interviews indicated that employees and their managers felt that the incident impacted on their work performance. The following indicators were most obvious:

- Tiredness, concentration, high stress levels and irritability were the most obvious indicators in the workplace.
- Work performance was restored and was good at the time when the interviews were conducted.
- Work attendance and relationship with colleagues were not affected.
- Family and family life were affected as a result of the critical incident.
- Interesting to note is that managers felt that employees were no longer affected by the incident while employees' responses indicated that the majority felt that they were still affected in some way.

Recommendations

As it is evident from the empirical data collected from the semi-structured interviews with employees and their managers that work performance was affected and restored at the time of the interview, the following recommendations can be made:

- Managers should be made aware of the trauma of their employees in order to support them in restoring work performance and psychosocial functioning as soon as possible
- As managers are less directly involved, they may observe employees' performing in certain ways and can assist in making employees more aware of this behaviour or reactions displayed in the workplace.
- Managers should be sensitive to employees' reactions and must be trained to confront them in a constructive way and to discuss and reflect on their observations in order to

restore the employees' work performance and psychosocial functioning, or to refer if necessary.

- Managers should realise that a critical incident impacts on the employee's family and family life and, therefore, should know the resources that the company has available for family members in order to restore family dynamics as soon as possible after the incident.

7.2.5 Implication of this study for practice

It is evident from the study that employees were severely affected by the critical incidents they were exposed to. Trauma risk factors and situational factors largely contributed to their experience of being affected. Post-trauma non risk factors played a pertinent role to enhance the recovery as these factors indicated the support network and resilience of the employee.

The majority of respondents presented with numerous physical, emotional, cognitive and behavioural symptoms as a result of the trauma. Some of the respondents presented with symptoms associated with acute stress disorder. A third of the respondents in the study presented with symptoms associated with chronic PTSD.

The data on the clinical notes of therapists indicated that the incident impacted on the majority of the employees' work performance in terms of their concentration, functioning, ability to do their work, attendance, work satisfaction and motivation.

From the clinical notes of therapists it was further evident that all respondents were emotionally distressed to some degree.

From the therapists' clinical notes it was also evident that the treatment outcome was positive as the majority of employees reached their treatment goals and showed significant improvement.

Data from semi-structured interviews with employees and managers further confirmed that work performance and family life were affected as a result of the critical incident.

Employees' psychosocial functioning and work performance was affected by the critical incident as was confirmed by:

- data collected from the questionnaire completed by employees and therapists (quantitative)
- data collected from the clinical case notes (qualitative)
- data collected from the semi-structured interviews with employees and managers (qualitative)

There is further confirmation that employees' who received individual therapy showed significant improvement in terms of their work performance and psychosocial functioning.

In terms of the formulated hypothesis, the study proved that the hypothesis is true. If an employee is exposed to a critical incident, the critical incident will have a negative effect on the psychosocial functioning and work performance of the employee – unless such an employee receives proper counselling or debriefing.

After being exposed to a critical incident, the psychosocial functioning and work performance of employees who do not receive proper counselling or debriefing are negatively affected in the long-term. The study further managed to provide sufficient evidence on the impact of the critical incident on the psychosocial functioning and work performance of the employee. The research proved that individual counselling is effective in working through the incident and improving the psychosocial functioning and work performance significantly.

As the majority of employees' psychosocial functioning and work performance were significantly affected, the impact of the individual's performance was inevitably affecting the company he/she worked for as a result of the way he/she was being affected. Whether it was his/her productivity levels, absenteeism or presenteeism, concentration or relationship with colleagues– if any of these were affected, it impacted on the company he/she worked for in a smaller or a larger way. The study also proved that intervention in the form of defusing, debriefing, individual counselling and aftercare is effective in addressing employees' reactions, supporting them to recover emotionally from the critical incident and improving their psychosocial functioning and subsequently their work performance.

If organisations can be more aware of the effects of a critical incident in the workplace and understand the importance of effective intervention to improve work performance and psychosocial functioning, they will be more willing to obtain and support a programme that

can improve the quality of life of their employees and ultimately improve their work performance. By offering CISM services to employees, the organisation gains in terms of increased work performance and business effectiveness.

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APPENDIX 1

Dear Therapist

PARTICIPATION IN RESEARCH PROJECT

I am a doctoral student at the University of Pretoria and the topic of my dissertation is: "**An impact assessment of exposure to a critical incident on the psychosocial functioning and work performance of employees".**

The purpose of the envisaged study is to determine the effect critical incidents have on employees and how their functioning, psychosocially and at work, is affected. Furthermore, the researcher wishes to determine how the employees' functioning changes after accessing the EAP. The study will differentiate between different levels of intervention in order to better assess the impact of that particular intervention.

