# From trauma debriefing to trauma support: A South African experience of responding to individuals and communities in the aftermath of traumatising events

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**This paper documents the approach and experience of Traumaclinic, a Cape Town based organisation offering a trauma support service. The controversy over single session debriefing interventions is examined and it is concluded that interventions that invite intense emotional expression should not be offered indiscriminately or forced on those who do not want them. When they do occur, they need to be carefully managed and take place over several sessions. A review of contemporary approaches to intervention following trauma highlights their comprehensive and flexible nature and the inclusion of multiple components that are introduced in a manner responsive to the needs of the situation. This is the basis of the current model used by Traumaclinic. The principles of that model are summarised and examples given of the application of the approach to specific cases.**

**Keywords:** acute stress disorder, critical incident stress debriefing, trauma recovery, trauma support

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## Introduction

Traumaclinic is one of several South African organisations providing consultation, assessment and intervention for organisations and communities affected by such traumatic events as work-related trauma, criminal violence and motor vehicle accidents (MVAs). It is a network of South African psychologists who offer a trauma support service based on a comprehensive assessment and intervention model. This paper provides a rationale for and summary of the model as well as case illustrations of the model in action.

## The psychological debriefing controversy

Early psychological intervention for those affected by traumatic events has long been associated with the term 'debriefing'. The emphasis on debriefing arose from the search for ways to prevent the development of PTSD in trauma victims. It was widely believed that a focused intervention that engaged individuals emotionally with the trauma they had experienced served to protect them from psychological problems in the future. 'Debriefing' is a military term referring to interviews in which critical incidents are examined by those involved in them and those in authority. These kinds of interventions have been used by the police in Britain for at least 30 years (Dunning 1999). The term 'psychological debriefing' (PD) is particularly appropriate in the context of the military and emergency services such as the police, firefighters and ambulance services as it suggests that the intervention is not a form of counselling (i.e. a quasi-medical intervention) but a normal extension of institutional culture (Litz, Gray, Bryant and

Adler 2002). However the term now has very wide currency. A counsellor at this university recently told the second author that she had just been asked to give a 'trauma debriefing' to students in a residence, where one of the students had shot himself. As Bisson, McFarlane and Rose (2000, p. 39) observe, 'forms of debriefing have become the most written about, widely practised and well-recognised forms of early psychological intervention following trauma.' It was widely believed that if victims could have at least one debriefing session in which they could talk about and express some of the feelings evoked by the event, their long term adjustment would be improved and they would be at less risk for developing PTSD.

### Debriefing: criticism and disillusionment

However, five years ago, critical papers began to appear warning that debriefing could be harmful. Rather than being beneficial, it was claimed, it could actually increase the risk of chronic PTSD. Even where it was not harmful, there was little evidence that it was beneficial. Bisson *et al.* (2000) and Rose, Bisson, and Wessely (2001) in their Cochrane Review summarised the results of randomised controlled trials published in 1996 and 1997. In two of these with MVA survivors, and women who had miscarried, there was no evidence that debriefing was better than no debriefing; in one with burn survivors, debriefing was associated with a worse outcome and the longer the debriefing session took.the worse the outcome. Only in one study, of debriefing for those affected by a hurricane, was there evidence of benefit, and the debriefing took place only six months later,

not in the immediate aftermath. Several less well controlled studies failed to find a positive effect of debriefing in comparison to a non-debriefed group, and one study found that firefighters who were debriefed, though less likely to develop an acute stress reaction, were more at risk for delayed PTSD. Road accident victims who received debriefing were worse off three years later than those who had not been debriefed in terms of general psychiatric symptoms as well as in their overall level of functioning (Mayou, Ehlers, and Hobbs 2000). Litz *et al.* (2002) who calculated effect sizes for the more rigorous studies concluded that PD resulted in 'slightly worse PTSD scores at follow-up,' however, the effect sizes were too small for it to be concluded PD was either 'detrimental or helpful' (p. 116). They recommended against 'the indiscriminate use of single-session psychological debriefing' and suggested that attention should be given to identifying and assisting 'only those individuals who are not likely to recover over time on their own' (p. 118).