For the purposes of this study, a critical incident is determined as: "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 Post Traumatic Stress Disorder (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 affects his or her psychosocial functioning to some extent, whether temporarily or permanently.**

The research approach will be both qualitative and quantitative in nature. As part of the quantitative study, the researcher will make use of the one-group post-test design. With the assistance of The Careways Group, **30** affiliates in the Gauteng area have been identified. Data will be collected by sending each affiliate two questionnaires to be completed by two different respondents. The therapist should use his/her own integrity to decide which clients to involve based on the abovementioned definition of a critical incident and his/her clinical expertise regarding traumatised clients. The questionnaire will explain the purpose of the study, assure confidentiality and gather information regarding the impact of a critical incident on the psychosocial functioning and work performance of the employee.

The data collection instrument consists of four parts. Parts 1 and 2 of the questionnaire form part of the quantitative study. The employee completes part 1 (section A and section B) and the therapist completes part 2 of the questionnaire. This procedure will not take up time during a therapeutic session as the employee can take the questionnaire home and bring the completed questionnaire back the following session when both parts of the questionnaire can be placed in the provided envelope. Participation in this part of the study is voluntary and anonymous.

The approach applied to the second part (parts 3 and 4) of the study is qualitative in nature. The researcher will use qualitative research methods to establish how and to what extent the psychosocial functioning and work performance of the employee have been affected by the critical incident.

Respondents will be selected if they indicate that they are prepared to participate in the qualitative part of the study (part 1 section B). These employees and their first-level managers will be interviewed separately, using a semi-structured interview schedule as a means of data collection. Case notes submitted by the therapist will also be used for data collection.

Your participation and cooperation in this regard will be highly appreciated.

Yours faithfully

Andre van Wyk
Senior Casemanager

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After completing both the questionnaires and receiving back the completed questionnaires from the client, please call me or sms me on 083 277 0674

APPENDIX 2

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

AN IMPACT ASSESSMENT OF EXPOSURE TO A CRITICAL INCIDENT ON THE PSYCHOSOCIAL FUNCTIONING AND WORK PERFORMANCE OF EMPLOYEES

Dear Therapist

As part of my doctoral thesis I am conducting research to establish the impact of a critical incident on the psychosocial functioning and work performance of employees.

By completing this questionnaire you will contribute to the collection of valuable information necessary for the completion of the research report. It is a short questionnaire and you are requested to complete it with regard to the selected client. The questionnaire will take approximately 15 – 20 minutes to complete.

In answering the questionnaire you will be requested to indicate the reactions and symptoms presented by your client as a result of exposure to a critical incident. Participation is anonymous and all the information will be treated as confidential.

The information gathered from the questionnaire will be analysed in order to assess the impact of exposure to a critical incident on the psychosocial functioning and work performance of employees. The researcher hopes to reach some valuable conclusions and make recommendations that will benefit other employees and help their respective organisations to assist them.

For any further information please contact me on (011) 8474089 (W) or 083 2770674 (C).

Thank you for your interest and participation.

ANDRE VAN WYK
RESEARCHER

APPENDIX 3

UNIVERSITEIT VAN PRETORIA
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Respondent V1 | | | |

PART 1

AN IMPACT ASSESSMENT OF EXPOSURE TO A CRITICAL INCIDENT ON THE PSYCHOSOCIAL FUNCTIONING AND WORK PERFORMANCE OF EMPLOYEES

RESEARCH QUESTIONNAIRE

The questionnaire consists of 2 sections (Section A and B). Sections A and B should be completed by all participants.

SECTION A
To be completed by the client

1. BACKGROUND INFORMATION
(Please mark all applicable information with an X)

1.1. Age

Please state your current age		V2

1.2. Gender

Male	1	V3
Female	2	

1.3. Highest qualifications

Grade 8	1	V4
Grade 10	2	
Grade 12	3	
Post school certificate or diploma	4	
Degree	5	
Other/specify (e.g. computer literacy)		

1.4 Years worked for present employer/company

Please indicate the duration of your current employment (in years)		V5

1.5 Level of functioning in the organisation

Senior manager	1	V6	
Middle manager	2		
Supervisory	3		
Non-supervisory	4		

Other (please specify) _____

_____

1.6 Marital status

Never married	1	V7	
Married	2		
Divorced	3		
Widowed	4		

Other (e.g. living with someone, please specify) _____

_____

1.7 Dependants
(Please indicate the number of dependants)

Spouse		V8	
Children		V9	
Parents		V10	
Relatives (e.g. uncle, cousin)		V11	
Other (e.g. domestic worker, please specify)		V12	
		V13	

_____

2. MEANING OF WORK

2.1 Indicate your motive(s) for performing your current job (Mark all applicable boxes with an X)

2.1	Having a job is an opportunity to earn money	1	V14	
2.2	Job performance is an opportunity for social interaction	2	V15	
2.3	Job performance gives me work satisfaction	3	V16	

2.4	My work gives me a position of status	4	V17	
2.5	My work gives me an opportunity for self-development	5	V18	
2.6	My work contributes to my physical well-being	6	V19	
2.7	My work gives me the opportunity to express my interests	7	V20	
2.8	My work gives me the opportunity to apply my skills	8	V21	
2.9	Any other reason why you are working (please specify):			
	_____		V22	
	_____		V23	

2.10 Which one of the motives you have marked is the most prominent motive for performing your current job (Please specify number, e.g. 2.8)

V24 ☐

_____

_____

_____

3. CRITICAL INCIDENT

3.1. To which of the following critical incidents have you and/or family member or someone close to you been exposed? (Mark the applicable boxes with an X)

In the case of a family member/someone close to you, please specify (Please mark applicable box)

Spouse	1	V25	
Child/children	2	V26	
Other relative	3	V27	
Co-worker/employee	4	V28	
Friend	5	V29	
Other	6	V30	

		Self			Family member/loved one				
		1 Repeatedly	2 Within the last 6 months	3 Prior to the last 6 months	4 Prior to the last 6 months	5 Repeatedly	6 Within the last 6 months		
3.1.1	Assault	1	2	3	4	5	6	V31	
3.1.2	Torture	1	2	3	4	5	6	V32	
3.1.3	War situation (e.g. in the DRC)	1	2	3	4	5	6	V33	
3.1.4	Industrial accident and/or fire	1	2	3	4	5	6	V34	
3.1.5	Motor vehicle accident	1	2	3	4	5	6	V35	
3.1.6	Natural disasters, e.g. floods, fires, hurricanes, tornadoes and earthquakes (e.g. abroad)	1	2	3	4	5	6	V36	
3.1.7	Child molestation and/or child abuse	1	2	3	4	5	6	V37	
3.1.8	Incest	1	2	3	4	5	6	V38	
3.1.9	Rape and/or sexual violence	1	2	3	4	5	6	V39	
3.1.10	Civil violence/riots	1	2	3	4	5	6	V40	
3.1.11	Crime situations and crime	1	2	3	4	5	6	V41	
3.1.12	Armed robbery	1	2	3	4	5	6	V42	
3.1.13	Robbery	1	2	3	4	5	6	V43	
3.1.14	Hijacking	1	2	3	4	5	6	V44	
3.1.15	Smash and grab	1	2	3	4	5	6	V45	
3.1.16	Physical violence either as a victim or as a witness	1	2	3	4	5	6	V46	
3.1.17	Responsible for shooting incident or accident	1	2	3	4	5	6	V47	
3.1.18	Witnessing a shooting incident or accident	1	2	3	4	5	6	V48	
3.1.19	Domestic violence	1	2	3	4	5	6	V49	
3.1.20	Divorce	1	2	3	4	5	6	V50	
3.1.21	Death of a loved one	1	2	3	4	5	6	V51	
3.1.22	Retrenchment	1	2	3	4	5	6	V52	
3.1.23	Retirement	1	2	3	4	5	6	V53	
3.1.24	Loss of income	1	2	3	4	5	6	V54	
3.1.25	Any other event that traumatised you or a family member/loved one (please specify):	1	2	3	4	5	6	V55	

3.2 Trauma risk factors

There are a few variables relating to the type of critical incident you might have experienced that seem to be influential on its impact (Please mark one option per category)

Which of the incidents as specified in **3.1** was the most traumatic (Please specify, e.g. 3.1.14)

V56 ☐

(Questions 3.2.1 to 4.4 refer to the incident that was specified as the most traumatic as indicated above)

3.2.1 Degree of life threat

1	2	3	4	V57 ☐
None	Mild	Moderate	Extreme	

3.2.2 Onset of the critical incident

1	2	V58 ☐
Unexpected	Expected	

3.2.3 Degree of disturbance in home routine

1	2	3	4	V59 ☐
Not disturbed	Mildly disturbed	Moderately disturbed	Severely disturbed	