### Debriefing: confusion of terms

This research challenged many of the assumptions held by therapists offering crisis intervention to traumatised individuals. Some responded to the findings with incredulity and even denial. In some quarters there was a backlash and the term 'debriefing' became synonymous with doing harm. It was concluded that qualitative feedback from many participants who found it valuable was misleading with respect to its actual impact. It was suggested that the fact that most trauma survivors do not go on to develop chronic PTSD may have generated 'a spurious sense of efficacy regarding the preventative value of psychological debriefing' (Bisson, *et al.* 2000). Like most frontline organisations that offer support in the aftermath of trauma, we at Traumaclinic had worked on the assumption that it was important to provide debriefing style interventions where possible as a means of preventing the development of future mental health problems. In light of these research findings, we began to re-evaluate our procedures for crisis intervention. As we examined the literature closely, we recognised that it was important to clarify the meaning of terms and to separate out several different issues that might otherwise be confused.

Mitchell and Everly (1995, p. 271) describe Critical Incident Stress Debriefing (CISD) which has been in use for 20 years and is the prototype of debriefing interventions. It is a structured seven phase 'structured group meeting or discussion' usually lasting two to three hours in which affected individuals:

> are given the opportunity to discuss their thoughts and emotions about that event in a controlled, structured and rational manner. They also get the opportunity to see that they are not alone in their reactions.

The process has 'both psychological and educational elements, but it should not be considered psychotherapy'. After, the team members have been introduced to the group, participants are asked to describe what happened 'on a cognitive level' (i.e. intense display of emotion is not encouraged at this point). Next they are asked for their most prominent thoughts about it and this is likely to evoke 'some leakage of emotion into the discussion' (p. 272). The fourth phase focuses on questions like: 'What was the worst thing about the situation for you personally?' (p. 272) and what was 'the most emotionally powerful'. Following this there is a shift back from 'emotionally laden content ... to more cognitively oriented material' by focusing on descriptions of specific symptoms that individuals have been experiencing. This is used as a springboard for psychoeducation about likely stress reactions, suggestions for practical coping strategies and advice on a range of practical issues such as 'diet, exercise, rest, talking to one's family, [and] working with supervisors' on appropriate changes in response to what has happened. There is a final re-entry phase in which further questions are answered and concerns clarified.

Although originally designed for emergency services personnel, CSID has been used widely with victims in many contexts including schools, industrial settings and natural disasters. When first introduced, CISD was not a stand-alone intervention, but part of a 'comprehensive intervention system [that] consists of multiple crisis intervention components which functionally span the entire temporal spectrum of a crisis' (Everly and Mitchell 2000 p. 213). Unfortunately, the term CISD was used to refer to the specific group intervention as well as to the overall package. This was rectified with the introduction of the term Critical Incident Stress Management (CISM) for the overall programme. There are large similarities between CISM and other comprehensive approaches to be referred to later. In interpreting the data that has created the debriefing controversy, it is important to recognise that the confusion about the meaning of CSID is part of a general tendency to use terms like counselling and debriefing quite loosely. CISD was not designed to be a stand-alone intervention or an individual intervention. One of its goals is to promote social support among group members. However, none of the studies which found negative effects of debriefing used the Mitchell and Everly protocol and several of them used single individual sessions of one hour in duration (e.g. Mayou, Ehlers, and Hobbs 2000). Such interventions would be likely to activate intense emotions without contributing to social support, and Everly and Mitchell (2000) warn that 'clinicians should use caution implementing a group crisis intervention protocol with individuals singularly'.