3.2.4 Degree of exposure to death, dying and destruction

1	2	3	4	V60 ☐
None	Moderate	High	Extremely high	

3.2.5 Degree of moral conflict inherent in the situation

1	2	3	4	V61
None	Moderate	High	Extremely high	

3.2.6 Your role in the trauma

1	2	3	4	V62
Heard about	Witness	Indirectly involved	Directly involved	

3.2.7 Proportion of community affected

1	2	3	V63
Small	Large	Total community	

3.2.8 Degree of bereavement

1	2	3	4	V64
None	Moderate	High	Extremely high	

3.2.9 Duration of feeling traumatised

1	2	3	4	V65
Less than 1 week	1-4 weeks	5 weeks – 3 months	Longer	

3.2.10 Potential for recurrence of the incident

1	2	3	V66
Not likely	Likely	Very Likely	

3.3 Situational factors

3.3.1 Please indicate whether the critical incident occurred in one of the following ways (mark only one):

1. Suddenly
2. Suddenly but expectedly
3. Expectedly
4. Suddenly but unexpectedly

1
2
3
4

V67

5. Unexpectedly | 5 |

3.3.2 Nature of the crisis.
(Please mark the applicable box with an X)

Man-made situation (critical incident as a result of the action of another human being)	1	V68
Natural disaster/natural incident (impersonal event)	2	

3.3.3 Severity of the crisis
In your experience was the critical incident

1	2	3	4	
Minor	Moderate	Severe	Unbearable	V69

3.3.4 Physical proximity to the incident

1	2	3	4	
Far/Distant	Moderately close	Close	Very close	V70

3.3.5 Feelings of guilt

1	2	3	
None	Some feelings of guilt	Intense feelings of guilt	V71

3.3.6 Duration of the incident

1	2	3	4	
Less than an hour	More than an hour	1 Day	More than 1 day	V72

3.3.7 Psychological proximity to person involved in the incident (Please refer to incident as indicated in question 3.2)

Self	1	V73
Child	2	V74
Spouse	3	V75

Parent	4	V76	
Sibling	5	V76	
Relative	6	V78	
Friend/colleague	7	V79	
Someone I know	8	V80	

3.3.8 Your stress level directly after the incident

1	2	3	V81	
Low	Medium	High		

3.3.9 Role and conflict overload
Were you exposed to the critical incident as a:

Social worker	1	V82	
Psychologist	2		
Counsellor	3		
Nurse	4		
Paramedic	5		
Not applicable	6		
Other (please specify)			

3.4 Post-trauma non-risk factors

Did you experience any support after the critical incident?
(Please mark the applicable box with an X)

3.4.1	The availability of a close loving relationship and support	1 Yes	2 No	3 NA	V83
3.4.2	A stable and supportive family environment	1 Yes	2 No	3 NA	V84
3.4.3	Sources of emotional support outside the family, e.g. community, church,	1 Yes	2 No	3 NA	V85

	school					
3.4.4	Role models who display positive problem solving skills and who themselves have lived through a critical incident	1 Yes	2 No	3 NA	V86	

3.5 Reactions to a critical incident

Which of the following symptoms did you experience after the critical incident? (Please mark all applicable boxes with an X to indicate reactions and their frequency)

3.5.1 Physical symptoms

	Once	Daily	Weekly	Regularly for more than 3 months		
1. Chills	1	2	3	4	V87	
2. Thirst	1	2	3	4	V88	
3. Fatigue	1	2	3	4	V89	
4. Nausea	1	2	3	4	V90	
5. Fainting	1	2	3	4	V91	
6. Muscle twitches	1	2	3	4	V92	
7. Vomiting	1	2	3	4	V93	
8. Dizziness	1	2	3	4	V94	
9. Weakness	1	2	3	4	V95	
10. Chest pains	1	2	3	4	V96	
11. Headaches	1	2	3	4	V97	
12. Elevated blood pressure	1	2	3	4	V98	
13. Rapid heart rate	1	2	3	4	V99	
14. Muscle tremors	1	2	3	4	V100	
15. Grinding of teeth	1	2	3	4	V101	
16. Visual difficulties	1	2	3	4	V102	
17. Profuse sweating	1	2	3	4	V103	
18. Breathing difficulties	1	2	3	4	V104	
Which one of the symptoms you have marked did you experience as most prominent? (Pease specify number, e.g 14)					V105	

3.5.2 Cognitive symptoms

	Once	Daily	Weekly	Regularly for more than 3 months		
1. Confusion	1	2	3	4	V106	
2. Nightmares	1	2	3	4	V107	
3. Uncertainty	1	2	3	4	V108	
4. Hyper-vigilance	1	2	3	4	V109	
5. Suspiciousness	1	2	3	4	V110	
6. Intrusive images	1	2	3	4	V111	
7. Blaming someone	1	2	3	4	V112	
8. Poor problem solving	1	2	3	4	V113	
9. Poor abstract thinking	1	2	3	4	V114	
10. Poor concentration	1	2	3	4	V115	
11. Poor memory	1	2	3	4	V116	
12. Disorientation i.t.o. time	1	2	3	4	V117	
13. Disorientation i.t.o. place	1	2	3	4	V118	
14. Disorientation i.t.o. person	1	2	3	4	V119	
15. Heightened alertness	1	2	3	4	V120	
16. Lowered alertness	1	2	3	4	V121	
Which one of the symptoms you have marked did you experience as most prominent ?(Pease specify number, e.g. 4)					V122	

3.5.3 Emotional symptoms

	Once	Daily	Weekly	Regularly for more than 3 months		
1. Fear	1	2	3	4	V123	
2. Guilt	1	2	3	4	V124	

3. Grief/loss	1	2	3	4	V125	
4. Panic	1	2	3	4	V126	
5. Denial	1	2	3	4	V127	
6. Anxiety	1	2	3	4	V128	
7. Agitation	1	2	3	4	V129	
8. Irritability	1	2	3	4	V130	
9. Depression	1	2	3	4	V131	
10. Intense anger	1	2	3	4	V132	
11. Emotional shock	1	2	3	4	V133	
12. Emotional outbursts	1	2	3	4	V134	
13. Feeling overwhelmed	1	2	3	4	V135	
14. Loss of emotional control	1	2	3	4	V136	
15. Inappropriate responses	1	2	3	4	V137	
Which one of the symptoms you have marked did you experience as most prominent? (Pease specify number, e.g.4)					V138	

3.5.4 Behavioural symptoms

	Once	Daily	Weekly	Regularly for more than 3 months		
1. Social withdrawal	1	2	3	4	V139	
2. Anti-social acts	1	2	3	4	V140	
3. Inability to rest	1	2	3	4	V141	
4. Intensified pacing	1	2	3	4	V142	
5. Erratic movement	1	2	3	4	V143	
6. Change in social activities	1	2	3	4	V144	
7. Change in speech patterns	1	2	3	4	V145	
8. Increased appetite	1	2	3	4	V146	
9. Decreased appetite	1	2	3	4	V147	
10. Hyper-alert to environment	1	2	3	4	V148	
11. Increased alcohol consumption	1	2	3	4	V149	
12. Decreased alcohol consumption	1	2	3	4	V150	

Which one of the symptoms you have marked did you experience as most prominent? (Pease specify number, e.g. 4)		V151	

3.6 Shattering of assumptions

Did the critical incident shatter any of the following assumptions you had made about your world? (Please mark all applicable boxes with an X)

3.6.1	The assumption of my invulnerability	1	V152	
3.6.2	The assumption of my rationality	2	V153	
3.6.3	My sense of other people's morality	3	V154	
3.6.4	My sense of self-identity	4	V155	
3.6.5	Specify other assumptions about the world that were disturbed by the critical incident		V156	
			V157	

3.5.6 Which of the shattered assumptions you have marked did you experience as most prominent? (Please specify number, e.g. 3.6.1)

V158

4 INTERVENTIONS

4.1Did you receive any defusing from a therapist immediately after the critical incident? (Defusing is done in a group context. The goal of defusing is to defuse the impact of the event and to assess the needs of the group. The process is brief and usually takes between 20–45 minutes)

(Please mark applicable box with an X)

1 Yes	2 No		
		V159	

If 'yes', please complete the following; if 'no' move to question 4.3
Did the defusing process help you to
(Please indicate by marking all the applicable boxes with an X)

4.1.1	Recover your sense of safety	1	V160	
4.1.2	Rebuild your confidence	2	V161	
4.1.3	Calm down	3	V162	
4.1.4	Establish/clarify what happened	4	V163	
4.1.5	Feel supported emotionally	5	V164	
4.1.6	Deal with practical or physical needs	6	V165	
4.1.7	Regain control and routine	7	V166	

4.1.8 Understand the process of intervention | 8 | V167 | |

4.2 In which way do you feel the defusing process helped you most? Refer to the ones you marked above (Please specify the number e.g. 4.14)

_____ V168 |

4.3 Did you receive any debriefing after the critical incident from a therapist? (This is usually done in a group format, within 24 hours of the critical incident, following the defusing process)

(Please mark applicable box with a X) | 1 Yes | 2 No | V169 |

If 'yes', please indicate if the debriefing process helped you in any of the following ways (Please indicate by marking all applicable boxes with an X.) If 'no', move to question 4.4

4.3.1	Educated me about stress	1	V 170	
4.3.2	Helped me to think clearly/clarified my thoughts	2	V171	
4.3.3	Reassured me that the stress response is controllable and that recovery is likely	3	V172	
4.3.4	Decreased individual or group tension	4	V173	
4.3.5	Prepared me for possible symptoms and reactions	5	V174	
4.3.6	Indicated that I might need additional support	6	V175	
4.3.7	Referred me for additional support	7	V176	

4.4 Aftercare

4.4.1 Did the therapist/debriefer indicate that further assistance was available for those individuals who needed it after the debriefing?