The confusion in the field can be seen from the fact that the Academy of Cognitive Therapy (2005) guidelines for professionals involved in responding to those affected by traumatic events include the recommendation: 'Helpers are advised not to include psychological interventions at this early phase.' It is not easy to determine where practical support leaves off and psychological interventions begin, but hopefully, the writer is not warning us against offering empathic listening, giving information to normalise symptoms, or attempting to correct exaggerated negative cognitive appraisals. Offering emotional support and helping individuals to share difficult feelings is experienced as helpful by many people. The literature suggests that it may be insufficient to prevent the development of problems in the future when offered in the format of a one-off session. However protection is provided by an ongoing support

system of trusted individuals with whom one can share feelings and thoughts on an ongoing basis. For this reason, it is best to give priority to encouraging individuals to draw on and consolidate their existing social supports. Gist, Woodall and Magenheimer (1999) warn of the danger of promoting what they call 'trauma tourism' (p. 275), where well-meaning people travel to the site of disasters with the intention of offering debriefing style interventions. This creates the misleading impression that all individuals need specialist counselling offered by outsiders. Nevertheless, there are many individuals who are vulnerable because they lack social support, and experience relief when trauma workers facilitate having some form of sharing with other affected people, especially if they are work colleagues or family members. While more research is needed to clarify these points, contemporary practice is to ensure that 'psychological interventions' take their place as part of a comprehensive range of interventions designed to address problems at all levels, and that one-off emotionally intensive interventions are avoided.

### Debriefing in South Africa
The idea that an intensive single session could be of therapeutic value has been very influential in South Africa. Straker and Moosa's (1994) work with those traumatised by government political repression and brutality emphasised the value of providing the opportunity for those affected to talk, and express what they were feeling. Although they did not specifically recommend a single session, they pointed out that in the unstable political and social conditions counsellors could not count on seeing these individuals more than once. The single session assessment and intervention developed by Pynoos and Eth (1986) was and still is widely used with children, although nowadays it is usually part of a series of interventions (Leibowitz-Levy 2005, this issue).

In South Africa, the term 'debriefing' has been used rather flexibly to refer to a range of interventions. Peeke, Molet-sane, Tshivhula and Keel (1998) describe a 'trauma debriefing' intervention offered to employees (mostly women) in a financial institution following an armed robbery by four black men one Saturday morning. No one was injured, but all been held hostage at gunpoint while robbers forced employees to open the safe. When staff returned on Monday they did not feel safe, fearing that the robbers were still inside or might return. However, there was pressure on employees to get back to work. The human resources manager had been trained in crisis intervention and had identified 'at risk' individuals who, because of other recent losses, might need individual attention, and made arrangements for them.

The intervention included three group debriefing sessions. The first was difficult to conduct because several women were in extreme distress and 'cried and ran in and out of the session' (p. 24). The counsellor divided the group into two and dealt first with those who were coping least and elicited those who were coping to support those who were not. Many white employees had developed a generalised fear of, and anger towards, all black people. This made it difficult for them to relate to their black

colleagues. This issue was constructively addressed. In a later session employees felt empowered by the fact that managers were also undergoing emotional strain, and managers felt supported by the way in which the crisis intervention staff assisted with immediate decisions. Another problem was that staff who were not on duty at the time of the robbery became resentful of the attention given to the others and intolerant of their distress. The final session focused on re-empowerment and 'the managers were able to reclaim their positions of leadership, which added to a sense of containment'. It can be seen how this 'debriefing' intervention involved a range of pragmatic as well as psychological components.

### Disability and compensation: the importance of prevention
Despite the emphasis on resilience, there is continuing concern about PTSD among emergency services personnel. This is not only motivated by the need to protect the health and effective functioning of employees, but also by the cost to organisations of disability or compensation payouts on the basis of PTSD (Edwards, Sakasa and Van Wyk 2005, this issue). Mitchell (1999) describes how, following the 1989 Hillsborough Football stadium disaster in the UK in which 93 spectators died, there were several such disability claims from policemen. This led to an investigation into how response to trauma was handled in the police in the UK, and she found an absence of systematic infrastructure. Some units had trained peer debriefers who were experienced as providing a valuable service, while others provided little or no psychological support. Since debriefing in groups can heighten interpersonal tensions, 'one-to-one counselling is common, and there is evidence that individuals may fare better using this modality' (p. 261). There were reports of 'informal or natural debriefing' (p. 257) in which peers spontaneously discussed traumatic events among themselves, but nothing like this occurred in nearly 40% of incidents described by respondents.

PTSD has also emerged as a significant problem in the South African Police Service (SAPS), where, since 1994, when the first democratic government was elected, there has been a dramatic increase in disability claims on the basis of chronic PTSD. There is evidence that this is at least in part due to organisational changes in the police where a politically driven process of transformation has resulted in many of those in the police before 1994 experiencing lower job satisfaction and lack of institutional support, both significant factors in promoting resilience. Recently, in the Eastern Cape, there was an outcry as the SAPS attempted to force officers on long term sick leave to go back to work. One hundred and ten officers were involved, who had been 'certified ill by doctors — most suffering from post-traumatic stress' (Mathewson 2004, p. 1). This may be an example of the way in which granting sick leave after trauma increases the incidence of avoidance behaviour leading to absenteeism and staff turnover. Another factor, however, may be the attractiveness of PTSD as a route to medical boarding, since, SAPS authorities accused many of the claimants of malingering as they had been transferred to other centres and did not want to

move. This conflict has been exacerbated by the fact that institutional culture does not provide support for the emotional processing of traumatic events. Many emergency workers and police officers to whom debriefing was offered, regarded it as a waste of time. Kopel and Friedman (1997, 1999) found that police appear to deal with exposure to traumatic events by distancing themselves from the unpleasant experience and avoiding dwelling on it. For some individuals, this avoidance, rather than being dysfunctional, seems to be an effective means of coping, but it is likely to increase the risk of at least some individuals developing PTSD and to render them unable to benefit from interventions that could resolve it.

### Individual intervention in the prevention of PTSD

Although the practice of pushing people to confront distressing memories has been called into question in the context of one-off crisis intervention sessions, it has a central place in current psychological treatments for PTSD. Evidence has been accumulating to show that risk of PTSD can be substantially reduced by a structured series of as few as five sessions of cognitive-behaviour therapy (CBT) that includes emotionally intense exposure sessions. Foa, Hearst-Ikeda and Perry (1995) offered female assault victims four two-hour sessions of a CBT intervention that included relaxation training, information about the importance of facing the painful memories, a session of guided reliving, recommendations to relive the situation at home on several occasions, and cognitive restructuring. In most cases the intervention began within two weeks of the assault. Two months post-assault only 10% met criteria for PTSD, as compared to 70% in a matched group who received repeated assessments. Six months post-assault, the difference between the groups was considerably less, but the CBT group had a significantly lower level of re-experiencing symptoms and was significantly less depressed.

The same positive effects of CBT have been shown in four randomised controlled trials from Bryant's group. Bryant, Harvey, Dang, Sackville, and Basten (1998), and Bryant, Sackville, Dang, Moulds, and Guthrie (1999) offered five sessions of CBT or supportive counselling (SC) to MVA survivors with ASD. CBT markedly reduced incidence of PTSD: six months later less than 20% of those offered CBT had PTSD, as compared to two thirds of the SC group. Bryant, Moulds, Guthrie, and Nixon (2003) offered five sessions of CBT or SC to trauma survivors with mild traumatic brain injury and ASD within two weeks of the traumatic event. Fifty-eight per cent of the SC group still had PTSD post-treatment and at six month follow-up. In the CBT group the figures were 8% and 17% respectively. Bryant, Moulds, Guthrie, and Nixon (2005) offered trauma survivors with ASD six sessions of SC, CBT or CBT with hypnosis (CBTH). The latter group received a hypnotic induction before exposure sessions that included the suggestion that they enter into the events fully and 'experience as much affective and sensory detail as possible' (p. 335). At six months follow-up, 59% of the SC group met criteria for PTSD as opposed to 21% in the CBT group and 22% in the CBTH. There was little difference between CBT

and CBTH, except that the latter group showed a greater drop in re-experiencing symptoms