(Please mark applicable box with an X) | 1 Yes | 2 No | V177 |

4.4.2 Did you feel that you needed further assistance after the debriefing process?

(Please mark applicable box with an X) | 1 Yes | 2 No | V178 |

If yes, please explain why

_____ V179 |

_____ V180 |

_____ V181 |

4.4.3 Did the therapist/debriefer suggest or arrange further assistance for you?

(Please mark applicable box with an X)

1 Yes	2 No		
		V182	

If 'yes', please specify the type of assistance which was arranged. (Mark applicable boxes with an X)

Medical assistance	1	V183	
Legal assistance	2	V184	
Family support	3	V185	
Individual counselling	4	V186	
Other (specify) _____		V187	
_____		V188	

4.4.4 Did you make use of this referral to a professional after the debriefing?

(Please mark applicable box with an X)

1 Yes	2 No		
		V189	

If yes, please specify who you consulted

_____	V190	
_____	V191	
_____	V192	

4.4.5 Did you find that the assistance you received from a professional (as indicated in 4.4.4) helped you to recover from the trauma?
(Please mark applicable box with an X)

1 Yes	2 No		
		V193	

If yes, please specify in what way

_____	V194	
_____	V195	
_____	V196	

4.4.6 Did you experience any of the following after the individual counselling?
(Please mark all the applicable boxes with an X)

	1 Yes	2 No	3 N/A		
1. Felt just the same				V197	

2. Felt less emotional	1 Yes	2 No	3 N/A	V198	
3. Felt my life was back to normal	1 Yes	2 No	3 N/A	V199	
4. Felt my sleeping pattern had normalised	1 Yes	2 No	3 N/A	V200	
5. Felt my eating pattern had normalised	1 Yes	2 No	3 N/A	V201	
6. Felt my energy levels had normalised	1 Yes	2 No	3 N/A	V202	
7. Felt less irritated	1 Yes	2 No	3 N/A	V203	
8. Felt my memory had normalised	1 Yes	2 No	3 N/A	V204	
9. Felt my work performance had improved	1 Yes	2 No	3 N/A	V205	
10. Felt less depressed	1 Yes	2 No	3 N/A	V206	
11. Felt less anxious	1 Yes	2 No	3 N/A	V207	
12. Felt my alcohol usage had stabilised	1 Yes	2 No	3 N/A	V208	

4.4.7 Did you benefit from the individual counselling?
(Please mark applicable box with an X)

1 Yes	2 No	V209	

If yes, which one of the outcomes in 4.4.6 was the most prominent? (Please specify number, e.g. 4)

V210 _____

SECTION B
This section should be completed by all participants

1. **The second part of the research study is focused on work performance and the normalisation of reactions after the critical incident. This part of the study is also voluntary and confidential but will require contact with your manager to verify if she or he experienced any changes in your psychosocial functioning and work performance. This will entail a short telephonic interview with both yourself and your direct manager regarding your psychosocial functioning and work performance before and after the incident.**

1.1. Will you be willing to participate in a telephonic interview to determine changes in your psychosocial functioning and work performance?

(Please mark applicable box with an X)

Yes	No

If yes, please provide information about where you can be contacted

Cell number : _____

Tel no (home) : _____

Tel no (work) : _____

Email address : _____

1.2 Are you willing to give permission for the researcher to contact your manager or immediate supervisor to establish if he or she feels there were any changes in your psychosocial functioning and work performance as a result of the incident?

(Please mark applicable box with an X)

Yes	No

If yes, please supply the following details

Name and surname of manager :

Tel no (work) :

Email address :

Signature of employee

APPENDIX 4

Respondent V1 | | | |

PART 2

AN IMPACT ASSESSMENT OF EXPOSURE TO A CRITICAL INCIDENT ON THE PSYCHOSOCIAL FUNCTIONING AND WORK PERFORMANCE OF EMPLOYEES

(To be completed by therapist)

1 TRAUMA REACTIONS

1.1 Did the client experience, witness or hear about an event or events that involved actual death, or threatened death or serious injury, or a threat to the physical integrity of self?