### Lessons from the debriefing controversy

The debriefing controversy began with scepticism on the part of critics about the value of interventions that promoted emotional processing and was fuelled by studies which showed that in certain contexts such interventions could be harmful. Although there is no doubt that many benefit from being able to share their feelings with peers or a counsellor, it became clear that interventions that intensify negative emotions may be counterproductive at a time when psychological recovery is best supported by reducing emotional intensity and focussing on practical adjustment (Litz *et al.*, 2002). In the immediate aftermath it is important to focus on creating a sense of safety both practically and interpersonally, a goal that may be undermined by pushing for emotional expression. The more emotionally charged phases of the Mitchell and Everly (1995) structure may therefore be contra-indicated, although it is possible that only certain vulnerable individuals are at risk.

Several cautions are therefore in order when offering crisis intervention following traumatic events. First, it is not appropriate to assume that all individuals need specialist help in the form of group or individual counselling. The literature on vulnerability and resilience reviewed by Edwards, Sakasa and Van Wyk (2005, this issue) highlights the wide range of individual differences in response to traumatic events and the resourcefulness and resilience that characterise a significant proportion of affected people. Second, while group meetings can enhance group cohesiveness and strengthen social support, they can also lead to alienation and conflict because not all those affected may be ready to become vulnerable, or be comfortable seeing others doing so (Mitchell 1999). Third, a focus on the horror of the trauma and its negative impact can create the expectancy that psychopathology is a common consequence of trauma and therefore render individuals more vulnerable to becoming and remaining symptomatic (Herbert and Sageman 2004).

These cautions can be observed within a comprehensive approach to trauma intervention which balances the salutogenic, resilience enhancing perspective, with the recognition that emotional processing is part of normal recovery for most people and that it can often be fostered within existing social support networks. When using individual or group interventions that invite expression of feelings and facing the emotional impact of what has happened, the risk of harm can probably be mitigated by being alert to individual differences, screening out vulnerable individuals, and maintaining a clear salutogenic perspective that focuses on each individual's capacity to find and build resilience (Dunning 1999).

### The Traumaclinic model for early trauma support

At Traumaclinic we have 'gone back to the drawing board' and re-evaluated and reformulated our practice in light of this research as well as our considerable experience on the ground over the past 15 years working with more than 3 000

individuals who have been exposed to potentially traumatising experiences. Our approach to early intervention is flexible, pragmatic, problem-oriented, phased and multifaceted and accords with guidelines emerging internationally described in the recent literature.

### Broad spectrum multi-component interventions: international models

Salzer and Bickman (1999) draw attention to the host of practical matters that need to be addressed in the immediate aftermath of a traumatising event and the need for immediate priority to be given to stabilising the situation, ensuring that affected individuals have the basic necessities of life, such as food and shelter, and creating a situation of safety where there are no further threats to life and property. Alongside this, interventions are needed to strengthen and build social support by helping individuals to work together to address the various effects of the trauma, and to help members to talk about what has happened in a manner that enables them to find direction, solve practical problems and return to constructive everyday activity. In addition it is important to identify vulnerable individuals, especially those who might not connect up with helping resources 'because of racial or educational level,' (p. 77) and offer them active assistance.

Everly and Mitchell's (2000) CISM is a set of multiple interventions that can be drawn on, as appropriate, as a crisis unfolds. In addition to the CSID group meeting, the approach includes stress inoculation training for emergency services personnel in preparation for traumatic incidents, assessment and referral for individual intervention; consultations with management in organisational settings, or with disaster response teams and other emergency services personnel; support for pastoral intervention from religious leaders and within religious institutions; and group crisis meetings with organisations or families.

Macy, Behar, Paulson, Delman, Schmid and Smith (2004) describe a comprehensive approach called 'post-traumatic stress management' (PTSM) developed by the Community Services Program in Boston, USA, which also provides an infrastructure for dealing with disasters and traumatic incidents. They emphasise that all significant role-players need to be involved in a process of assessment and planning of a range of interventions to meet the needs of all those affected. In the case of natural disasters and traumas that affect a considerable number of people, liaison with community leaders is essential, as it is they who will play major roles in organising, motivating and giving constructive direction to community members. For example, an intervention following a school bus accident in which four children died included identifying specific groups of affected individuals and providing support and 'resiliency based psychological coping groups' for each of them, identifying those in need of individual counselling, providing support at funeral rituals and the memorial service, facilitating classroom discussions, and running 'meetings with school administrators to help them assume leadership roles over time' (p. 221). A range of psycho-therapy interventions are incorporated, including psycho-education, expressive techniques, exposure methods, mindfulness training, and coping skills

enhancement and resource building. Some interventions are similar to CSID, however,

> rather than focusing primarily on disturbing or negative elements of the traumatic event, we take great care to build a sense of safety and stability at the beginning of our group sessions. We then focus on phenomena that elicit the expression of, and that promote, the resiliency of the group members and of the community as a whole (p. 221).

### A three-stage process

Because addressing individual emotional distress and supporting the emotional processing of what has happened is only one aspect of intervention, we refer to our work at Traumaclinic as 'trauma support' rather than 'trauma debriefing' or 'trauma counselling'.

The focus is on assessment and early identification of areas where intervention is needed. There is no predefined procedure or prescription. A variety of possible interventions is available, mostly familiar components of trauma crisis intervention. Interventions are selected in response to what is found in the initial and ongoing assessment process and in keeping with the emphasis of Gist and Woodall (1999, p. 217) on the importance of promoting resilience, and ensuring that such interventions 'supplement and reinforce resilient responses of individuals and organisations' and do not

> [supplant or replace] natural contacts and supports that promote autonomy and resilience with artificial structures that instead may reinforce vulnerability and encourage reliance on inappropriate, ineffective, or ill-timed strategies of coping and resolution.

A typical trauma support process will unfold in three stages. In Stage One, which will occur in the first few hours or up to two days following the incident, the focus is on providing direction and guidance in practical ways, structuring solutions to immediate problems (most importantly the need for safety and protection), assessing and, if necessary bolstering individuals' levels of social support, and responding empathically to the range of distressing emotions felt by the victims. These activities continue in Stage Two, which occurs after a few days and may last for two weeks. In addition, selected individuals are offered counselling or psychotherapy. Finally, in Stage Three, two to four weeks after the incident, we follow-up, re-assess whether further interventions are needed at the individual or organisational level, and encourage organisations and individuals to consolidate their capacity for support in a resilient manner.

Within these broad stages, the councillors attend to several parallel objectives in a manner designed to support, facilitate and optimise the processes which have been shown to contribute to normal recovery from trauma, and which occur naturally in the families and social networks of affected individuals. The trauma support staff act first as consultants or managers in the aftermath to trauma, rather than as counsellors. They do not expect to deal exclusively with victims and give attention to other important role players including work supervisors, work colleagues and family members. We recognise that different victims require different forms of help, and that different forms of help are

appropriate at different times for the same individual. We also attend to the traditional aim of trauma debriefing, namely to prevent the subsequent development of PTSD and other related disorders by focusing on early identification of factors that might complicate or hamper recovery, and, where appropriate offer individual or group counselling or therapy.