(Please mark the applicable box with an X.)

1 Yes	2 No	V2	

1.2 Did the client experience, witness or hear about an event or events that involved actual death, or threatened death or serious injury, or a threat to the physical integrity of others?

(Please mark the applicable box with an X.)

1 Yes	2 No	V3	

1.3 Did the person's response involve any of these feelings?
(Please mark the applicable boxes with an X.)

	1 Yes	2 No		
Fear	1 Yes	2 No	V4	
Helplessness	1 Yes	2 No	V5	
Horror	1 Yes	2 No	V6	

1.4 Re-experiencing the event

Did the client re-experience the critical incident in any of the following ways? (Please mark applicable boxes in each case)

1.4.1 Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions

1 Yes	2 No		
		V7	

1.4.2 Recurrent distressing dreams of the event

1 Yes	2 No		
		V8	

1.4.3 Acting or feeling as if the critical incident were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes)

1 Yes	2 No		
		V9	

1.4.4 Intense psychological distress on exposure to internal or external clues that symbolise or resemble an aspect of the critical incident

1 Yes	2 No		
		V10	

1.4.5 Intense psychological reactivity on exposure to internal or external clues that symbolise or resemble an aspect of the traumatic event

1 Yes	2 No		
		V11	

1.4.6 What was the duration of re-experiencing the event?

Less than 3 months	1	V12	
More than 3 months	2		
More than 6 months	3		

1.5 Avoidance of the event

Does the client experience persistent avoidance of stimuli associated with the incident and numbing of general responsiveness (not present before the trauma)? Please indicate which of the following are or have been present:

1.5.1 Efforts to avoid thoughts, feelings or conversations associated with the incident

1 Yes	2 No		
		V13	

1.5.2 Efforts to avoid activities, places or people that arouse recollections of the incident

1 Yes	2 No		
		V14	

1.5.3 Inability to recall an important aspect of the incident

1 Yes	2 No		
		V15	

1.5.4 Markedly diminished interest or participation in significant activities

1 Yes	2 No		
		V16	

1.5.5 Feelings of detachment or estrangement from others

1 Yes	2 No		
		V17	

1.5.6 Restricted range of affect (e.g. unable to have loving feelings)

1 Yes	2 No		
		V18	

1.5.7 Sense of a shortened future (e.g. does not expect to have a career, marriage, children or a normal life after this)

1 Yes	2 No		
		V19	

1.5.8 What was the duration of the avoidance of the event?

Less than 3 months	1	V20
More than 3 months	2	
More than 6 months	3	

1.6 Increased arousal

Has the client experienced persistent symptoms of increased arousal (not present before the trauma)?
Please indicate which of the following are or have been present:

1.6.1 Difficulty in falling or staying asleep

1 Yes	2 No	V21

1.6.2 Irritability

1 Yes	2 No	V22

1.6.3 Outbursts of anger

1 Yes	2 No	V23

1.6.4 Difficulty in concentration

1 Yes	2 No	V24

1.6.5 Hyper-vigilance

1 Yes	2 No	V25

1.6.6 Exaggerated startle response

1 Yes	2 No	V26

1.6.7 What was the duration of the increased arousal?

Less than 3 months	1	V27
More than 3 months	2	
More than 6 months	3	

1.7 Did the disturbance or incident cause any of the following? (Please mark all applicable boxes with an X.)

Clinically significant distress	1 Yes	2 No	V28
Impairment in social functionality	1 Yes	2 No	V29
Impairment of occupational functioning	1 Yes	2 No	V30
Or any other area of functioning	1 Yes	2 No	V31
If yes, please specify _____			V32
_____			V33
_____			V34

1.8 Did the client present any of the following reactions as a result of the critical incident?

1.8.1 Behavioural problems (please mark)

Impulsiveness	1	V35
Aggression	2	V36
Sexual acting out	3	V37
Eating disorders	4	V38
Alcohol abuse	5	V39
Drug abuse	6	V40
Self-mutilation	7	V41
Any other (please specify) _____		V42
_____		V43

1.8.2 Emotional problems (please mark)

Emotional instability	1	V44	
Anger outbursts	2	V45	
Panic attacks	3	V46	
Depression	4	V47	
Any other (please specify) _____		V48	
_____		V49	

1.8.3 Cognitive problems (please mark)

Fragmented thoughts	1	V50	
Dissociation	2	V51	
Amnesia	3	V52	
Any other (please specify) _____		V53	
_____		V54	

2. DISSOCIATIVE SYMPTOMS

2.1 Did the client experience any of the following dissociative symptoms? (Please mark all applicable boxes with an X.)

2.1.1 Numbing

The subjective experience of numbing

Detachment	1 Yes	2 No	V55
Absence of emotional reactions	1 Yes	2 No	V56

2.1.2 Dissociative amnesia

The inability to remember important aspects of the trauma	1 Yes	2 No	V57

2.1.3 Reduction in awareness

A lack of attention or response to the immediate environment as if in a “daze” or “world of his or her own”.