First, we incorporate strategies for normalising psychological responses to trauma, explicitly through psycho-education and implicitly in responding to people's experiences in an accepting manner. In the face of evidence that many individuals incorrectly misattribute these kinds of symptoms as being evidence of characterological weakness, moral turpitude or impending insanity, the offering of corrective information can have a stabilising effect. We provide an informational page entitled 'Useful information for trauma victims' which lists common symptoms (physical, emotional, behavioural and cognitive) of an acute stress reaction. They are described as 'the typical after-shock of a horrible event – they are normal reactions to an abnormal experience' and readers are told that this reaction is likely to 'diminish after a few days and in most cases life will return to normal after approximately three to four weeks.' The information sheet also includes guidelines for self-management such as: 'Structure your time – keep occupied', 'Reach out to others; ask for support – do not try to be "strong"', 'Do not make any big life decisions for a while', and 'Be careful of drugs, alcohol and medication to make things easier'. These accord with similar guidelines put out after the 2001 9/11 attacks in New York and Washington (Academy of Cognitive Therapy 2002) and after the London bombings in July 2005 (Traumatic Stress Clinic 2005) and support a balance between carrying on with life constructively and expressing and sharing one's emotional distress with supportive friends or colleagues in a manner that promotes reflection and processing of the implications of what has happened. They are also in line with the approach of Gist *et al.* (1999, p. 287)

> People are resilient; friends are important; conversation helps; time is a great healer; look out for others while you look out for yourself.

Second, we give a great deal of attention to social support, by identifying individuals who are vulnerable to isolation, and strengthening existing social support within peer groups or the family. We also work to prevent the families and peers of affected individuals from undermining the recovery process. The best professional assistance is often neutralised by input from the significant persons in the world of the trauma victim, such as spouses, managers, friends and colleagues who can exert much more impact, constructive or destructive, than those offering professional help.

Third, we try to identify distressed individuals who might not recover normally because of factors that are complicating or obstructing the normal recovery, and to address these complicating factors through individual counselling or psychotherapy, or interventions in the family or workplace.

Fourth, we discourage measures that might encourage victims from moving into a 'sick' role. There is little evidence that rest alone is a major factor in recovery. Although medication can play a helpful role (Foa, Davidson, Frances and Ross 1999), its provision can undermine the indivi-

dual's sense of efficacy in being able to rely on their own resources. This could account for the findings of Gelpin, Bonne, Peri, Brandes and Shalev (1996) who compared 13 survivors of terrorist attacks and work accidents treated with benzodiazepines with a matched control group who were not given medication. At one month and six month follow-up the benzodiazepine group was not more improved than the controls (nine still met criteria for PTSD compared to three of the controls). Thus we do not usually recommend the use of medication, particularly benzodiazepines. Similarly we advise against sick leave, unless a person has been physically injured. The literature shows that this can create difficulties in readjustment on return to work. When a correctional services employee escaped unhurt after his car was rocked, overturned and burnt by a mob while driving in a township, we did not recommend he be given sick leave as he was coping well. Management still offered it to him, but he did not take it and was found to be still coping well at follow-up. However we do encourage management to give leave to attend to practical matters such as giving evidence to the police or arranging or attending a funeral.

Finally, we ensure that our Traumaclinic personnel monitor their own capacity to work in trauma situations and take steps to protect themselves against burnout. In a study of lay trauma counsellors working with another South African organisation, Ortlepp and Friedman (2001, 2002) found a relationship between sense of coherence and stress, related to trauma work. They also found that the trauma counsellors obtained a great deal of satisfaction from their involvement in trauma work and the guidelines which limited the amount of consultation and counselling had been effective in protecting against burnout, since scores on a scale that measured this were generally low. The Traumaclinic recommendation is that counsellors should share their experiences with their peers informally or as part of peer supervision, and with other persons in their primary support system, just as it is recommended to trauma victims themselves.