1 Yes	2 No		
		V58	

2.1.4 Derealisation

	1 Yes	2 No		
Feels estranged or detached from the environment			V59	
Has a sense that the environment is unreal			V60	

2.1.5 Depersonalisation

Manifests as a distorted perception of one’s body, one’s identity or oneself as a coherent entity

1 Yes	2 No		
		V61	

2.1.6 In addition, have any of the following symptoms been present after the experience of the critical incident? (Please mark all applicable boxes with an X.)

Re-experiencing	1	V62	
Avoidance	2	V63	
Anxiety	3	V64	
Arousal symptoms	4	V65	

3 INTERVENTION

3.1 Do you feel the client benefited from the individual counselling she/he received from you as a therapist?

1 Yes	2 No		
		V66	

3.2 Which treatment model did you use in the therapy process, e.g. Mitchell's mode /Trauma incident reduction model?

Mitchell's Model	1	V67	
Trauma incident reduction model	2	V68	
Any other (please specify) _____		V69	
_____		V70	

3.3 Please indicate the reaction to the intervention (Mark the applicable box with an X.)

No improvement	1	V71	
Mild improvement	2	V72	
Improvement	3	V73	
Significant improvement	4	V74	
Excellent improvement	5	V75	

Please support your answer by providing detail

_____	V76	
_____	V77	
_____	V78	

APPENDIX 5

PART 3

SEMI-STRUCTURED INTERVIEW SCHEDULE
FOR THE EMPLOYEE
(QUALITATIVE STUDY)

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 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 used in the thesis.

1. When were you traumatised by the critical incident?

---

2. Are you still affected as a result of the critical incident? (Please indicate in what way you still feel affected).

---

3. Did the critical incident ever affect your work performance?

Yes	No

4. How would you describe your work performance at the present moment?

---

5. Did the critical incident impact on your work attendance?

Yes	No

6. **If your answer was "Yes" in question no 5, please describe in what way the critical incident is still impacting on your work performance.**

7. **Did the critical incident ever affect your relationship with people at work?**

Yes	No

8. **Does the critical incident impact on your relationship with people at work at the present moment? Please specify.**

9. **Did the critical incident affect your family and family life?**

Yes	No

Thank you for you participation.

APPENDIX 6

PART 4

SEMI-STRUCTURED INTERVIEW SCHEDULE
FOR THE MANAGER
(QUALITATIVE STUDY)

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 used in the thesis.

1. When was the employee traumatised by the critical incident?

---

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)

---

3. Did the critical incident ever affect the employee's work performance?

Yes	No

4. How would you describe the employee's work performance at the present moment?

---

5. Did the critical incident impact on the employee's work attendance?

Yes	No

6. **If your answer was "Yes" in question nr 5, please describe in what way the critical incident is still impacting on the employee's work performance.**

7. **Did the critical incident ever affect the employee's relationship with people at work?**

Yes	No

8. **Does the critical incident impact on the employee's relationship with people at work at the present moment? Please specify**

9. **Did the critical incident affect the employee's family and family life?**

Yes	No

Thank you for you participation.

APPENDIX 7

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

THE CAREWAYS GROUP

Mr André van Wyk

Please file
2005/5/26

Application for Research as part of Doctoral Studies

Dear André,

Your proposal and request for studies in The Careways Group refer. I support your field of study and give you permission to do your research in our organisation.

Please contact me to set up a meeting for the practical arrangements.

Kind Regards,

Dr André van Jaarsveld
0836539021

2005/5/3

Basic plan:

Nov 2005: Begin met studies: wil
- CISD. → betaal kom: → dit betaal
- Stuur CISM + CISA Bly insidente
- Wanda Kruger → kry kos vir by kom:
- identifiseer 2 moontlike customers:
- Vrouna werk: vervoer na kom:

APPENDIX 8

Certificate

I hereby declare that the thesis entitled

Impact Assessment of a Critical Incident on the Psychosocial Functioning and Work Performance of an Employee

by

Andre van Wyk

was language edited during
March 2011

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