### *Traumaclinic in action: Case examples*
Here are a few case examples which illustrate aspects of our approach.

*Case 1 — The Grassy Park petrol station murders:* In June 2002, six pump attendants on the night shift were shot dead at a petrol station in Grassy Park near Retreat on the Cape Flats. The members of the day shift arrived in the morning to find them dead. In many cases those who found them had family ties to or were friends of the dead men. Intervention involved a series of contacts with the survivors who were seen immediately and then one week, three weeks and six months after the murders. Formal counselling or debriefing was not possible because of language problems, but the owners and management were advised to provide practical support to the survivors in a number of ways. They paid to have the bodies transported to the respective homes for the funerals, they arranged transport to and from work for the survivors for the next few days, they provided practical support for the rituals that followed, for example, giving time for them to attend the funerals, and

they supported those who lived alone in finding somewhere else for them to stay for a while, or someone to stay with them. Management were advised on strategies for assisting their staff in readjusting to the work situation and to forestall the development of resistance and avoidance. With this intervention, all the survivors recovered within a few weeks and none developed PTSD, even though they received no formal counselling.

*Case 2 — Absenteeism following an armed robbery:* The positive response of management at the petrol station can be contrasted with what happened at a bottle store that was the target of an armed robbery before closing time on a Saturday night. The store manager was off duty and unavailable and the staff phoned the regional manager who simply instructed them to close up and go home. Traumaclinic was called in the next Tuesday because many staff were resisting coming to work. The regional manager had not visited the store and the seven staff members felt that management were not looking after them. They could not regain a sense of safety in their place of work and their fear was compounded by resentment against management and a pre-existing low morale. The store manager, caught in the middle between the reasonable needs of staff and the lack of interest on the part of regional management, became critical of the employees. Staff were offered individual and group sessions to assist them in regaining a sense of control and confidence, but absenteeism remained a problem. Staff turnover was high and two of the original seven members were eventually boarded on the grounds of stress.

*Cases 3 and 4 — The role of family members* in supporting or undermining an intervention is shown by what happened after another armed robbery at a jewellery store in 2001 during which three staff were held at gunpoint. Management were advised on improved security and responded positively and the affected staff each had individual sessions that focussed on establishing a sense of safety and overcoming behavioural avoidance. One of the three became symptomatic and a probable significant factor was the response of her husband who, instead of being encouraging, said, 'I don't want you to go back there, it's a dangerous place.' Eventually she had to be transferred to a job in the head office. In another case the husband's response also seemed to be a factor contributing to the maintenance of his wife's symptoms. She was accosted in her kitchen by a man wielding a knife and screamed. The assailant ran away and nothing was taken. At first she seemed to recover well, but a few days later she snapped at her domestic worker who had been with the family for many years, asking her, 'Where were you when the attacker appeared?' Affronted, the worker resigned and left. As she became more symptomatic, her husband accused her of being dramatic and giving in to exaggerated fears. She was given four sessions of cognitive behaviour therapy followed by some conjoint marital sessions in which she expressed the wish that they install higher fences and remove hedges to improve visibility as a means of providing for more security in the home. The husband believed she was overreacting, was not sympathetic, and would not agree to

her suggestions. The eventual outcome of this case is not known, but it does show how important it can be for recovery for victims to feel understood and have their concerns validated by those close to them (Herman, 2001).

## Conclusions

The controversy resulting from the evaluation of certain specific 'debriefing' interventions has resulted in a careful re-evaluation of the principles of trauma intervention internationally and in South Africa. In line with the recommendations from current research, Traumaclinic's approach aims to find the balance between fostering resilience and offering specialist interventions that address intense distress, including those that treat PTSD. As in most areas of psychological intervention in South Africa, there is a need for more research. It would be particularly valuable to follow the example of Macy *et al.* (2004) by writing case studies of specific interventions as a basis for a comprehensive programme evaluation.

## Notes

## References

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